PRINTED: 06/17/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		155494	B. W	B. WING 05/25/2			/2022
				STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			TODD DR		
\ \\\ATEDG	S OF SCOTTSBUR	C THE			SBURG, IN 47170		
				30011			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
		he Investigation of Complaints	F 00	000			
	IN00377613, IN00	377290 and IN00377396.					
	G 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7(10, 0, 1,, 1,)					
		7613 - Substantiated - iencies related to the					
	allegations are cited	d at F677, F692, and F657.					
	Complaint INIO027	7290 - Substantiated -					
		iencies related to the					
		d at F677 and F657					
	anegations are enter	d at 10// and 105/					
	Complaint IN0037	77396 - Substantiated -					
		iency related to the allegation					
	is cited at F677.	ione, returne to the unegation					
	Survey dates: May	24 and 25, 2022.					
	, ,						
	Facility number: 0	00478					
	Provider number: 1	155494					
	AIM number: 100	290430					
	Census Bed Type:						
	SNF/NF: 58						
	Total: 58						
	Census Payor Type	2:					
	Medicare: 3						
	Medicaid: 41						
	Other: 14						
	Total: 58						
	These deficiencies	reflect State findings cited in					
	accordance with 41						
	accordance with 41	10 11 10.2-3.1					
	Quality review con	npleted on June 2, 2022.					
	Quality Teview Coll	inproceed on June 2, 2022.					
I	ı		I		ı		I

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000478

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

PRINTED: 06/17/2022 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î î	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155494	B. WING		05/25/2022
	ROVIDER OR SUPPLIER		STREE 1350 SCO		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 0657	483.21(b)(2)(i)-(iii)				
SS=E	Care Plan Timing				
Bldg. 00	_	ehensive Care Plans			
9 - 1		omprehensive care plan			
	must be-				
		in 7 days after completion			
	of the comprehens				
	•	n interdisciplinary team,			
	that includes but is	•			
	(A) The attending				
		urse with responsibility for			
	the resident.				
	(C) A nurse aide w	vith responsibility for the			
	resident.	, ,			
	(D) A member of fo	ood and nutrition services			
	staff.				
	(E) To the extent p	oracticable, the			
	participation of the	resident and the			
	resident's represe	ntative(s). An explanation			
	must be included i	n a resident's medical			
	record if the partic	ipation of the resident and			
	their resident repre	esentative is determined			
	not practicable for	the development of the			
	resident's care pla	n.			
	(F) Other appropri	ate staff or professionals			
	in disciplines as de	etermined by the resident's			
	needs or as reque	sted by the resident.			
	(iii)Reviewed and	revised by the			
	interdisciplinary te	am after each assessment,			
	-	comprehensive and			
	quarterly review as				
		and record review, the	F 0657	Preparation and execution of	this $06/17/2022$
	_	ure care plans were revised		plan of correction does not	
		ons for significant weight		constitute an admission of or	
		ents reviewed for care plan		agreement by the provider of	ihe
	revision. (Residents	B, H, F and C)		truth of the facts alleged or	
	Findings include:			conclusions set forth in the statement of deficiency. The p of correction is prepared and	olan
	1. The clinical recor	rd for Resident B was		executed solely because fede	ral

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OJOR11

Facility ID: 000478

If continuation sheet

Page 2 of 26

PRINTED: 06/17/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155494	B. W	ING		05/25/	2022
					-		
NAME OF F	ROVIDER OR SUPPLIER	<b>t</b>			ADDRESS, CITY, STATE, ZIP CODE		
					TODD DR		
WATERS	OF SCOTTSBUR	G, THE		SCOTT	SBURG, IN 47170		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	BROWINEDS BLANCE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	reviewed on 5/24/2	1 at 10:48 a.m. The diagnoses			and state law require it.		
		not limited to, malignant			Compliance has been and will	be	
	neoplasm of bronch	nus and lung, dementia,			achieved no later than, the las	t	
	schizoaffective disc	order, liver disease, acute			completion date identified in the	ne	
	kidney disease, and	chronic obstructive			POC. Compliance will be		
	pulmonary disease				maintained as provided in the	plan	
					of correction. Failure to disput	e or	
	The Quarterly MDS	S (Minimum Data Set)			challenge the alleged deficien	су	
	assessment, dated 2	/2/22, indicated the resident			below is not an admission that	t the	
	was severely cognit	tively impaired. He required			alleged facts occurred as		
	total dependence wa	ith bathing and personal			presented in the statements. I	his	
	hygiene with the as	sistance of one staff member.			report in its entirety has been		
					reviewed by our quality		
					Assurance Committee.		
	The care plan, dated	d 6/14/13 and last revised on					
		he resident was on a pureed					
	-	ht loss related to poor intake.					
		ncluded, but were not limited			F657 Timing and Revision of		
	_	dinner, grilled cheese at			Care Plans		
		l and fluid intake, chocolate					
		monitor weight per facility					
		lti vitamin) per physician's			1. On 5/25/22 the dietitian		
		dian and physician as needed,			completed a dietary assessme		
		ered Dietician) as needed,			On 5/25/22 the intradisciplinar	-	
	•	or appetite stimulant, serve			team reviewed resident B's pla		
	, -	ular diet/thin liquids), diet			care and revised the care plar		
	-	butter sandwich at 2:00 p.m.			include actual weight loss and		
		l eat sherbert, and likes			interventions were updated on	the	
	strawberry ice creat	m.			care plan to address		
					individualized interventions for	•	
	*	d 4/20/21, indicated Resident			weight loss.		
		eight loss related to decline in			0 5/05/00 !! !! !!!		
		ed to lung cancer and poor			On 5/25/22 the dietitian compl		
		ns include, but were not			a dietary assessment On 5/25	122	
	· ·	rdered, notify physician and			the intradisciplinary team		
	-	ffer substitutions if indicated,			reviewed resident H's plan of	care	
	and Registered Diet	tician as needed.			and revised the care plan to		
					include actual weight loss and		
	The physician's ord	ers indicated the following:			interventions were updated on	the	
			1		care plan to address		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OJOR11 Facility ID: 000478

