DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING 00 B. WING	07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF SCOTTSBURG, THE	1350 N TODD DR SCOTTSBURG, IN 47170

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00411472, IN00412043 and IN00412843. Complaint IN00411472 - No deficiencies related to the allegations are cited. Complaint IN00412043 - Federal/State deficiencies related to the allegations are cited at F550 and F609. Complaint IN00412843 - No deficiencies related to the allegations are cited. Survey dates: July 16, 17 and 18, 2023 Facility number: 000478 Provider number: 155494 AIM number: 100290430 Census Bed Type: SNF/NF: 71 Total: 71 Census Payor Type: Medicare: 2 Medicaid: 49 Other: 20 Total: 71 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 24, 2023.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melinda Hewitt	Administrator	08/14/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			

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	Based on observation, interview and record review, the facility failed to ensure a staff member did not videotape a resident, without the resident/resident representative permission, for 1 of 3 residents reviewed for resident rights. (Resident B) Findings include: The clinical record for Resident B was reviewed on 7/17/23 at 10:38 a.m. The diagnoses included, but were not limited to, dementia with other behavioral disturbance, senile degeneration of the brain and Alzheimer's disease. On 7/16/23 at 6:25 p.m., the resident was observed sitting in the dining room finishing his dinner meal. He showed no behaviors or psychosocial distress. The behavior note, dated 7/8/23 at 8:53 p.m., by LPN (Licensed Practical Nurse) 5 indicated Resident B would not move away from the medication cart, he followed the nurse to every resident room during medication pass, put trash from the floor on the medication cart, and paced back and forth in front of the nurse's station and/or medication cart. The resident presented the behaviors more frequently when this nurse was on shift. During an interview on 7/16/23 at 6:31 p.m., CNA (Certified Nursing Aide) 6 indicated she observed LPN 5 point her phone towards the resident, however, she could not tell if the nurse videotaped or took pictures. The resident had a different behavior when LPN 5 was around. The written statement from CNA 6, dated 7/9/23 and untimed, indicated at around 6:30 p.m. on	F 0550	Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 10, 2023. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after August 10, 2023. F0550 It is the policy of this facility to promote an environment of Respect and Dignity. All residents have the potential to be negatively impacted by this deficient practice. Resident B was assessed and had no negative outcome. Licensed Nurse #5 left at beginning of shift on date of allegation and was terminated from employment. All staff were in-serviced on the following policies , Dignity, Resident Rights, Cell Phone	08/10/2023

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	7/9/23, LPN 5 took her phone out and appeared to video Resident B. The resident was by the nurse's station and within a few minutes, started to strip his pants and brief off. LPN 6 looked to be videotaping him. LPN 5 explained to CNA 6 that it needed to be known exactly how his behaviors were when she worked. On 7/17/23 at 12:15 p.m., LPN 9 indicated she had walked back on the unit to get a trash bag. LPN 5 showed her how she was recording Resident B so it would be known that Resident B was the problem and not her, since management wanted to move her off the unit. The written statement from LPN 9, dated 7/9/23 and untimed, indicated upon exiting the locked unit, LPN 5 walked over to LPN 9. LPN 5's phone was in recording mode. LPN 5 told LPN 9 that she was going to show them that "it was the resident and not her" and "this was proof". The written statement from LPN 4, undated and untimed, indicated LPN 5 told her she recorded the resident on her phone for the purpose of showing management that she'd had enough of the resident's behavior. On 7/17/23 at 1:24 p.m., the Director of Nursing (DON) indicated LPN 13 notified her on 7/9/23 that LPN 5 had videotaped Resident B. She called LPN 5 to ask her about it and tell her she could not do that. When LPN 5 got on the phone, she told her she could not videotape the resident. LPN 5 responded, "yes I can". She again told LPN 5 that she could not. LPN 5 again stated "yes I can". LPN 5 then handed the to phone to DNA 6 who reported to the DON that it appeared LPN 5 videotaped the resident. She had told LPN 5 that she could work one of the other halls to give her a		Policy, Social Media Policy, Abuse, by the Administrator or designee by 8/10/2023. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. The Administrator or designee will utilize QAPI tool entitled "Dignity, Resident Rights, Cell Phone Policy, Social Media Policy, Abuse." Auditing will be completely daily in morning clinically meeting for a period of 6 months. Any concerns noted will be immediately addressed and corrected. Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plans will be written by the QAPI Committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. Monitoring will continue for a period of six months. If there are no concerns identified, monitoring will discontinue at that time. If concerns are identified, monitoring will continue for an additional 3 months.	

