PRINTED:	01/27/2022
FORM API	PROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVI	CES
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CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/20/2021
	ROVIDER OR SUPPLIER		1350 N	ADDRESS, CITY, STATE, ZIP COD TODD DR SBURG, IN 47170	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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)	(X5) COMPLETION DATE
	REGERIORI ON		ind		DATE
F 0000 Bldg. 00 F 0580 SS=E Bldg. 00	This visit was for a Licensure Survey an Complaint IN00368 This visit resulted in Substandard Quality Jeopardy. Complaint IN00368 lack of evidence. Survey dates: Decer 20, 2021. Facility number: 00 Provider number: 11 AIM number: 1002 Census Bed Type: SNF/NF: 71 Total: 71 Census Payor Type: Medicare: 6 Medicaid: 44 Other: 21 Total: 71 These deficiencies n accordance with 410 Quality review com 483.10(g)(14)(i)-(ir	Recertification and State nd the Investigation of 2732. n an Extended Survey - y of Care - Immediate 2732 - Unsubstantiated due to mber 13, 14, 15, 16, 17, 18, and 0478 55494 90430 : reflect State Findings cited in 0 IAC 16.2-3.1. pleted on January 2, 2022.	F 0000		
	(i) A facility must in	mmediately inform the			
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 12/20/2021	
NAME OF	PROVIDER OR SUPPLI	ER		ADDRESS, CITY, STATE, ZIP (TODD DR	COD	
WATER	S OF SCOTTSBUR	RG, THE		SBURG, IN 47170		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIO
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	physician; and n her authority, the when there is- (A) An accident is results in injury a requiring physici (B) A significant physical, mental (that is, a deterior psychosocial stat conditions or clir (C) A need to alt (that is, a need to form of treatment consequences, of of treatment); or (D) A decision to resident from the §483.15(c)(1)(ii). (ii) When making (g)(14)(i) of this s ensure that all pain in §483.15(c)(2) upon request to (iii) The facility m resident and the any, when there (A) A change in assignment as s (B) A change in or State law or re paragraph (e)(10)	change in the resident's or psychosocial status oration in health, mental, or tus in either life-threatening nical complications); er treatment significantly o discontinue an existing t due to adverse or to commence a new form e transfer or discharge the e facility as specified in a notification under paragraph section, the facility must ertinent information specified is available and provided the physician. nust also promptly notify the resident representative, if is- room or roommate pecified in §483.10(e)(6); or resident rights under Federal egulations as specified in b) of this section. nust record and periodically ess (mailing and email) and f the resident				
		omposite distinct part. A				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 12/20/2021 155494 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, THE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on observation, record review, and F 0580 01/20/2022 interview, the facility failed provide timely F580 Change in notification to the physician of blood glucose Condition levels for 1 of 19 reviewed for Notification of p="" paraid="1184384737" Change. (Resident 46) paraeid="{760a8ac4-6304-42eb-90 d5-b3c6e50b0337}{56}"> On Findings include: 12/16/21 Resident #46's primary physician was contacted by the During an observation, on 12/15/21 at 10:53 a.m., Director of Nursing and notified Resident 46 was observed walking into the that the endocrinologist visit had memory care unit dining room. There was a large not been scheduled. The primary pool of liquid on the dining room floor. CNA 8 physician recommended no indicated the resident had just had an accident changes in treatment at that time and she had gotten him cleaned up. This had and scheduled a facility visit on happened for the third time recently and he was Saturday 12/18/21.Referral urinating quite frequently. documentation was scanned to Dr. Endocrinologist in Sellersburg, During a continuous observation, on 12/16/21 IN on 12/16/21 and the office was from 10:15 a.m. to 11:15 a.m., Resident 46 was contacted for an appointment. On confused as normal, walking about the memory 12/17/21 the office scheduled an care unit dining room. He would sit for short appointment for resident #46 on periods in the dining room, and then get up and January 10,2022 at 11AM. walk around the room. At 10:42 a.m. he sat down Residents family (daughter) in another resident's geriatric wheelchair in the contacted and agreed to hallway and closed his eyes. CNA 9 assisted the appointment. On January 10,2022 resident to his bed. resident #46 was seen by the endocrinologist and medication The clinical record for Resident 46 was reviewed adjustment was completed. on 12/16/21 at 8:30 a.m. Diagnoses included, but On 12/16/21 The Director of were not limited to, cerebral infarction, alcohol Nursing completed an RN dependence with alcohol induced persisting assessment on resident #46. The dementia, atrial fibrillation, altered mental status, assessment included but is not

