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	05/25/2022

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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 IN00377613, IN00377290 and IN00377396. Complaint IN00377613 - Substantiated - Federal/State deficiencies related to the allegations are cited at F677, F692, and F657. Complaint IN00377290 - Substantiated - Federal/State deficiencies related to the allegations are cited at F677 and F657 Complaint IN00377396 - Substantiated - Federal/State deficiency related to the allegation is cited at F677. Survey dates: May 24 and 25, 2022. Facility number: 000478 Provider number: 155494 AIM number: 100290430 Census Bed Type: SNF/NF: 58 Total: 58 Census Payor Type: Medicare: 3 Medicaid: 41 Other: 14 Total: 58 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on June 2, 2022.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to ensure care plans were revised to reflect interventions for significant weight loss for 4 of 8 residents reviewed for care plan revision. (Residents B, H, F and C) Findings include: 1. The clinical record for Resident B was	F 0657	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. The plan of correction is prepared and executed solely because federal	06/17/2022

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	reviewed on 5/24/21 at 10:48 a.m. The diagnoses included, but were not limited to, malignant neoplasm of bronchus and lung, dementia, schizoaffective disorder, liver disease, acute kidney disease, and chronic obstructive pulmonary disease The Quarterly MDS (Minimum Data Set) assessment, dated 2/2/22, indicated the resident was severely cognitively impaired. He required total dependence with bathing and personal hygiene with the assistance of one staff member. The care plan, dated 6/14/13 and last revised on 4/20/21, indicated the resident was on a pureed diet and had a weight loss related to poor intake. The interventions included, but were not limited to, cheeseburger at dinner, grilled cheese at lunch, monitor food and fluid intake, chocolate milk with all meals monitor weight per facility protocol, MVI (multi vitamin) per physician's order, refer to guardian and physician as needed, refer to RD (Registered Dietician) as needed, remeron per order for appetite stimulant, serve diet as ordered (regular diet/thin liquids), diet condiments, peanut butter sandwich at 2:00 p.m. and at bedtime, will eat sherbert, and likes strawberry ice cream. The care plan, dated 4/20/21, indicated Resident B was at risk for weight loss related to decline in overall health related to lung cancer and poor intakes. Interventions include, but were not limited to, diet as ordered, notify physician and family as needed, offer substitutions if indicated, and Registered Dietician as needed. The physician's orders indicated the following:		and state law require it. Compliance has been and will be achieved no later than, the last completion date identified in the POC. Compliance will be maintained as provided in the plan of correction. Failure to dispute or challenge the alleged deficiency below is not an admission that the alleged facts occurred as presented in the statements. This report in its entirety has been reviewed by our quality Assurance Committee. **F657 Timing and Revision of Care Plans** 1. On 5/25/22 the dietitian completed a dietary assessment On 5/25/22 the intradisciplinary team reviewed resident B's plan of care and revised the care plan to include actual weight loss and interventions were updated on the care plan to address individualized interventions for weight loss. On 5/25/22 the dietitian completed a dietary assessment On 5/25/22 the intradisciplinary team reviewed resident H's plan of care and revised the care plan to include actual weight loss and interventions were updated on the care plan to address	

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	- A frozen nutritional treat with a start date of 2/3/22. - General diet mechanical soft texture and thin consistency with a start date of 4/27/22. - Health shake three times a day between meals and at bedtime with a start date of 2/3/22. - Double protein three times a day for weight monitoring with a start date of 3/18/22. - Med pass 2.0 90 ml (milliliter) three times day for supplement with a start date of 1/26/22. - Mirtazpine 15 mg (milligram) by mouth at bedtime for appetite stimulant with a start date of 2/24/22. On 4/1/22 the resident weighed 117.2. lbs, which was a - (negative) 14.45 % (percent) weight loss from his prior weight of 137.0 on 12/13/22. The clinical record lacked documentation of any revision to the resident's care plan to address actual weight loss and nutritional assessments. 2. The clinical record for Resident H was reviewed on 5/25/22 at 9:48 a.m. The diagnoses included, but were not limited to, dementia, lobar pneumonia, aphasia, hypertension, anxiety disorder, vitamin deficiency, and abnormal weight loss. The Quarterly MDS assessment, dated 1/31/22, indicated the resident was rarely or never understood. She required total dependence with bathing and personal hygiene with the assistance of one to two staff members assistance. The resident had a history of holding food in her mouth or cheek with residual food in her mouth after meals. The physician's order, dated 1/1/22, indicated the resident received a general diet, pureed texture		individualized interventions for weight loss. On 5/25/22 the dietitian completed a dietary assessment On 5/25/22 the intradisciplinary team reviewed resident C's plan of care and revised the care plan to include actual weight loss and interventions were updated on the care plan to address individualized interventions for weight loss On 5/25/22 the dietitian completed a dietary assessment On 5/25/22 the intradisciplinary team reviewed resident F's plan of care and revised the care plan to include actual weight loss and interventions were updated on the care plan to address individualized interventions for weight loss *(For future reference the intradisciplinary team consists of at least three of the following team members: Director of Nursing, Assistant Director of Nursing, Dietitian, Dietary staff, Licensed and Certified Nursing, MDS Coordinator, Administrator, Physician/Physician extender, Therapy, Social Services, and*	