If continuation sheet Page 3 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155494	B. W		<u> </u>	05/25/	
		100 10 1				00/20/	2022
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
					TODD DR		
WATERS	S OF SCOTTSBUR	G, THE		SCOTT	SBURG, IN 47170		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		nal treat with a start date of			individualized interventions fo	r	
	2/3/22.				weight loss.		
	- General diet mechanical soft texture and thin						
		start date of 4/27/22.					
		e times a day between meals			On 5/25/22 the dietitian comp		
		a start date of $2/3/22$ .			a dietary assessment On 5/25	5/22	
	_	ree times a day for weight			the intradisciplinary team		
	_	tart date of 3/18/22.			reviewed resident C's plan of	care	
	_	ml (milliliter) three times day			and revised the care plan to		
		n a start date of 1/26/22.			include actual weight loss and		
	-	g (milligram) by mouth at			interventions were updated or	n the	
		e stimulant with a start date of			care plan to address		
	2/24/22.				individualized interventions fo	r	
					weight loss		
		ent weighed 117.2. lbs, which					
	, -	4.45 % (percent) weight loss			On 5/25/22 the dietitian comp		
	from his prior weig	ht of 137.0 on 12/13/22.			a dietary assessment On 5/25	5/22	
					the intradisciplinary team		
		lacked documentation of any			reviewed resident F's plan of	care	
		lent's care plan to address			and revised the care plan to		
	actual weight loss a	and nutritional assessments.			include actual weight loss and		
					interventions were updated or	n the	
		rd for Resident H was			care plan to address		
		2 at 9:48 a.m. The diagnoses			individualized interventions fo	r	
		not limited to, dementia, lobar			weight loss		
		a, hypertension, anxiety					
		eficiency, and abnormal			(For future reference		
	weight loss.				intradisciplinary team consists	of	
					at least three of the following		
	•	S assessment, dated 1/31/22,			team		
		nt was rarely or never			members: Director of	f	
		quired total dependence with			Nursing, Assistant Director of		
		al hygiene with the assistance			Nursing, Dietitian, Dietary sta	ff,	
		members assistance. The			Licensed and		
		ry of holding food in her			Certified Nursing, ML	os	
	mouth or cheek with residual food in her mouth				Coordinator, Administrator,		
	after meals.				Physician/Physician extender	,	
	Th	1-4-11/1/22 : 1: 4 1.1			Therapy, Social		
		er, dated 1/1/22, indicated the			Services, and		
	resident received a	general diet, pureed texture			1		I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION X			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155494	B. W	NG		05/25/	/2022
				CTDEET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
\\/\TEDC	OF COOTTOBUD	C THE			TODD DR		
WATERS	S OF SCOTTSBUR	G, THE		SCOTT	SBURG, IN 47170		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	with thin liquids co	nsistency.			Activities).		
	_	d 7/16/18 and revised on					
		the resident received a puree			2. On 5/25/22, the dietitian		
		uids diet. The interventions			reviewed monthly weights to		
		not limited to, diet per order,			identify all residents with		
		imption od all meals, monitor			significant weight loss.		
		ician as needed, observe for					
	_	allowing problems, offer			On 6/1/22 residents residing		
		resident consumes 50% or			within the facility were reviewe	ed	
	less of meal, refer to	o speech therapy as needed.			by the intradisciplinary team		
					during the S.W.A.T (Skin and		
		sident weighed 125.2 lbs, on			Weight) to ensure appropriate	;	
		1 4/4/22 108.0 lbs, and on			nutritional assessments were		
	5/7/22 115.0 lbs wi	th a -8.15% loss.			completed and that each		
		. 1.12/20/2021 4.02			resident's care planned		
		ated 12/28/2021 at 4:09 p.m.,			addressed triggered weight lo		
		nt continued the need for			of 5% in 30 days, 7.5% weigh		
		on her level of current			loss in 90 days and 10% weig		
		ived speech therapy services			loss in 180 days. Care plans v		
		ng difficulties, dysphagia. The			revised to include individualize	ea	
		antibiotic for aspiration 275% of her breakfast and			interventions for weight loss.		
	1 ^	time. She was assisted with					
		She would feed self at times,			3. On 6/1/22, the Executive		
	_	eceived pureed diet and fluids			Director -initiated re-education	,	
	were encouraged.	ecorred purced diet and maids			with the intradisciplinary team	-	
	were encouraged.				regarding the components of		
	The nurse's note, da	ated 1/2/2022 at 2:35 a.m.,			F657 with a focus on		
		ent continued with daily			individualized care plans for		
		ated to aspiration pneumonia.			weight loss and completion of		
	_	ed speech therapy services			nutritional assessments. The		
		and swallowing difficulties.			process for completing wound	l and	
		ot consume food this shift.			weight SWAT meetings were		
	The resident receive				reviewed during this in-service		
		-			Participants were required to		
	The clinical record	lacked documentation of any			complete a Post test for		
	revision to the resident's care plan to address				competency.		
		and nutritional assessments.					
					On 6/1/22, the Executive Dire	ctor	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155494	B. WI			05/25/	
						00/20/	
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
					TODD DR		
WATERS	S OF SCOTTSBUR	G, THE		SCOTT	SBURG, IN 47170		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		v on 5/25/22 at 11:40 a.m.,			and Director of Nursing review		
	LPN 3 (Licensed Pr	ractical Nurse) indicated the			the procedure for "S.W.A.T (S	kin	
	care plan should ha	ve been updated and revised			and weight loss meeting) "and		
	when there was a cl	hange in the resident's			found the policy to be accepta	ble.	
	condition or a chan	ge in an order.			The intradisciplinary team is		
					responsible for completing we	ekly	
	During an interview	v on 5/25/22 at 1:03 p.m., the			wound and weight meetings. <sup>-</sup>		
	MDS Coordinator i	ndicated if a resident had a			team is lead by the Dietitian o		
	weight loss of 5% i	n 30 days a weight loss the			Administrative Nursing staff ea	ach	
	care plan should ha	ve been started or revised. If a			week.		
	resident was startin	g to lose weight, but not 5% a					
	potential for weight	loss care plan should have			(Facility Intradisciplinary team		
	been added to the c	are plan. A care plan would be			members will not be allowed t	0	
	added if there was a	a change in condition and			work after the date of complia	nce	
	reviewed quarterly.	For weight loss the resident			unless they have successfully		
	would be monitored	d for the underlying cause like			completed all assigned		
	dental issues, medic	cations, intake swallowing and			education).		
	chewing issues. A c	change in the care plan would			Caacanony.		
	be when the event of	occurred.					
	3. The clinical reco	rd for Resident C was					
	reviewed on 5/24/2	2 at 10:30 a.m. The diagnoses					
	included, but were	not limited to, adrenocortical			4. On 6/1/22, a Care Plan ar	d	
	insufficiency, cereb	oral palsy, mood disorder,			Nutritional Weight Loss Qua		
	anoxic brain injury,	dysphagia, major depressive			Review Tool was reviewed ar	-	
	disorder, contractur	e of right elbow, contracture			accepted by the Quality	iu	
	of right knee, seizu	res, hemorrhoids, localized			Assurance Performance		
	edema, constipation	n, contracture, insomnia,			Improvement Committee. (For	r	
	abnormal posture, a	phasia, frontotemporal			l '		
	dementia, allergic r	hinitis, and disorder of adult			future reference the QAPI Committee consists of the		
	personality and beh	aviors.					
					Medical Director, Director of		
	The Annual MDS a	ssessment, dated 2/22/22,			Nursing and at least two of the	9	
	indicated the reside	nt was moderately			following team members:		
	cognitively impaire	d, and there was no			administrator, assistant direct		
	significant weight l	oss.			of nursing, licensed nursing st		
	Significant Holgh 1995.				certified nursing staff, therapy	,	
	The care plan, dated 7/6/21, indicated the				activities, dietary staff, social		
	resident had a poter	ntial for weight loss due to			services, MDS coordinators,		
	_	efusal of some meals. The			maintenance, business office		
	_	led, but were not limited to,			manager, human resources, a	nd	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SURV	EY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	•
		155494	B. W	NG		05/25/2022	2
				CTREET	ADDRESS SITE STATE SID CODE		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
					TODD DR		
WATERS	OF SCOTTSBURG	3, THE		SCOTT	SBURG, IN 47170		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COM	MPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	diet as ordered, noti	fy physician and family as			housekeeping staff). The Direc	tor	
	needed, offer substi	tutions if indicated,			of Nursing/Designated		
	Registered Dietician	n as needed, and snacks upon			Administrative Nursing staff wi	II 📗	
	request.				complete care plan and weigh	:	
	_				loss reviews using the Care Pl		
	The weights summa	ary indicated, on 2/9/22, the			and Nutritional Weight Loss		
	resident weighed 12	28.5 lbs.			Quality Review Audit Tool, to		
					validate that resident who are		
	On 3/31/22, the resi	dent weighed 115.8 lbs,			identified as having weight los	s	
	which was a 9.88%	weight loss from her prior			have accurate nutritional		
	weight on 2/9/22.				assessments and care plan		
					interventions to meet residents	;	
	On 5/23/22, the resi	dent weighed 104.2 lbs,			individual needs related to wei	ght	
	which was a 18.91%	6 loss from her weight on			loss. Any concerns identified		
	2/9/22, and a 10.029	% weight loss from her			during the quality reviews will	be	
	weight on 3/31/22.				addressed at the time of the		
					review and additional educatio	n	
	The clinical record	lacked documentation of any			will be completed at that time.	The	
	revision to the resid	ent's care plan to address her			Care Plan and Nutritional		
	actual weight loss.				Weight Loss Quality Review		
					Audit will be completed once a	a	
	4. The clinical recor	rd for Resident F was			week for all identified residents	s	
	reviewed on 5/25/22	2, at 1:36 p.m. The diagnoses			"with 5 % weight loss in 30 day	/S,	
	included, but were i	not limited to, irritable bowel			7.5% weight loss in 90 days ar	nd	
	syndrome with cons				10% weight loss in 180days" fo	or	
	gastro-esophageal r	eflux disease (GERD), type 2			twelve weeks. These audits wi	II	
	diabetes mellitus, d	ysphagia, cognitive			include all residents identified	with	
		icit, aphasia, weakness,			triggered weight loss. The resu	ılts	
	vitamin deficiency,	and chronic fatigue.			of the Audits will be submitted	to	
					the Quality Assurance		
		S assessment, dated 3/31/22,			Performance Improvement		
	indicated the reside				Committee monthly. The QAP		
		d and she had a weight loss of			Committee will determine if		
		the last month or 10% or			additional education or		
		6 months without a			competencies are required, ba		
	physician prescribe	d weight loss program.			on the compliance reported fro		
					the Quality Reviews. Following		
	The Quarterly Nutritional Risk Review, dated				initial twelve-week review, Aud	lits	
		he resident had no weight			will continue twice a month for	all	
	loss and was stable	at 181 lbs with a BMI of 31			at risk residents until 100%		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OJOR11 Facility ID: 000478