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	break from the dementia unit and she declined. During an interview on 7/17/23 at 12:00 p.m., CNA 7 indicated it was against facility policy to videotape or take pictures of residents. On 7/18/23 at 2:30 p.m., the Executive Director provided an undated, current copy of the document titled "Resident Rights". It included, but was not limited to, "As a resident of this facility, you have the right to ad dignified existence...This facility will protect your rights...Quality of Life...The facility must care for you in a manner...that enhances or promotes your quality of life...Dignity...The facility will treat you with dignity and respect in full recognition of your individuality...." This Federal tag relates to Complaint IN00412043 3.1-3(a)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the			

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	administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility administration failed to report an incident to the Indiana Department of Health, in a timely manner, when a staff member videotaped the resident (Resident B) without the consent of the resident/resident representative for 1 of 6 facility reported incidents. Findings include: The clinical record for Resident B was reviewed on 7/17/23 at 10:38 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia with behavioral disturbance and senile degeneration of the brain. The incident report, dated 7/17/23, indicated on 7/9/23 at 6:30 p.m. staff reported an allegation that LPN (Licensed Practical Nurse) 5 took videos of a male resident (Resident B). During an interview on 7/16/23 at 6:31 p.m., CNA (Certified Nursing Aide) 6 indicated on 7/9/23, she witnessed LPN 5 with her personal phone pointed towards Resident B. She claimed she did not know	F 0609	Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 18, 2023. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after August 18, 2023.	08/18/2023

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	how to work the phone, however, LPN 5 said she was doing it so Resident B would change his behavior. The day shift nurse witnessed (LPN 9) the incident and reported it to another nurse (LPN 13). It was against facility policy to videotape or take pictures of any resident. During an interview on 7/17/23 at 12:15 p.m., LPN 9 indicated at the end of her shift on 7/9/23, she walked back on the dementia unit to get a trash bag as that was where they were kept. LPN 5 had her phone on and showed LPN 9 how she was recording Resident B to prove to management that the resident was the problem, not her, since management wanted to move her off the unit. LPN 9 left the unit and reported the incident to LPN 13 who then called the DON (Director of Nursing). During an interview on 7/17/23 at 1:24 p.m., the DON indicated she had received a call from the night shift nurse (LPN 13) and was told LPN 5 videotaped Resident B. She then called LPN 5 and told her she could not do that. LPN 5 told the DON "yes I can". The DON again told LPN 5 she could not do that and, again LPN 5 responded "yes I can" at which time she handed the phone to CNA 6. CNA 6 told her at that time that it appeared as though LPN 5 videotaped the resident. She reported the incident to the ED (Executive Director) on the morning on 7/10/23. During an interview on 717/23 at 1:30 p.m., the ED indicated LPN 5 told her she attempted to take a picture of a soiled brief that the resident had placed on top of the water pitcher on the medication cart. LPN 5 told the ED she did not take a video or picture. At 4:47 p.m., the ED indicated she did not report the incident, as she was told LPN 5 took a picture of a brief and not a resident. She was just informed last night about a		F609 It is the policy of this facility to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately. All residents have the potential to be negatively impacted by this deficient practice. The Administrator and DON were inserviced by the Regional Director of Operations. All staff were in-serviced on the following policies, Reporting of Alleged Violations and Abuse, by the Regional Director of Operations by 8/18/2023. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. The Regional Director of Operations will utilize QAPI tool entitled “Reporting of Alleged Violations and Abuse” Any concerns noted will be immediately addressed and corrected. Auditing will be completed daily in morning clinical meeting Monday through Friday for 6 months. If no concerns are identified, monitoring will be discontinued at this time. If concerns are identified, monitoring will continue for an additional 3 months.	

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	possible video. During an interview on 7/18/23 at 3:20 p.m., the Regional Nurse Consultant indicated the facility followed the Indiana Department of Health incident reporting guidelines. On 7/18/23 at 3:23 p.m., the Regional Nurse Consultant provided a current, undated copy of the document titled "Accident Incident Reporting Policy". It included, but was not limited to, "Purpose...To ensure that...incidents that occur with residents are...reported, investigated, and resolved...." This Federal tag relates to Complaint IN00412043 3-1.28(c)		Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plans will be written by the QAPI Committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	