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	with thin liquids consistency. The care plan, dated 7/16/18 and revised on 11/15/21, indicated the resident received a puree consistency thin liquids diet. The interventions included, but were not limited to, diet per order, monitor meal consumption od all meals, monitor weight, notify physician as needed, observe for chewing and or swallowing problems, offer substitutions when resident consumes 50% or less of meal, refer to speech therapy as needed. On 12/13/21 the resident weighed 125.2 lbs, on 1/7/22 120.0 lbs, on 4/4/22 108.0 lbs, and on 5/7/22 115.0 lbs with a -8.15% loss. The nurse's note, dated 12/28/2021 at 4:09 p.m., indicated the resident continued the need for skilled care based on her level of current condition. She received speech therapy services related to swallowing difficulties, dysphagia. The resident was on an antibiotic for aspiration pneumonia. She ate 75% of her breakfast and about 50% at lunch time. She was assisted with her meals per staff. She would feed self at times, but not often. She received pureed diet and fluids were encouraged. The nurse's note, dated 1/2/2022 at 2:35 a.m., indicated the resident continued with daily skilled charting related to aspiration pneumonia. The resident received speech therapy services related to chewing and swallowing difficulties. She generally did not consume food this shift. The resident received a pureed diet. The clinical record lacked documentation of any revision to the resident's care plan to address actual weight loss and nutritional assessments.		*Activities).* 2. On 5/25/22, the dietitian reviewed monthly weights to identify all residents with significant weight loss. On 6/1/22 residents residing within the facility were reviewed by the intradisciplinary team during the S.W.A.T (Skin and Weight) to ensure appropriate nutritional assessments were completed and that each resident's care planned addressed triggered weight losses of 5% in 30 days, 7.5% weight loss in 90 days and 10% weight loss in 180 days. Care plans were revised to include individualized interventions for weight loss. 3. On 6/1/22, the Executive Director -initiated re-education with the intradisciplinary team regarding the components of F657 with a focus on individualized care plans for weight loss and completion of nutritional assessments. The process for completing wound and weight SWAT meetings were also reviewed during this in-service. Participants were required to complete a Post test for competency. On 6/1/22, the Executive Director	

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	During an interview on 5/25/22 at 11:40 a.m., LPN 3 (Licensed Practical Nurse) indicated the care plan should have been updated and revised when there was a change in the resident's condition or a change in an order. During an interview on 5/25/22 at 1:03 p.m., the MDS Coordinator indicated if a resident had a weight loss of 5% in 30 days a weight loss the care plan should have been started or revised. If a resident was starting to lose weight, but not 5% a potential for weight loss care plan should have been added to the care plan. A care plan would be added if there was a change in condition and reviewed quarterly. For weight loss the resident would be monitored for the underlying cause like dental issues, medications, intake swallowing and chewing issues. A change in the care plan would be when the event occurred. 3. The clinical record for Resident C was reviewed on 5/24/22 at 10:30 a.m. The diagnoses included, but were not limited to, adrenocortical insufficiency, cerebral palsy, mood disorder, anoxic brain injury, dysphagia, major depressive disorder, contracture of right elbow, contracture of right knee, seizures, hemorrhoids, localized edema, constipation, contracture, insomnia, abnormal posture, aphasia, frontotemporal dementia, allergic rhinitis, and disorder of adult personality and behaviors. The Annual MDS assessment, dated 2/22/22, indicated the resident was moderately cognitively impaired, and there was no significant weight loss. The care plan, dated 7/6/21, indicated the resident had a potential for weight loss due to poor intakes, and refusal of some meals. The interventions included, but were not limited to,		and Director of Nursing reviewed the procedure for "S.W.A.T (Skin and weight loss meeting) "and found the policy to be acceptable. The intradisciplinary team is responsible for completing weekly wound and weight meetings. This team is lead by the Dietitian or Administrative Nursing staff each week. *(Facility Intradisciplinary team members will not be allowed to work after the date of compliance unless they have successfully completed all assigned education).* 4. On 6/1/22, a **Care Plan and Nutritional Weight Loss Quality Review Tool** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. (*For future reference the QAPI Committee consists of the Medical Director, Director of Nursing and at least two of the following team members: administrator, assistant director of nursing, licensed nursing staff, certified nursing staff, therapy, activities, dietary staff, social services, MDS coordinators, maintenance, business office manager, human resources, and*	