If continuation sheet Page 7 of 26

PRINTED: 06/17/2022 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155494		ľ í	UILDING	00	COMPL 05/25/	ETED	
	PROVIDER OR SUPPLIER			1350 N	ADDRESS, CITY, STATE, ZIP CODE TODD DR SBURG, IN 47170		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	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.				compliance has been determined by the QAPI committee. (A minimum of seven months must be completed).		
	On 2/7/22, the resid was a weight loss of	ent weighed 170.6 lbs, which £ 5.27 %.			-		
	which was a weight	dent weighed 152.6 lbs, loss of 15.27% from her and a weight loss of 10.55% 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.						
		acked documentation of any ent's care plan to address her r any nutritional					
	Executive Director included, but was no Comprehensive Car updated every quart may need to review based on changes in	policy was provided by the on 5/25/22 at 11:13 a.m., and of limited to, "9. The e Plans will be reviewed and er at a minimum. The facility the care plans more often the resident's condition oped health/psycho-social					
	This Federal tag relations IN00377290 and IN	-					
	3.1-35(2)(B)						
F 0677 SS=E Bldg. 00		d for Dependent Residents esident who is unable to					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OJOR11 Facility ID: 000478

If continuation sheet

Page 8 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155494	B. WING 05/25/2022			/2022	
				CERTEE	ADDRESS STEV STATE TO SODE		-
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					TODD DR		
WATERS	S OF SCOTTSBUR	G, THE		SCOTT	SBURG, IN 47170		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDENCE NAME CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	carry out activities	s of daily living receives the					
		es to maintain good					
		g, and personal and oral					
	hygiene;						
		and record review, the	F 00	577	F677 ADL Care provided to		06/17/2022
		sure showers were provided			Dependent Residents		
		ents for 4 of 8 residents					
	reviewed for Activi	ties of Daily Living (ADLs).					
	(Residents C, E, B,	F, and H)			1. On 5/25/22 Resident B wa	s	
					provided a shower by certified		
	Findings included:				staff.		
	1. The clinical reco	rd for Resident B was			On 5/25/22 Resident H was		
	reviewed on 5/24/2	2 at 10:00 a.m. The diagnoses			provided a shower by certified		
	included, but were	not limited to, malignant			staff.		
	neoplasm of bronch	nus and lung, dementia,					
	schizoaffective disc	order, liver disease, acute			On 5/26/22 Resident C was		
	kidney disease, and	chronic obstructive			provided a shower by certified		
	pulmonary disease				staff.		
		S (Minimum Data Set)			On 5/26/22 Resident E was		
		2/2/22, indicated the resident			provided a shower by certified		
		tively impaired. He required			staff.		
	_	ith bathing and personal			<b>75.6</b> 6		
	nygiene with the as	sistance of one staff member.			(For future reference t		
	The core when deter	d 6/1/12 indicated the			intradisciplinary team consists	ΟŤ	
	-	d 6/1/13, indicated the			at least three of the following		
	_	sistance with ADL's Living). The interventions			team		
		not limited to, assist as			members: Director of		
		was clean and dry, assist with			Nursing, Assistant Director of	_	
		nd bathing, encourage resident			Nursing, Dietitian, Dietary staf	f,	
		h as they were able, shampoo			Licensed and		
		t as needed for transfers with			Certified Nursing, MD	S	
	the assistance of on				Coordinator, Administrator,		
	are applicance of on	- Start Momoon			Physician/Physician extender,		
	The resident's show	ver records for April and May			Therapy, Social		
	indicated the follow				Services, and		
		· <del>0</del> -			Activities).		
	- The resident recei	ved one shower on 4/29/22.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OJOR11 Facility ID: 000478