Event ID:

PL0011 Facility

Facility ID: 000478 I

If continuation sheet Page

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RRECTION DER OR SUPPLIE SCOTTSBUF	IDENTIFICATION NUMBER 155494	A. BUILDING B. WING		OMPLETED
SCOTTSBUR	155494	B. WING		
SCOTTSBUR		· · · · ·	12	2/20/2021
SCOTTSBUR	B	STREET	ADDRESS, CITY, STATE, ZIP COD	
			I TODD DR ISBURG, IN 47170	
SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
l cognitive imp	pairment, cognitive		limited to the following items:	
munication de	ficit, Type 2 diabetes mellitus		physical assessment, vital signs,	
out complication	ions, polyneuropathy,		glucose monitoring review (last	
ertension, and	heart disease.		seven days), current medication	
Quarterly MD	OS (Minimum Data Set)		orders to treat diabetes and	
ssment, dated	11/5/21, indicated the resident		specialty	
severely cogn	itively impaired, had diabetes		referrals/recommendations. On	
litus, and requi	ired injections of insulin daily		12/17/21 A telehealth review was	
			completed with Reliant Health	
hospital disch	arge summary, dated 4/9/21,		Care. During the telehealth review	
-	ent would need to continue		licensed nursing staff reviewed the	
	l glucose monitoring) after		RN assessment, the residents	
	me after discharged and would		blood sugars (for the past seven	
	ed on high dose sliding scale		days) and current treatment plan	
	ursing home medical doctor to		for diabetes. New orders were	
	eeded. Orders at the time of		received, and family notified. (New	
	cility included, but were not		orders received for Resident #46	
-	glargine 26 units every morning,			
			include the following changes:	
-	nits three times daily every 6		Discontinue Metformin 500mg	
-	scale as ordered, after giving		TID Start metformin 1000mg BID	
	insulin) do not recheck finger or		and sliding scale insulin). On	
	il next scheduled check. Give		12/17/21 the intradisciplinary team	
	based on blood glucose 70 to		completed an intradisciplinary	
	insulin (none), 151 to 200 give 3		care plan meeting to review	
	give 6 units, 251 to 300 give 9		resident #46 related to diabetes	
-	give 12 units, for blood sugars		management. (For future reference	;
r 350 call the p	rovider.		the intradisciplinary team included	
			the following participants: Director	
· ·	iated on 6/14/21, indicated the		of Nursing, Assistant Director of	
	2 diabetes with risk for		Nursing, Dietary Manager, Director	
	hyperglycemia. Interventions		of Activities, Social Services,	
			Therapy, certified Nursing	
-	-		Assistant). The comprehensive	
od sugar results	s outside specified parameters.		review included but was not limited	
			to the following items: RN	
physician's or	der, dated 10/22/21, indicated		assessment Nurse	
resident's parai	neters were changed to notify		Practitioner/Physician	
-			-	
physician of ar	-		-	
			-	
included, but were not limited to, check blood sugar per order and as needed, and notify MD of blood sugar results outside specified parameters. The physician's order, dated 10/22/21, indicated the resident's parameters were changed to notify the physician of any blood sugar levels below 60 or above 400.		sugar results outside specified parameters. ysician's order, dated 10/22/21, indicated ident's parameters were changed to notify /sician of any blood sugar levels below 60	ber order and as needed, and notify MD of sugar results outside specified parameters. Assistant). The comprehensive review included but was not limited to the following items: RN assessment Nurse Practitioner/Physician recommendations Blood glucose	