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	diet as ordered, notify physician and family as needed, offer substitutions if indicated, Registered Dietician as needed, and snacks upon request. The weights summary indicated, on 2/9/22, the resident weighed 128.5 lbs. On 3/31/22, the resident weighed 115.8 lbs, which was a 9.88% weight loss from her prior weight on 2/9/22. On 5/23/22, the resident weighed 104.2 lbs, which was a 18.91% loss from her weight on 2/9/22, and a 10.02% weight loss from her weight on 3/31/22. The clinical record lacked documentation of any revision to the resident's care plan to address her actual weight loss. 4. The clinical record for Resident F was reviewed on 5/25/22, at 1:36 p.m. The diagnoses included, but were not limited to, irritable bowel syndrome with constipation, dementia, gastro-esophageal reflux disease (GERD), type 2 diabetes mellitus, dysphagia, cognitive communication deficit, aphasia, weakness, vitamin deficiency, and chronic fatigue. The Quarterly MDS assessment, dated 3/31/22, indicated the resident was moderately cognitively impaired and she had a weight loss of 5% or more within the last month or 10% or more within the last 6 months without a physician prescribed weight loss program. The Quarterly Nutritional Risk Review, dated 1/26/22, indicated the resident had no weight loss and was stable at 181 lbs with a BMI of 31		*housekeeping staff).* The Director of Nursing/Designated Administrative Nursing staff will complete care plan and weight loss reviews using the **Care Plan and Nutritional Weight Loss Quality Review Audit Tool**, to validate that resident who are identified as having weight loss have accurate nutritional assessments and care plan interventions to meet residents individual needs related to weight loss. Any concerns identified during the **quality reviews** will be addressed at the time of the review and additional education will be completed at that time. The **Care Plan and Nutritional Weight Loss Quality Review Audit** will be completed once a week for all identified residents "with 5 % weight loss in 30 days, 7.5% weight loss in 90 days and 10% weight loss in 180days" for twelve weeks. These audits will include all residents identified with triggered weight loss. The results of the **Audits** will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Following the initial twelve-week review, Audits will continue twice a month for all at risk residents until 100%	

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	which was desirable for her age. Her current diet order was a general diet and mechanical soft with pureed meats per resident request. No new recommendations were given. On 2/7/22, the resident weighed 170.6 lbs, which was a weight loss of 5.27 %. On 3/31/22, the resident weighed 152.6 lbs, which was a weight loss of 15.27% from her weight on 1/30/22, and a weight loss of 10.55% from her weight on 2/7/22. On 5/4/22, the resident weighed 144 lbs, which was a weight loss of 20.04% from her weight on 1/30/22. The clinical record lacked documentation of any revision to the resident's care plan to address her actual weight loss or any nutritional interventions. A current care plan policy was provided by the Executive Director on 5/25/22 at 11:13 a.m., and included, but was not limited to, "...9. The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum. The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psycho-social issues..." This Federal tag relates to Complaints IN00377290 and IN00377613. 3.1-35(2)(B)		compliance has been determined by the QAPI committee. *(A minimum of seven months must be completed).*	
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to			

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	carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview and record review, the facility failed to ensure showers were provided for dependent residents for 4 of 8 residents reviewed for Activities of Daily Living (ADLs). (Residents C, E, B, F, and H) Findings included: 1. The clinical record for Resident B was reviewed on 5/24/22 at 10:00 a.m. The diagnoses included, but were not limited to, malignant neoplasm of bronchus and lung, dementia, schizoaffective disorder, liver disease, acute kidney disease, and chronic obstructive pulmonary disease The Quarterly MDS (Minimum Data Set) assessment, dated 2/2/22, indicated the resident was severely cognitively impaired. He required total dependence with bathing and personal hygiene with the assistance of one staff member. The care plan, dated 6/1/13, indicated the resident required assistance with ADL's (Activities of Daily Living). The interventions included, but were not limited to, assist as needed so resident was clean and dry, assist with personal hygiene and bathing, encourage resident to complete as much as they were able, shampoo per order, and assist as needed for transfers with the assistance of one staff member. The resident's shower records for April and May indicated the following: - The resident received one shower on 4/29/22.	F 0677	**F677 ADL Care provided to Dependent Residents** 1. On 5/25/22 Resident B was provided a shower by certified staff. On 5/25/22 Resident H was provided a shower by certified staff. On 5/26/22 Resident C was provided a shower by certified staff. On 5/26/22 Resident E was provided a shower by certified staff. *(For future reference the intradisciplinary team consists of at least three of the following team members: Director of Nursing, Assistant Director of Nursing, Dietitian, Dietary staff, Licensed and Certified Nursing, MDS Coordinator, Administrator, Physician/Physician extender, Therapy, Social Services, and Activities).*	06/17/2022