If continuation sheet Page 9 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155494	B. W	ING		05/25/	2022
		l .		STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R			TODD DR		
\\/\TED	S OF SCOTTSBUR	C THE			SBURG, IN 47170		
WATERS	S OF SCOTTSBURG	G, THE		30011	3BURG, IN 47 170		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	- The only documen	nted refusals of showers was					
	on 4/4/22.				2. On 5/26/22, the Assistant		
					Director of Clinical Services		
	The clinical record	lacked documentation the			identified residents residing in	the	
	resident received ar	ny other showers for the			facility that require assistance	with	
	months of April 1 tl	hru April 28, 2022, and May 1			showers and activities of daily		
	thru May 23, 2022.				living. Each resident identified		
					was offered a shower. The sho	ower	
	_	v on 5/24/22 at 9:45 a.m.,			schedule was reviewed and		
	1	rse Aide) 2 indicated she had			revised if indicated based on		
	a list of showers for	r the day, and she would give			individual resident preference.		
		idents that were not					
		wer. If a resident refused a					
	· ·	approach the resident later,					
	1	ould take their shower. She			3. On 5/26/22, the Administra	ative	
	_	vas good on her shifts. She			Nursing staff -initiated		
	was able to get her	work done.			re-education with licensed and	i	
					certified staff regarding		
		rd for Resident H was			completion of showers and		
		2 at 9:48 a.m. The diagnoses			documentation of showers		
		not limited to, dementia, lobar			including documentation of an	-	
		n, hypertension, anxiety			refusals of care. Each participa		
	· ·	eficiency, and abnormal			will be required to complete a	post	
	weight loss.				test for competency.		
	The Quarterly MDS	S assessment, dated 1/31/22			On 5/27/22, the Executive		
	indicated the reside	nt was rarely or never			Director and Director of Nursir	ng	
	understood. She rec	quired total dependence with			reviewed the procedure for		
	bathing and persona	al hygiene with the assistance			"completing showers "and four	nd	
	of one staff member	r.			the policy to be acceptable.		
					Licensed and certified nursing		
	The care plan, dated	d 7/17/18, indicated the			staff are responsible for follow	ing	
	resident requires as	sistant with ADL's. The			the shower schedules and		
	interventions include	led, but were not limited to,			documenting care that is recei	ved	
	assist as needed so the resident was clean and				under the supervision of the		
		ent preference 2 times a week			Director of Nursing.		
	and as needed, enco	ourage resident to complete as					
	much as they are able, keep call light within				(Facility licensed and certified		
	reach, notify physic	cian as needed, and staff to			staff and agency staff will not i	be	
	assist as needed wit	th eating.			allowed to work after the date		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155494	B. WI	NG		05/25/	2022
		100 10 1				00/20/	2022
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
					TODD DR		
WATERS	S OF SCOTTSBUR	G, THE		SCOTT	SBURG, IN 47170		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					compliance unless they have		
		rer records for April and May			successfully completed all		
	indicated the follow	ving:			assigned education).		
	- The resident recei	ved only one shower on					
	4/25/22.						
	- The resident recei	ved no showers the month of					
	May.				4. On 6/1/22, a <b>Shower and</b>		
					ADL Assistance Quality Rev		
	There were no docu	mented refusals of showers.			Tool was reviewed and accep		
					by the Quality Assurance	, to u	
	The clinical record	lacked any other			Performance Improvement		
		resident received a shower			Committee. (For future refere	nce	
		pril 1 thru April 25, 2022,			the QAPI Committee consists		
	and May 1 thru Ma						
		rd for Resident C was			the Medical Director, Director		
		2 at 10:00 a.m. The diagnoses			Nursing and at least two of th	е	
		not limited to, cerebral palsy,			following team members:		
		e, major depressive disorder,			administrator, assistant direct		
	_	right elbow and right knee,			of nursing, licensed nursing s		
		rontotemporal dementia, and			certified nursing staff, therapy	<b>,</b>	
	_	rsonality and behavior.			activities, dietary staff, social		
	•	•			services, MDS coordinators,		
	The Annual MDS a	ssessment, dated 2/22/22,			maintenance, business office		
	indicated the reside				manager, human resources, a	and	
		d, required extensive assist of			housekeeping staff). The Direct	ctor	
		l hygiene, and was totally			of Nursing/Designated		
	_	aff members for bathing.			Administrative Nursing staff w	rill	
		S			complete the quality review to	)	
	The care plan, dated	d 3/20/15, last revised 8/3/21,			validate that assistance with A	ADLs	
	-	nt required assistance with			are provided and documented	d for	
		agnoses of anoxic brain injury			dependent residents-including	9	
		and as of 3/7/22 may refuse			showers using the Shower ar	nd	
		ons included, but were not			ADL Assistance Quality Rev	iew	
		needed so resident was clean			Audit Tool. Any concerns		
	and dry, bathe per preference, see shower				identified during the quality		
		e resident to complete as			reviews will be addressed at	the	
	much as they are able, lotion to skin after				time of the review and additio	nal	
	-	tial bath if she refuses her			education will be completed a	t that	
	_	assist of 2 staff with ADL's,			time. The <b>Shower and ADL</b>		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155494	B. W	ING		05/25/	2022
NAME OF P	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
					TODD DR		
WATERS	OF SCOTTSBUR	G, THE		SCOTT	SBURG, IN 47170		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	and staff may use to	otal body mechanical lift x 2			Assistance Quality Review		
	as needed for transf	fers.			Audit will be completed once	а	
					week for all identified resident	s	
	The shower schedu	le indicated the resident was			identified as needing assistan	ce	
	supposed to receive	e showers twice weekly on			with showers for twelve weeks	3.	
	evening shifts on T	uesdays and Fridays.			These audits will include all		
					residents identified with trigge	red	
	The resident's show	ver records for April indicated			weight loss. The results of the		
	the following:				Audits will be submitted to the	e	
					Quality Assurance Performan	ce	
	- The resident did n	not receive any showers in			Improvement Committee mon	thly.	
	April.				The QAPI Committee will		
		nted refusals of showers were			determine if additional educati		
	for April 12, 16, 19	, and 26, 2022.			or competencies are required,		
					based on the compliance repo	orted	
		mentation of any showers, bed			from the Quality Reviews.		
		f either for April 1 thru April			Following the initial twelve-we		
	_	thru April 15, 2022, or April			review, Audits will continue tw		
	20 thru 25, 2022.				month for all at risk residents	until	
					100% compliance has been		
		ver records for May indicated			determined by the QAPI		
	the following:				committee. (A minimum of sev	/en	
					months must be completed).		
		received showers on May 2					
	· ·	On May 10, 2022, the					
	resident received a	•					
		nted refusals of showers was					
	on May 4, 2022.						
	Thomas versa manda ave	mantation of any above and					
		mentation of any showers, bed f either for May 5 thru May 9,					
		May 16, 2022, or May 18					
	thru May 22, 2022.						
	unu way 22, 2022.						
	4. The clinical reco	rd 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),						
	_	degeneration, lumbosacral					
		mary osteoarthritis of knee,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OJOR11 Facility ID: 000478

If continuation sheet Page 12 of 26

PRINTED: 06/17/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	B. W	UILDING	00	COMPL	
		155494	D. W			05/25	/2022
NAME OF P	ROVIDER OR SUPPLIEF	}			DDRESS, CITY, STATE, ZIP CODE		
			1350 N TODD DR				
WATERS	OF SCOTTSBUR	G, THE		SCOTT	SBURG, IN 47170		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		disorder, weakness,					
	-	g, recurrent depressive					
	-	pain, muscle spasm, and					
	myositis.						
	The Quarterly MDS	S assessment, dated 3/10/22,					
		nt was cognitively intact and					
		n with one staff member's					
		with personal hygiene and					
	bathing.	1 32					
	-	d 10/12/18, indicated the					
	-	showers. Interventions					
		not limited to, shower per					
		oach, offer bed bath or partial					
	bed bath.						
	The shower schedu	le, indicated the resident was					
		twice weekly on day shift, on					
	Tuesdays and Frida						
	j						
	The resident's show	ver records for April indicated					
	the following:						
	TTI '1 . 1	. 1 1 4 4					
	- The resident only 23, 2022.	received one shower on April					
	· ·	nted refusals of showers were					
	for April 12 and 26						
	1	dated 4/26/22 indicated the					
	·	d his shower because he					
	wanted to wait for o	different staff to come in later					
	and provide his sho	wer, there was no follow up					
	documentation of the	ne shower being completed.					
		mentation of any showers, bed					
		f either for April 1 thru April					
	27 thru April 30, 20	thru April 25, 2022, or April					
	27 unu Aprii 50, 20	144.					
	The resident's show	ver records for May indicated					
		<i></i>					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OJOR11

Facility ID: 000478

If continuation sheet

Page 13 of 26

PRINTED: 06/17/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì í	ULTIPLE CO JILDING	NSTRUCTION	COMPL		
AND PLAN	OF CORRECTION	155494	B. W		00	05/25/	
		133494	В. 11			03/23/	2022
NAME OF P	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
\444.TED6	05.000	0. 7115			TODD DR		
WATERS	OF SCOTTSBUR	G, THE		SCOTT	SBURG, IN 47170		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the following:						
	TEN 11 4 1	· 11					
	and May 20, 2022.	received showers on May 8					
		cumented refusals of showers					
	for the Month of M						
	ior the Month of M	ay.					
	There was no docur	mentation of any showers, bed					
		f either for May 1 thru May 7,					
		May 19, 2022, or May 21 thru					
	May 23, 2022.						
		rd for Resident F was					
		2 at 10:30 a.m. The diagnoses					
	· · · · · · · · · · · · · · · · · · ·	not limited to, dementia,					
		ack of coordination, cognitive					
		icit, difficulty in walking,					
		normalities of gait and					
	mobility, osteoartin	ritis, and chronic fatigue.					
	The Quarterly MDS	S assessment, dated 3/31/22,					
	indicated the reside						
		ed, and required extensive					
		aff member with personal					
	hygiene, and was to	otally dependent of one staff					
	member with bathir	ng.					
	1 /	d 7/9/18, indicated the					
		sistance with ADL's. The					
		led, but were not limited to,					
		oreference 2 times weekly and					
	as needed.						
	The shower schedu	le, indicated the resident was					
		twice weekly on day shift					
	(Mondays and Thui						
	, , , <b></b>	• /					
	The resident's show	ver records for April indicated					
	the following:						
	-						
			1				1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OJOR11

Facility ID: 000478

If continuation sheet

Page 14 of 26

PRINTED: 06/17/2022 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155494			UILDING	00	COMPL 05/25/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
TAG	- The resident only 11, 18, 19, 21, and 2 - The only documer for April 14, howeve bath.  There was no docume baths, or refusals of 6 or April 22 thru A  The resident's show the following:  - The resident only 4, 17, and 19.  - There were no doc for the Month of M  There was no docume baths, or refusals of 16, or May 20 thru  During an interview CNA 5 indicated sh complete all of her enough time to	mentation of any showers, bed feither for April 1 thru April pril 27.  er records for May indicated  received showers on May 2,  rementation of any showers ay.  mentation of any showers, bed feither for May 5 thru May May 24.  on 5/25/22 at 10:28 a.m., e did not always have time to work, and did not always have pleted showers. Sometimes refuse their shower or they breaks and then they could Sometimes night shift would		TAG	DEFICIENCY)		DATE	
		on 5/25/22 at 1:24 p.m., the Director of Nursing) indicated						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OJOR11 Facility ID: 000478

If continuation sheet

Page 15 of 26

PRINTED: 06/17/2022 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155494			JILDING	00	COMPL 05/25/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  1350 N TODD DR  SCOTTSBURG, IN 47170				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	schedules to fit the bit better. It was a lowerk. She was not a showers being compataff about filling or resident refused the them to offer it three nurse go in if the reshower or bed bath. nurse then she would anything, a partial be would really like the continued to refuse. had most residents and some three time documenting it on to trying to start a proplace and was lucky that she did, because everywhere. She has sheets reflected he days.  The most current Be 5/25/22 at 1:41 p.m. included, but was not cleanse the skin and Procedure 1. Veri Bed Bath Comple resident's entire boofface, hands, underal buttocks (assistance	athing policy, provided on by the Executive Director, ot limited to, " Policy: To to promote circulation fy bath schedule or need te Bath- Involves washing ly Partial Bath- Involves ms, perineum, back and as needed)"					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OJOR11 Facility ID: 000478