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	- The only documented refusals of showers was on 4/4/22. The clinical record lacked documentation the resident received any other showers for the months of April 1 thru April 28, 2022, and May 1 thru May 23, 2022. During an interview on 5/24/22 at 9:45 a.m., CNA (Certified Nurse Aide) 2 indicated she had a list of showers for the day, and she would give bed baths to the residents that were not scheduled for a shower. If a resident refused a shower, she would approach the resident later, and they usually would take their shower. She indicated staffing was good on her shifts. She was able to get her work done. 2. The clinical record for Resident H was reviewed on 5/25/22 at 9:48 a.m. The diagnoses included, but were not limited to, dementia, lobar pneumonia, aphasia, hypertension, anxiety disorder, vitamin deficiency, and abnormal weight loss. The Quarterly MDS assessment, dated 1/31/22 indicated the resident was rarely or never understood. She required total dependence with bathing and personal hygiene with the assistance of one staff member. The care plan, dated 7/17/18, indicated the resident requires assistant with ADL's. The interventions included, but were not limited to, assist as needed so the resident was clean and dry, bathe per resident preference 2 times a week and as needed, encourage resident to complete as much as they are able, keep call light within reach, notify physician as needed, and staff to assist as needed with eating.		2. On 5/26/22, the Assistant Director of Clinical Services identified residents residing in the facility that require assistance with showers and activities of daily living. Each resident identified was offered a shower. The shower schedule was reviewed and revised if indicated based on individual resident preference. 3. On 5/26/22, the Administrative Nursing staff -initiated re-education with licensed and certified staff regarding completion of showers and documentation of showers including documentation of any refusals of care. Each participant will be required to complete a post test for competency. On 5/27/22, the Executive Director and Director of Nursing reviewed the procedure for “completing showers “and found the policy to be acceptable. Licensed and certified nursing staff are responsible for following the shower schedules and documenting care that is received under the supervision of the Director of Nursing. *(Facility licensed and certified staff and agency staff will not be allowed to work after the date of*	

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	The resident's shower records for April and May indicated the following: - The resident received only one shower on 4/25/22. - The resident received no showers the month of May. There were no documented refusals of showers. The clinical record lacked any other documentation the resident received a shower for the months of April 1 thru April 25, 2022, and May 1 thru May 23, 2022. 3. The clinical record for Resident C was reviewed on 5/24/22 at 10:00 a.m. The diagnoses included, but were not limited to, cerebral palsy, anoxic brain damage, major depressive disorder, contractures of the right elbow and right knee, abnormal posture, frontotemporal dementia, and disorder of adult personality and behavior. The Annual MDS assessment, dated 2/22/22, indicated the resident was moderately cognitively impaired, required extensive assist of 2 staff with personal hygiene, and was totally dependent of two staff members for bathing. The care plan, dated 3/20/15, last revised 8/3/21, indicated the resident required assistance with ADL's related to diagnoses of anoxic brain injury and cerebral palsy and as of 3/7/22 may refuse showers. Interventions included, but were not limited to, assist as needed so resident was clean and dry, bathe per preference, see shower schedule, encourage resident to complete as much as they are able, lotion to skin after showers, offer a partial bath if she refuses her shower, resident is assist of 2 staff with ADL's,		*compliance unless they have successfully completed all assigned education).* 4. On 6/1/22, a **Shower and ADL Assistance Quality Review Tool** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. (*For future reference the QAPI Committee consists of the Medical Director, Director of Nursing and at least two of the following team members: administrator, assistant director of nursing, licensed nursing staff, certified nursing staff, therapy, activities, dietary staff, social services, MDS coordinators, maintenance, business office manager, human resources, and housekeeping staff).* The Director of Nursing/Designated Administrative Nursing staff will complete the quality review to validate that assistance with ADLs are provided and documented for dependent residents-including showers using the **Shower and ADL Assistance Quality Review Audit Tool**. Any concerns identified during the **quality reviews** will be addressed at the time of the review and additional education will be completed at that time. The **Shower and ADL**	

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	and staff may use total body mechanical lift x 2 as needed for transfers. The shower schedule indicated the resident was supposed to receive showers twice weekly on evening shifts on Tuesdays and Fridays. The resident's shower records for April indicated the following: - The resident did not receive any showers in April. - The only documented refusals of showers were for April 12, 16, 19, and 26, 2022. There was no documentation of any showers, bed baths, or refusals of either for April 1 thru April 11, 2022, April 13 thru April 15, 2022, or April 20 thru 25, 2022. The resident's shower records for May indicated the following: - The resident only received showers on May 2 and May 17, 2022. On May 10, 2022, the resident received a complete bed bath. - The only documented refusals of showers was on May 4, 2022. There was no documentation of any showers, bed baths, or refusals of either for May 5 thru May 9, 2022, May 11 thru May 16, 2022, or May 18 thru May 22, 2022. 4. The clinical record for Resident E was reviewed on 5/25/22 at 9:55 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), interverterbral disc degeneration, lumbosacral region, bilateral primary osteoarthritis of knee,		**Assistance Quality Review Audit** will be completed once a week for all identified residents identified as needing assistance with showers for twelve weeks. These audits will include all residents identified with triggered weight loss. The results of the **Audits** will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Following the initial twelve-week review, Audits will continue twice a month for all at risk residents until 100% compliance has been determined by the QAPI committee. *(A minimum of seven months must be completed).*	

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	155494	A. BUILDING 00 B. WING	05/25/2022

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	generalized anxiety disorder, weakness, difficulty in walking, recurrent depressive disorders, chronic pain, muscle spasm, and myositis. The Quarterly MDS assessment, dated 3/10/22, indicated the resident was cognitively intact and required supervision with one staff member's physical assistance with personal hygiene and bathing. The care plan, dated 10/12/18, indicated the resident may refuse showers. Interventions included, but were not limited to, shower per preference, re-approach, offer bed bath or partial bed bath. The shower schedule, indicated the resident was to receive showers twice weekly on day shift, on Tuesdays and Fridays. The resident's shower records for April indicated the following: - The resident only received one shower on April 23, 2022. - The only documented refusals of showers were for April 12 and 26, 2022. - The shower sheet, dated 4/26/22 indicated the resident had refused his shower because he wanted to wait for different staff to come in later and provide his shower, there was no follow up documentation of the shower being completed. There was no documentation of any showers, bed baths, or refusals of either for April 1 thru April 11, 2022, April 13 thru April 25, 2022, or April 27 thru April 30, 2022. The resident's shower records for May indicated			

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	the following: - The resident only received showers on May 8 and May 20, 2022. - There were no documented refusals of showers for the Month of May. There was no documentation of any showers, bed baths, or refusals of either for May 1 thru May 7, 2022, May 9 thru May 19, 2022, or May 21 thru May 23, 2022. 5. The clinical record for Resident F was reviewed on 5/25/22 at 10:30 a.m. The diagnoses included, but were not limited to, dementia, muscle weakness, lack of coordination, cognitive communication deficit, difficulty in walking, weakness, other abnormalities of gait and mobility, osteoarthritis, and chronic fatigue. The Quarterly MDS assessment, dated 3/31/22, indicated the resident was moderately cognitively impaired, and required extensive assistance of one staff member with personal hygiene, and was totally dependent of one staff member with bathing. The care plan, dated 7/9/18, indicated the resident required assistance with ADL's. The interventions included, but were not limited to, bathe per resident preference 2 times weekly and as needed. The shower schedule, indicated the resident was to receive showers twice weekly on day shift (Mondays and Thursdays). The resident's shower records for April indicated the following:			

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	- The resident only received showers on April 7, 11, 18, 19, 21, and 28. - The only documented refusals of showers were for April 14, however she had a complete bed bath. There was no documentation of any showers, bed baths, or refusals of either for April 1 thru April 6 or April 22 thru April 27. The resident's shower records for May indicated the following: - The resident only received showers on May 2, 4, 17, and 19. - There were no documented refusals of showers for the Month of May. There was no documentation of any showers, bed baths, or refusals of either for May 5 thru May 16, or May 20 thru May 24. During an interview on 5/25/22 at 10:28 a.m., CNA 5 indicated she did not always have time to complete all of her work, and did not always have enough time to completed showers. Sometimes the resident's would refuse their shower or they would go on smoke breaks and then they could not get them done. Sometimes night shift would catch the showers up for day shift. During an interview on 5/25/22 at 10:33 a.m., LPN (Licensed Practical Nurse) 6 indicated she asked her CNA's daily if they got their showers done. If a shower wasn't done she wanted to know why and would chart a refusal or see if the resident wanted to take their shower later. During an interview on 5/25/22 at 1:24 p.m., the ADON (Assistant Director of Nursing) indicated			

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	she was working on revamping the shower schedules to fit the resident's preferences a little bit better. It was a lengthy process to make it all work. She was not aware of any issues with showers being completed, but had been talking to staff about filling out the shower sheets. If a resident refused their shower she would like them to offer it three different times, have the nurse go in if the resident refused, and offer a shower or bed bath. If they still refused with the nurse then she would like them to try to get anything, a partial bed bath or something. She would really like them to notify family if they continued to refuse. The current shower schedule had most residents getting a bath twice weekly, and some three times a week. Staff should be documenting it on their shower days. She was trying to start a process and get things put into place and was lucky she found the shower sheets that she did, because there were piles everywhere. She had seen Resident B's shower sheets reflected he only had one shower in 30 days. The most current Bathing policy, provided on 5/25/22 at 1:41 p.m. by the Executive Director, included, but was not limited to, "... Policy: To cleanse the skin and to promote circulation... Procedure... 1. Verify bath schedule or need... Bed Bath... Complete Bath- Involves washing resident's entire body... Partial Bath- Involves face, hands, underarms, perineum, back and buttocks (assistance as needed)..." This Federal tag relates to Complaints IN00377396, IN00377613, and IN00377290. 3.1-38(a)(2)			

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F 0692 SS=E Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to ensure resident's with significant weight loss were assessed by the Registered Dietician and interventions were implemented to prevent further weight loss for 4 of 8 residents reviewed for nutrition. (Residents C, F, B and H) Findings include: 1. The clinical record for Resident C was reviewed on 5/24/22 at 10:30 a.m. The diagnoses included, but were not limited to, adrenocortical insufficiency, cerebral palsy, mood disorder,	F 0692	p paraid="1569147352" paraeid="{e33e45ad-e65f-4587-8fd9-84aed5f8b846}{227}" >F692 Nutrition/Hydration Status Maintenance On 5/25/22 the dietitian completed a dietary assessment on resident C. On 5/25/22 the intradisciplinary	06/17/2022