If continuation sheet

Page 16 of 26

PRINTED: 06/17/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE  A. BUILDING OO COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00			
		155494	_		05/25/2022		
NAME OF F	PROVIDER OR SUPPLIEI	3		ADDRESS, CITY, STATE, ZIP CODE			
WATERS	OF SCOTTSBUR	G, THE	1350 N TODD DR SCOTTSBURG, IN 47170				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	``	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
F 0692 SS=E	483.25(g)(1)-(3)	n Status Maintenance					
Bldg. 00		ed nutrition and hydration.					
Diag. 00	- '-'	astric and gastrostomy					
	,	taneous endoscopic					
	gastrostomy and	percutaneous endoscopic					
	1	enteral fluids). Based on a					
		hensive assessment, the					
	facility must ensu	re that a resident-					
	8/83 25(a)(1) Ma	intains acceptable					
	(0,1,	ritional status, such as					
	l ·	t or desirable body weight					
		lyte balance, unless the					
	_	condition demonstrates that					
	this is not possible	e or resident preferences					
	indicate otherwise	<b>;</b>					
	§483.25(g)(2) Is o	offered sufficient fluid					
	intake to maintain	proper hydration and					
	health;						
		offered a therapeutic diet					
		utritional problem and the					
	health care provided the diet.	ler orders a therapeutic					
	Based on record rev	view and interview, the	F 0692	p paraid="1569147352"	06/17/2022		
	facility failed to en			paraeid="{e33e45ad-e65f-458			
		oss were assessed by the		d9-84aed5f8b846}{227}" >F69	92		
	~	n and interventions were		Nutrition/Hydration Status			
		event further weight loss for 4		Maintenance			
	C, F, B and H)	wed for nutrition. (Residents					
	С, г, в ана п)						
	Findings include:						
	1. The clinical reco	rd for Resident C was					
		2 at 10:30 a.m. The diagnoses		On 5/25/22 the dietitian compl			
		not limited to, adrenocortical		a dietary assessment on resid			
	insufficiency, cereb	oral palsy, mood disorder,		C. On 5/25/22 the intradiscipling	nary		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OJOR11

Facility ID: 000478

If continuation sheet Page 17 of 26

PRINTED: 06/17/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155494		l í	JILDING	onstruction 00	(X3) DATE S COMPLI 05/25/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	disorder, contractur of right knee, seizur edema, constipation abnormal posture, a	dysphagia, major depressive e of right elbow, contracture res, hemorrhoids, localized , contracture, insomnia, phasia, frontotemporal ninitis, and disorder of adult aviors.			team reviewed resident C's placare and revised the care plan include actual weight loss and interventions were updated on care plan to address individualized interventions for weight loss.	to the	
	was moderately cog indicated the resident weight loss.  The care plan, dated resident had a potent poor intakes, and re Interventions included diet as ordered, notineeded, offer substi	/22/22, indicated the resident mitively impaired, and and the did not have any significant 17/6/21, indicated the stial for weight loss due to fusal of some meals. led, but were not limited to, fy physician and family as			On 5/25/22 the dietitian compl a dietary assessment on resid F. On 5/25/22 the intradisciplir team reviewed resident F's pla care and revised the care plan include actual weight loss and interventions were updated on care plan to address individualized interventions for weight loss.	ent lary in of to	
	indicated the resider with a BMI (Body Market Weight gain was be current diet orders was oft, grilled cheese intake was approximately bedtime snacks, and interventions were resident.	on Review, dated 2/22/22, and weighed 130 lbs (pounds) Mass Index) that was 20.2 It as within normal limits. Ineficial for the resident. Her were general diet, mechanical twice daily. Her average mately 81% of meals, 95% of It no additional nutritional necessary at the time.  The review of the resident of the resident of the review of the resident. Her average mately 81% of meals, 95% of It no additional nutritional necessary at the time.  The review of the resident of the resident of the review of th			On 5/25/22 the dietitian compl a dietary assessment on resid B. On 5/25/22the intradisciplin team reviewed resident B's pla care and revised the care plan include actual weight loss and interventions were updated on care plan to address individualized interventions for weight loss	ent ary an of to	
		dent weighed 115.8 lbs, weight loss from her prior			On 5/25/22 the dietitian compl	eted	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OJOR11

Facility ID: 000478

If continuation sheet

Page 18 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ЛLDING	00	COMPL	ETED
		155494	B. W	ING		05/25/	/2022
NAME OF F	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
					TODD DR		
WATERS	OF SCOTTSBUR	G, THE		SCOTT	SBURG, IN 47170		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	Ι		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
IAG	REGULATORT OR	LESC IDENTIFY ING INFORMATION)	+	IAG			DATE
	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				a dietary assessment on resid		
					H. On 5/25/22 the intradisciplin	•	
					team reviewed resident H's pla		
					care and revised the care plan	to	
	weight on 3/31/22.				include actual weight loss and		
					interventions were updated on	the	
	The Quarterly Nutr	itional Risk Review, dated			care plan to address		
	4/22, lacked any do	cumentation, and was left			individualized interventions for		
	blank.				weight loss		
	The April Nutrition	al Risk Quarterly Review					
	lacked any docume	ntation, the assessment was					
	left blank.	,			(For future reference t	he	
					intradisciplinary team consists		
	The clinical record	lacked documentation of any			at least three of the following	0.	
		ents or interventions after the			team		
		oss the resident experienced			team		
	on 3/31/22 until 5/2	-			members: Director of		
	011 3/31/22 unun 3/2	.3/22.					
	D	5/25/22 A DD			Nursing, Assistant Director of		
	-	v, on 5/25/22, the RD			Nursing, Dietitian, Dietary staff	,	
		should have a progress note			Licensed and		
		f them experiencing a			0	_	
	-	oss (5% in 30 days or 10% in			Certified Nursing, MD	S	
		t C should have had a			Coordinator, Administrator,		
		n the month of April and			Physician/Physician extender,		
		ntakes had a nutritional			Therapy, Social		
		t time. She did a nutritional					
	assessment on the r	esident on March 31, 2022,					
	and asked for a rew	eigh on the resident, and it			p paraid="237312697"		
	took some time. Th	e reweigh was not conducted			paraeid="{fe401542-7fdd-4e02	2-a8	
	until May 23, 2022,	, and it should have been			ce-15815649530e}{129}"		
	conducted within th	ne next few days and then she			> Services, and		
	would follow up on	her next facility visit. She			Activities).		
	would have done so	ome kind of intervention had					
	the weight been cor	nfirmed, but it was not. She					
	-	note and figured out what kind					
		led to be put into place at that					
		riggered for a significant					
		ould be weighed weekly,					
	-	it weight loss they should be			On 5/25/22, the dietitian review	hav	
	prior to a significan	a weight loss they should be	1		On Sizsizz, the dictitian fevier	vGu	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OJOR11 Facility ID: 000478