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	anoxic brain injury, dysphagia, major depressive disorder, contracture of right elbow, contracture of right knee, seizures, hemorrhoids, localized edema, constipation, contracture, insomnia, abnormal posture, aphasia, frontotemporal dementia, allergic rhinitis, and disorder of adult personality and behaviors. The Annual MDS (Minimum Data Set) assessment, dated 2/22/22, indicated the resident was moderately cognitively impaired, and indicated the resident did not have any significant weight loss. The care plan, dated 7/6/21, indicated the resident had a potential for weight loss due to poor intakes, and refusal of some meals. Interventions included, but were not limited to, diet as ordered, notify physician and family as needed, offer substitutions if indicated, Registered Dietician (RD) as needed, and snacks upon request. The Annual Nutrition Review, dated 2/22/22, indicated the resident weighed 130 lbs (pounds) with a BMI (Body Mass Index) that was 20.2 which was specified as within normal limits. Weight gain was beneficial for the resident. Her current diet orders were general diet, mechanical soft, grilled cheese twice daily. Her average intake was approximately 81% of meals, 95% of bedtime snacks, and no additional nutritional interventions were necessary at the time. The weights summary indicated on 2/9/22 the resident weighed 128.5 lbs. On 3/31/22, the resident weighed 115.8 lbs, which was a 9.88% weight loss from her prior weight on 2/9/22.		team reviewed resident C's plan of care and revised the care plan to include actual weight loss and interventions were updated on the care plan to address individualized interventions for weight loss. On 5/25/22 the dietitian completed a dietary assessment on resident F. On 5/25/22 the intradisciplinary team reviewed resident F's plan of care and revised the care plan to include actual weight loss and interventions were updated on the care plan to address individualized interventions for weight loss. On 5/25/22 the dietitian completed a dietary assessment on resident B. On 5/25/22the intradisciplinary team reviewed resident B's plan of care and revised the care plan to include actual weight loss and interventions were updated on the care plan to address individualized interventions for weight loss On 5/25/22 the dietitian completed	

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	On 5/23/22, the resident weighed 104.2 lbs, which was a 18.91% loss from her weight on 2/9/22, and a 10.02% weight loss from her weight on 3/31/22. The Quarterly Nutritional Risk Review, dated 4/22, lacked any documentation, and was left blank. The April Nutritional Risk Quarterly Review lacked any documentation, the assessment was left blank. The clinical record lacked documentation of any nutritional assessments or interventions after the significant weight loss the resident experienced on 3/31/22 until 5/23/22. During an interview, on 5/25/22, the RD indicated residents should have a progress note within the month of them experiencing a significant weight loss (5% in 30 days or 10% in 6 months). Resident C should have had a progress note within the month of April and depending on her intakes had a nutritional interventions at that time. She did a nutritional assessment on the resident on March 31, 2022, and asked for a reweigh on the resident, and it took some time. The reweigh was not conducted until May 23, 2022, and it should have been conducted within the next few days and then she would follow up on her next facility visit. She would have done some kind of intervention had the weight been confirmed, but it was not. She would have done a note and figured out what kind of intervention needed to be put into place at that time. If a resident triggered for a significant weight loss, they should be weighed weekly, prior to a significant weight loss they should be		a dietary assessment on resident H. On 5/25/22 the intradisciplinary team reviewed resident H's plan of care and revised the care plan to include actual weight loss and interventions were updated on the care plan to address individualized interventions for weight loss (For future reference the intradisciplinary team consists of at least three of the following team members: Director of Nursing, Assistant Director of Nursing, Dietitian, Dietary staff, Licensed and Certified Nursing, MDS Coordinator, Administrator, Physician/Physician extender, Therapy, Social p paraid="237312697" paraeid="{fe401542-7fdd-4e02-a8ce-15815649530e}{129}" > Services, and Activities). On 5/25/22, the dietitian reviewed	

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	weighed monthly. She would have implemented weekly weights after the resident had a significant weight loss. 2. The clinical record for Resident F was reviewed on 5/25/22, at 1:36 p.m. The diagnoses included, but were not limited to, irritable bowel syndrome with constipation, dementia, gastro-esophageal reflux disease (GERD), type 2 diabetes mellitus, dysphagia, cognitive communication deficit, aphasia, weakness, vitamin deficiency, and chronic fatigue. The Quarterly MDS assessment, dated 3/31/22, indicated the resident was moderately cognitively impaired and had a weight loss of 5% or more within the last month or 10% or more within the last 6 months, without a physician prescribed weight loss program. The Quarterly Nutritional Risk Review, dated 1/26/22, indicated the resident had no weight loss and was stable at 181 lbs with a BMI of 31 which was desirable for her age. Her current diet order was a general diet, mechanical soft with pureed meats per resident request. No new recommendations were given. On 2/7/22 the resident weighed 170.6 lbs, which was a weight loss of 5.27 %. On 3/31/22, the resident weighed 152.6 lbs, which was a weight loss of 15.27% from her weight on 1/30/22, and a weight loss of 10.55% from her weight on 2/7/22. On 5/4/22, the resident weighed 144 lbs, which was a weight loss of 20.04% from her weight on 1/30/22.		monthly weights to identify all residents with significant weight loss. p paraid="1726709625" paraeid="{fe401542-7fdd-4e02-a8ce-15815649530e}{164}" >6/1/22 residents residing within the facility were reviewed by the intradisciplinary team during the S.W.A.T (Skin and Weight) to ensure appropriate nutritional assessments were completed and that each resident's care planned addressed triggered weight losses of 5% in 30 days, 7.5% weight loss in 90 days and 10% weight loss in 180 days. Care plans were revised to include individualized interventions for weight loss. On 6/1/22 the Executive Director -initiated re-education with the intradisciplinary team regarding the components of F657 with a focus on individualized care plans for weight loss and completion of nutritional assessments. The process for completing wound and weight SWAT meetings were also reviewed during this in-service.	

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	The clinical record lacked documentation of any nutritional assessments or interventions until 5/4/22. The SWAT (Skin and Weight Assessment Team) note for weight loss, dated 5/4/22, indicated the resident had a 5% weight change. The resident's diet was regular pureed with thin liquids. No new nutritional interventions were indicated aside from continue to monitor. Recommendations indicated to continue weekly weights. The Quarterly Nutritional Risk Review, dated 5/4/22, indicated the resident had a weight loss of more than 5% in the last month or 10% in the last six months and was not on a prescribed weight loss regimen. Her diet order was changed to pureed, however no further nutritional interventions were implemented at the time. During an interview, on 5/25/22 at 12:50 p.m., the RD indicated there was nothing on Resident F between December of 2021 and April of 2022. In December 2021, she had an annual assessment, but then she started that weight loss in December and further on until her present weight. She didn't see anything in between December and when she started as the RD in April. In April the resident's intake was slightly decreased, however she declined any additional interventions at that time. On 5/4/22 she saw the resident again and speech therapy changed her diet to pureed which might make it easier for her to eat, and since then her weight had come up. The resident should have had an assessment probably in January. Speech changed her diet to a puree diet. 3. The clinical record was reviewed for Resident H on 5/25/21, at 9:48 a.m., The diagnoses included, but were not limited to, dementia, lobar		Participants were required to complete a Post test for competency. On 6/1/22, the Executive Director and Director of Nursing reviewed the procedure for “S.W.A.T (Skin and weight loss meeting) “and found the policy to be acceptable. The intradisciplinary team is responsible for completing weekly wound and weight meetings. This team is lead by the Dietitian or Administrative Nursing staff each week. On 6/1/22 Residents with triggered weight loss were reviewed by the MDS Coordinator to determine if any of the identified residents required a significant change MDS. (Facility Intradisciplinary team members will not be allowed to work after the date of compliance unless they have successfully completed all assigned education). p paraid="1579190430" paraeid="{932541f0-8523-4168-b	

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	pneumonia, aphasia, hypertension, anxiety disorder, vitamin deficiency, and abnormal weight loss. The Quarterly MDS assessment, dated 1/31/22, indicated the resident was rarely or never understood. The resident had a history of holding food in her mouth or cheek or residual food in her mouth after meals. The assessment identified no significant weight loss. The physician's order, dated 1/1/22, indicated a general diet of pureed texture with thin liquids consistency. The care plan, dated 7/16/18 and revised on 11/15/21, indicated the resident received a puree consistency thin liquids diet. The interventions included, but were not limited to, diet per order, monitor meal consumption of all meals, monitor weight, notify physician as needed, observe for chewing and or swallowing problems, offer substitutions when resident consumes 50% or less of meal, refer to speech therapy as needed. On 12/13/21 the resident weighted 125.2 lbs, on 1/7/22 120.0 lbs, on 4/4/22 108.0 lbs, and on 5/7/22 115.0 lbs with a -8.15% loss. The clinical record lacked documentation of nutritional assessments after the date of 12/13/21 until 4/20/22 The dietary progress note, dated 4/20/22 at 11:20 a.m., a weight change review indicated the residents weight was 108 lbs on 4/4/22. Her BMI was 20.4 which was less desirable for her age. She had a significant weight loss of -10% x 90 days, 12.5% x 180 days. Her oral intake seemed to vary. Her current diet was pureed texture, thin		a92-3750c4075db5}{66}" > On 6/1/22 a Care Plan and Nutritional Weight Loss Quality Review Tool was reviewed and accepted by the Quality Assurance Performance Improvement Committee. (For future reference the QAPI Committee consists of the Medical Director, Director of Nursing and at least two of the following team members: administrator, assistant director of nursing, licensed nursing staff, certified nursing staff, therapy, activities, dietary staff, social services, MDS coordinators, maintenance, business office manager, human resources, and housekeeping staff).The Director of Nursing/Designated Administrative Nursing staff will complete care plan and weight loss reviews using the Care Plan and Nutritional Weight Loss Quality Review Audit Tool, to validate that resident who are identified as having weight loss have accurate nutritional assessments and care plan interventions to meet residents individual needs related to weight loss. Any concerns identified	