If continuation sheet Page 19 of 26

PRINTED: 06/17/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í		DNSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		155494	B. W	ING		05/25/	2022
	PROVIDER OR SUPPLIER			1350 N	ADDRESS, CITY, STATE, ZIP CODE TODD DR SBURG, IN 47170	•	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		he would have implemented			monthly weights to identify all		
	weekly weights afte	-			residents with significant weig	ht	
	significant weight le				loss.	110	
	significant weight it	J55.			1033.		
	reviewed on 5/25/22 included, but were resyndrome with consignation especially diabetes mellitus, decommunication defivitamin deficiency,  The Quarterly MDS indicated the residence or more within the last 6 more prescribed weight loss and was stable which was desirable order was a general	eflux disease (GERD), type 2 ysphagia, cognitive cit, aphasia, weakness, and chronic fatigue.  assessment, dated 3/31/22, at was moderately d and had a weight loss of 5% ast month or 10% or more ast month or 10% or more ast month or aphysician ass program.  tional Risk Review, dated are resident had no weight at 181 lbs with a BMI of 31 at for her age. Her current diet diet, mechanical soft with sident request. No new			p paraid="1726709625" paraeid="{fe401542-7fdd-4e0.ce-15815649530e}{164}" >6/1 residents residing within the facility were reviewed by the intradisciplinary team during ti S.W.A.T (Skin and Weight) to ensure appropriate nutritional assessments were completed that each resident's care plan addressed triggered weight lo of 5% in 30 days, 7.5% weigh loss in 90 days and 10% weig loss in 180 days. Care plans vervised to include individualize interventions for weight loss.	and ned sses t ht vere	
	On 2/7/22 the reside was a weight loss of	ent weighed 170.6 lbs, which f 5.27 %.					
	which was a weight weight on 1/30/22, from her weight on On 5/4/22, the resid	dent weighed 152.6 lbs, loss of 15.27% from her and a weight loss of 10.55% 2/7/22. ent weighed 144 lbs, which f 20.04% from her weight on			On 6/1/22 the Executive Directinitiated re-education with the intradisciplinary team regarding the components of F657 with focus on individualized care process for weight loss and completion nutritional assessments. The process for completing wound weight SWAT meetings were reviewed during this in-service.	e ng a lans n of l and also	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OJOR11

Facility ID: 000478

If continuation sheet

Page 20 of 26

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155494	B. W			05/25/	
		100 10 1				00/20/	
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
					TODD DR		
WATERS	S OF SCOTTSBUR	G, THE		SCOTT	SBURG, IN 47170		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	BROWINERIC BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	\ I E	DATE
	The clinical record	lacked documentation of any			Participants were required to		
	nutritional assessments or interventions until				complete a Post test for		
	5/4/22.				competency.		
	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 pur	reed with thin liquids. No new			On 6/1/22, the Executive Dire	ctor	
	nutritional interven	tions were indicated aside			and Director of Nursing review	ved	
	from continue to me	onitor. Recommendations			the procedure for "S.W.A.T (S	kin	
	indicated to continue weekly weights.  The Quarterly Nutritional Risk Review, dated 5/4/22, indicated the resident had a weight loss				and weight loss meeting) "and	i	
					found the policy to be accepta	ıble.	
					The intradisciplinary team is		
					responsible for completing we	ekly	
	of more than 5% in	the last month or 10% in the			wound and weight meetings.	This	
	last six months and	was not on a prescribed			team is lead by the Dietitian o	r	
	weight loss regimer	n. Her diet order was changed			Administrative Nursing staff e	ach	
	to pureed, however	no further nutritional			week.		
	interventions were	implemented at the time.					
	_	v, on 5/25/22 at 12:50 p.m.,					
		ere was nothing on Resident F			On 6/1/22 Residents with		
		of 2021 and April of 2022.			triggered weight loss were		
	In December 2021,				reviewed by the MDS Coordir	ator	
		n she started that weight loss			to determine if any of the		
		orther on until her present			identified residents required a		
	_	ee anything in between			significant change MDS.		
		n she started as the RD in					
		resident's intake was slightly					
		she declined any additional					
		t time. On 5/4/22 she saw the			(Facility Intradisciplinary team		
		speech therapy changed her			members will not be allowed t		
	_	h might make it easier for her			work after the date of complia		
	·	en her weight had come up.			unless they have successfully		
	The resident should have had an assessment				completed all assigned		
		. Speech changed her diet to a			education).		
	puree diet.	10.5					
		rd was reviewed for Resident					
		48 a.m., The diagnoses			p paraid="1579190430"		
	included, but were	not limited to, dementia, lobar			paraeid="{932541f0-8523-416	68-b	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	LETED
		155494	B. W	ING		05/25	/2022
		<u> </u>		CTREET	ADDRESS CITY STATE ZID CORE		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
\\\\\	OF CONTROL ID	C THE			TODD DR		
WATERS	S OF SCOTTSBUR	G, IHE		SCOTT	SBURG, IN 47170		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	a, hypertension, anxiety			a92-3750c4075db5}{66}" >		
		eficiency, and abnormal					
	weight loss.						
		S assessment, dated 1/31/22,					
		ent was rarely or never					
		sident had a history of holding					
		or cheek or residual food in					
		als. The assessment identified			0 04/00 0 -:		
	no significant weig	ht loss.			On 6/1/22 a Care Plan and		
	TEL 1	1 1 1 1 1 1 1 1 1 2 2 2 2 2 2 2 2 2 2 2			Nutritional Weight Loss Quali	-	
		der, dated 1/1/22, indicated a			Review Tool was reviewed an	nd	
	1 -	eed texture with thin liquids			accepted by the Quality		
	consistency.				Assurance Performance		
	The core when dete	d 7/16/19 and rayised ar			Improvement Committee. (Fo	Л	
	_	d 7/16/18 and revised on			future reference the QAPI Committee consists of the Me	ndica!	
		the resident received a puree quids diet. The interventions			Director, Director of Nursing		
	I -	not limited to, diet per order,			at least two of the following to		
		amption of all meals, monitor			members: administrator, assi		
		sician as needed, observe for			director of nursing, licensed	Jan	
		allowing problems, offer			nursing staff, certified nursing	1	
	_	resident consumes 50% or			staff, therapy, activities, dieta	-	
		so speech therapy as needed.			staff, social services, MDS	,	
	1355 51 111641, 16161	as aparent merupy as needed.			coordinators, maintenance,		
	On 12/13/21 the re-	sident weighted 125.2 lbs, on			business office manager, hur	man	
		n 4/4/22 108.0 lbs, and on			resources, and housekeeping		
	5/7/22 115.0 lbs wi				staff).The Director of	,	
					Nursing/Designated Administ	rative	
	The clinical record	lacked documentation of			Nursing staff will complete ca		
		ents after the date of			plan and weight loss reviews		
	12/13/21 until 4/20	/22			the Care Plan and Nutritional	-	
					Weight Loss Quality Review		
	The dietary progres	ss note, dated 4/20/22 at			Tool, to validate that resident		
		nt change review indicated the			are identified as having weigh		
	_	as 108 lbs on 4/4/22. Her BMI			loss have accurate nutritional		
		s less desirable for her age.			assessments and care plan		
		nt weight loss of -10% x 90			interventions to meet residen	ts	
		days. Her oral intake seemed			individual needs related to we	eight	
		t diet was pureed texture, thin			loss. Any concerns identified	-	