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	liquids with an inner lip plate and lidded cup. Oral intake of 76% providing 1,900 kcal, 72 g (grams) and protein + 35%. Bedtime snacks offered. The resident was reweighed to confirm a weight loss of -10& x 90 days and -12.5 x 180 days. 4. The clinical record was reviewed for Resident B, on 5/24/21 at 10:48 a.m., The diagnoses included, but were not limited to, malignant neoplasm of bronchus and lung, dementia, schizoaffective disorder, liver disease, acute kidney disease, and chronic obstructive pulmonary disease The Quarterly MDS (Minimum Data Set) assessment, dated 2/2/22, indicated the resident was severely cognitively impaired. He required total dependence with bathing and personal hygiene with the assistance of one staff member. The physician's order indicated a frozen nutritional treat with a start date of 2/3/22. General diet mechanical soft texture and thin consistency with a start date of 4/27/22. Health shake three times a day between meals and at bedtime with a start date of 2/3/22. Double protein three times a day for weight monitoring with a start date of 3/18/22. Med pass 2.0 90 ml (milliliter) three times day for supplement with a start date of 1/26/22. Mirtazpine 15 mg (milligram) by mouth at bedtime for appetite stimulant with a start date of 2/24/22. The care plan, dated 4/20/21, indicated Resident B was at risk for weight loss related to decline in overall health related to lung cancer and poor intakes. The interventions include, but were not limited to, diet as ordered, notify physician and family as needed, offer substitutions if indicated,		during the quality reviews will be addressed at the time of the review and additional education will be completed at that time. The Care Plan and Nutritional Weight Loss Quality Review Audit will be completed once a week for all identified residents “with 5 % weight loss in 30 days, 7.5% weight loss in 90 days and 10% weight loss in 180days” for twelve weeks. These audits will include all residents identified with triggered weight loss. The results of the Audits will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Following the initial twelve-week review, Audits will continue twice a month for all at risk residents until 100% compliance has been determined by the QAPI committee. (A minimum of seven months must be completed).	

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	05/25/2022

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

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	and Registered Dietician as needed. The care plan, dated 6/14/13 and revised on 4/20/21, indicated the resident was on a pureed diet and had a weight loss related to poor intake. Interventions included, but were not limited to, cheeseburger at dinner, grilled cheese at lunch, monitor food and fluid intake, chocolate milk with all meals, monitor wt per facility protocol, MVI (multi vitamin) per physician order, refer to guardian and physician as needed, refer to RD (Registered Dietician) as needed, remeron per order for appetite stimulant, serve diet as ordered- regular diet/thin liquids, diet condiments, peanut butter sandwich at 2:00 p.m. and at bedtime, will eat sherbert, and likes strawberry ice cream. On 4/1/22, the resident weighted 117.2. lbs, which was a -14.45 % weight loss from his prior weight of 137.0 on 12/13/22. The clinical record lacked documentation of documentation relating the the resident's nutritional assessments. The nutritional assessments were completed on 10/5/21 and 5/18/22. During an interview on 5/25/22 at 11:45 a.m., LPN 3 (Licensed Practical Nurse) indicated if a resident had a significant weight loss the nursing staff would inform the managers and the DON (Director of Nursing). The registered dietician would do a nutritional assessment. Supplements would be added, monitor intake and weights. Staff would assist the resident with eating or encourage the resident to eat. The resident would be added to SWAT for nutrition and weight loss. He indicated in the Point Click Care in the clinical record indicated if a resident had a 5%			

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	weight change in 30 days the computer would trigger the weight loss and management would be informed. During an interview on 5/25/22 at 11:55 a.m., RD indicated if there was a significant weight loss a nutritional assessment should have been done. The resident would be added to the SWAT management team. Meals would be monitored, and weights weekly. The nutritional assessments would be done quarterly unless there was a change in the resident's weight status. Resident H should have had a nutritional assessment and follow ups when there was a significant loss of 5% in 30 days, 7.5% in 90 days and 10% weight loss in 180 days. She should have had a nutritional assessment and interventions added in February. The most current S.W.A.T. Program (Skin and Weight Assessment Team) policy, provided on 5/25/22 at 1:37 p.m., by the Executive Director, included, but was not limited to, "... It is the policy of this facility to assess the nutritional status of each resident. SWAT is designed to aggressively review and address those residents exhibiting significant weight change or skin breakdown. These residents will be monitored through this team effort on a weekly basis, involving all applicable disciplines to best cater to the improvement of the resident's nutritional status... This team will appropriately determine clinical and dietary interventions to best address each resident's needs... Indicators determining implementation of SWAT monitoring... 5% or more weight change (undesirable) in 30 days... 10% or more weight change (undesirable) in 180 days..." This Federal tag relates to Complaint			

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