PRINTED: 06/17/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155494		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 05/25/2022	
	OF PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE  1350 N TODD DR  SCOTTSBURG, IN 47170				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	intake of 76% provand protein + 35%. resident was reweig of -10& x 90 days at 4. The clinical reco B, on 5/24/21 at 10 included, but were neoplasm of bronch schizoaffective disc kidney disease, and pulmonary disease  The Quarterly MDS assessment, dated 2 was severely cognit total dependence w	er lip plate and lidded cup. Oral iding 1,900 kcal, 72 g (grams) Bedtime snacks offered. The ghed to confirm a weight loss and -12.5 x 180 days.  In the diagnoses and limited to, malignant aus and lung, dementia, order, liver disease, acute chronic obstructive  G (Minimum Data Set)  1/2/22, indicated the resident interview impaired. He required inth bathing and personal sistance of one staff member.			during the quality reviews will I addressed at the time of the review and additional educatio will be completed at that time. Care Plan and Nutritional Weig Loss Quality Review Audit will completed once a week for all identified residents "with 5 % weight loss in 30 days, 7.5% weight loss in 90 days and 100 weight loss in 180days" for two weeks. These audits will include residents identified with trigger weight loss. The results of the Audits will be submitted to the Quality Assurance Performance Improvement Committee mont The QAPI Committee will determine if additional education competencies are required, based on the compliance repo	n The ght be live de all ed ee hly.	
	nutritional treat with General diet mechal consistency with a shake three times a bedtime with a start protein three times with a start date of (milliliter) three times start date of 1/26/22 (milligram) by mountain start date of 1/26/22 (milligram) by mountain with a start date of 1/26/22 (millig	er indicated a frozen h a start date of 2/3/22. nical soft texture and thin start date of 4/27/22. Health day between meals and at date of 2/3/22. Double a day for weight monitoring 3/18/22. Med pass 2.0 90 ml nes day for supplement with a 2. Mirtazpine 15 mg th at bedtime for appetite rt date of 2/24/22.  d 4/20/21, indicated Resident eight loss related to decline in ed to lung cancer and poor entions include, but were not redered, notify physician and ffer substitutions if indicated,			from the Quality Reviews. Following the initial twelve-wee review, Audits will continue twi month for all at risk residents to 100% compliance has been determined by the QAPI committee. (A minimum of sew months must be completed).	ce a ıntil	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OJOR11

Facility ID: 000478

If continuation sheet

Page 23 of 26

PRINTED: 06/17/2022 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  155494	IFICATION NUMBER: A. BUILDING 00			COMPLETED 05/25/2022	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
WATERS	OF SCOTTSBURG	S, THE			TODD DR SBURG, IN 47170		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)  ician as needed.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	The care plan, dated 4/20/21, indicated the diet and had a weight Interventions include cheeseburger at dimmonitor food and fluwith all meals, more MVI (multi vitaming guardian and physice (Registered Dieticial order for appetite strong ordered regular die condiments, peanut and at bedtime, will strawberry ice cream On 4/1/22, the reside which was a -14.45 weight of 137.0 on the clinical record I documentation relating nutritional assessments were consistent which was a sessessments were consistent with the clinical record I documentation relating nutritional assessments were consistent which was a sessessment where consistent were consistent with the compact of Nursing would do a nutrition would be added, monstaff would assist the encourage the reside be added to SWAT and the sweet of the courage the reside be added to SWAT and the sweet and t	a 6/14/13 and revised on the resident was on a pureed at loss related to poor intake. The loss related to poor intake, chocolate milk that the loss refer to loss refer to refer to a second poor interest to the loss refer to RD (a) per physician order, refer to ian as needed, refer to RD (b) as needed, remeron per limitant, serve diet as the loss from his prior loss from his prior loss from his prior loss from his prior loss. The nutritional loss from his prior loss from loss from his prior loss loss remeron per limitant loss from his prior lo					
		Point Click Care in the ated if a resident had a 5%					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OJOR11

Facility ID: 000478

If continuation sheet

Page 24 of 26

PRINTED: 06/17/2022 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:  155494	A. BU	A. BUILDING 00  B. WING		COMPLETED 05/25/2022			
NAME OF PROVIDER OR SUPPLIER  WATERS OF SCOTTSBURG, THE				STREET ADDRESS, CITY, STATE, ZIP CODE  1350 N TODD DR  SCOTTSBURG, IN 47170					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE		
	weight change in 30 days the computer would trigger the weight loss and management would be informed.								
	RD indicated if ther loss a nutritional ass done. The resident was management team. If and weights weekly would be done quark change in the reside H should have had a follow ups when the 5% in 30 days, 7.5% loss in 180 days. Shoutritional assessment February.  The most current S. Weight Assessment 5/25/22 at 1:37 p.m. included, but was not policy of this facility status of each reside aggressively review exhibiting significant breakdown. These rethrough this team of involving all application the improvement status This team we clinical and dietary is each resident's need implementation of Smore weight change	W.A.T. Program (Skin and Team) policy, provided on , by the Executive Director, of limited to, " It is the y to assess the nutritional nt. SWAT is designed to and address those residents at weight change or skin esidents will be monitored fort on a weekly basis, able disciplines to best cater of the resident's nutritional will appropriately determine interventions to best address s Indicators determining the WAT monitoring 5% or (undesirable) in 30 days te change (undesirable) in 180							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OJOR11 Facility ID: 000478

If continuation sheet Page 25 of 26

PRINTED: 06/17/2022 FORM APPROVED OMB NO. 0938-0391

STATEMEN	OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED			
155494		B. WING			05/25/2022				
NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG, THE				STREET ADDRESS, CITY, STATE, ZIP CODE  1350 N TODD DR  SCOTTSBURG, IN 47170					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)	16	DATE		
	IN00377613. 3.1-38(a)(2)								

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: OJOR11 Facility ID: 000478 If continuation sheet Page 26 of 26