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TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	-	Summary indicated the resident I sugar levels above 400 on the		diabetes including medication Resident/Fami preferences including		
		:50 a.m., BS level was 459 mg/dL, notification documented.		appointment/referral and c treatment of diabetes Care interventions were reviewe updated by licensed nursir	e Plan ed and	
		14 p.m., BS level was 566 mg/dL, notification documented.		as indicated during this rev include diabetic managem specialty referrals.	view to	
		47 p.m., BS level was 484 mg/dL, notification documented.		p="" paraid="2111795364" paraeid="{760a8ac4-6304-42eb-9 d5-b3c6e50b0337}		
	resident's parameter	der, dated 11/8/21, indicated the ers were changed to notify the lood sugar levels below 60 or		{156}"> Resident #46 will of to be monitored weekly by intradisciplinary team (inclu the residents' physician) for	the uding or a	
		Summary indicated the resident's were at/or above 500 on the		minimum of four weeks to that the current intervention effective for management diabetes. During the four w review the intradisciplinary	ns are of veeks	
		8:25 p.m., BS level 500 mg/dL, notification documented.		will complete a diabetic Mo Compliance audit that inclu following items- Oral/injec	onitoring udes the	
		8:08 p.m., BS level 500 mg/dL, notification documented.		meds given as ordered Blo sugars are monitored as o and MD is notified of blood	ood rdered	
		10:05 p.m., BS level 560 mg/dL, notification documented.		glucose levels below 60 or 400 ul="" role="list"		
	- November 16 at 7:39 a.m., BS level 500 mg/dL, with no physician notification documented.			Interventions are initiated a indicated to maintain blood between 60 -400 to include	d sugars	
		10:09 p.m., BS level 516 mg/dL, notification documented.		medication management b physician/nurse practitione Any concerns identified wil	ey the er	
		9:20 p.m., BS level 500 mg/dL, notification documented.		communicated to the phys the time of the review. Or 12/16/21 The Director of N	ician at า	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/20/2021	
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PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLE	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	- November 21 at	8:23 p.m., BS level 500 mg/dL,		identified fifteen Residents		
	with no physician	notification documented.		requiring glucose monitoring a	and	
				diabetes management.		
	- November 27 at	8:52 p.m., BS level 600 mg/dL,		On 12/16/21-12/17/21, The		
	with no physician	notification documented.		Director of Nursing completed	lan	
				RN assessment on fifteen of		
	- December 4 at 8:	34 p.m., BS level 500 mg/dL, with	1	fifteen residents. The assessr	nent	
	no physician notifi	cation documented.		included but is not limited to t	he	
			1	following items: physical		
	During an intervie	w, on 12/17/21 at 2:40 p.m.,		assessment, vital signs, gluco	ose	
	Resident 46's phys	ician indicated the resident was		monitoring review (last seven		
	on a sliding scale i	nsulin, and he was to be		days), current medication ord	ers	
	notified any time t	he resident's blood sugar level		to treat diabetes and specialty	/	
	was above 400. If	the resident was above 400, he		referrals/ recommendations.	On	
	would want him to	receive fast acting insulin.		12/16/21-12/17/21, a teleheal	th	
	There was a chang	e in nurses, who did not know		review was completed with R	eliant	
	the patients, so he	chose to use longer acting		Health Care for fifteen of fiftee	en	
	insulin because the	ere was less room for error.		residents. During the teleheal	th	
	Agency staff did n	ot know patients. He would		review licensed nursing staff		
	rather not give the	fast-acting insulin and would		reviewed each resident's RN		
	rather the patients	have a high blood sugar level.		assessment, blood sugars (fo	r the	
				past seven days) and current		
	· · · · · · · · · · · · · · · · · · ·	undated Chane in Resident's		treatment plan for		
	condition or Status	s policy, provided on 12/20/21		diabetes. Results-or		
	1 5	e DON (Director of Nursing)		recommendations All blood so	0	
		not limited to, " It is the policy		(for the last seven days), mos	it	
		sure that the resident's		recent A1C lab results, and		
		n and representative are		current diabetic treatment pla		
	-	s in the resident's condition or		reviewed by ADNS for fifteen		
		se will notify the resident's		fifteen residents with teleheal		
		n when There is a change in		clinician. All new orders recei		
		cal status There is a need		by clinician were entered into	the	
		t's treatment plan significantly		residents' clinical record and		
	Any result of a specifically ordered diagnostic test/evaluations that is outside normal			reviewed by DNS. During the		
		at is outside normal		telehealth reviews, three of fif		
	parameters"			residents received medication	-	
				adjustments and seven of fifte		
	3.1-5(a)(2)			residents received orders for	-	
	3.1-5(a)(3)			A1C. Licensed nursing staff		
	1		1	be required to monitor glucos	e	

STATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	LE CONSTRUCTION (X3) D		3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155494	A. BUILE B. WING	DING <u>00</u>	_	PLETED 0/2021	
		100-10-			_	0/2021	
NAME OF PF	ROVIDER OR SUPPLIE	R		treet address, city, state, zip c 350 N TODD DR	COD		
WATERS	OF SCOTTSBUF	RG, THE		COTTSBURG, IN 47170			
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PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PRI	EFIX (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	COMPLETIC	
TAG	REGULATORY C	PR LSC IDENTIFYING INFORMATION	T	AG DEFICIENCY)		DATE	
				results as ordered eac			
				report to the physician			
				practitioner if blood glu			
				are below 60 or above			
				otherwise specified by	the		
				physician). p="" paraid="12706963	226"		
				paraeid="{760a8ac4-6			
				d5-b3c6e50b0337}{23			
				Families notified of any	•		
				pertaining to clinician r			
				documented in the clin			
				For fifteen of fifteen res	sidents, no		
				referral request made	at this time		
				per telehealth clinician	, following		
				telehealth review. On			
				the intradisciplinary tea			
				completed an intradisc			
				care plan meeting for f	ifteen of		
				fifteen residents. The	included but		
				comprehensive review was not limited to the f			
				items: RN assessment	•		
				ul="" role="list"			
				Nurse Practitioner/Phy	rsician		
				recommendations			
				Blood glucose			
				levels Specialist/Refer	rals Current		
				interventions for mana	ging		
				diabetes including			
				medication Resident/F	amily		
				preferences including			
				appointment/referral a	na current		
				treatment of diabetes			
				Care Plan interventions were revi	iowod opd		
				updated by licensed nu			
				as indicated during this	-		
				include diabetic			
				Management and spec	cialty		
					,	1	

	T OF DEFICIENCIES DF CORRECTION	x1) provider/supplier/clia identification number 155494				(X3) DATE SURVEY COMPLETED 12/20/2021	
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TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	referrals. Ea	ich	DATE	
				monitored weekly by the intradisciplinary team (it the residents' physician minimum of weeks to validate that to interventions are effect management of diabete ensure follow up referra are complete indicated. During the for review the intradisciplin will complete a diabete Compliance audit includes the following it oral/injectable meds giv ordered, blood sugars monitored as ordered a notified of bl glucose levels below 60 400 unless otherwise s the physician, intervent initiated as indicated to p="" paraid="40091720"	including n) for a four the current tive for es and als ed as bur weeks hary team c Monitoring that tems: ven as are and MD is lood 0 or above specified by tions are		
				paraeid="{78b274b6-6f a-ca85ff012e11}{96}"> maintain blood sugars -400 to include medica management by the physician/nurse practiti	f3b-4581-bc3 between 60 tion ioner. Any entified will e physician w. On of Nursing ewed the licy and nges to the		

. ,		OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00		TON (X3) DATE SURVE COMPLETED 12/20/2021		
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CO	DD	
WATERS	OF SCOTTSBUR	C, THE		I TODD DR TSBURG, IN 47170		
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TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	initiated by executive did (note the executive did is also a licensed nurse management of diabete writing orders for special referrals and the revise for scheduling appointh education was mandate licensed nursing staff a administrative managen future reference admini managers include the fa Activities Director, Reha Manager, Dietary Mana Business Office Manag Assistant Director of Nu Director of Nursing, Ce Nursing Assistant, Dire Nursing, Administrator, Manager, Social Servic Development, and Hou and Maintenance Direct 12/17/21, 11 of 11 Adm staff, and 8 of 13 licens staff have received edu regarding diabetic man and communication of p referrals. Each participa required to complete a validate competency. K was measured by a PC that required 100% acc the answers. (Facility a Agency, Licensed nursi not be allowed to work 12/17/21 unless they ha successfully completed assigned education). p="" paraid="11181486 paraeid="{78b274b6-6f	irector ector, who e, regarding es including alty d process nents This ed for nd all rs. (For istrative ollowing: ab ager, ler, ursing, rtified ctor of Dietary les, staff sekeeping tor). As of ninistrative led nursing tor). As of ninistrative sed nursing tor). As of ninistrative sed nursing tor). As of ninistrative sed nursing cation agement physician ant was post-test to cnowledge DST TEST uracy of nd ing staff will after ave all	DATE

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155494		A (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		. í	(X3) DATE SURVEY COMPLETED 12/20/2021	
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WATERS OF S	SCOLLSBOR	RG, THE		SCOT	TSBURG, IN 47170		
PREFIX (EACH DEFICIE		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLET DATE
					a-ca85ff012e11}{159}">/ sugars will be reviewed of morning clinical meeting Monday through Friday f minimum of four weeks to licensed staff are complet physician notifications for resident with a blood sug than 60 or greater than 4 otherwise specified by th physician/physician extender. On 1/17/22 a of Condition Quality Rev was reviewed and accep Quality Assurance Perfor Improvement Committee Director of Nursing/Desig Nurse will complete the 6 Condition Quality Review validate that any residen a change in condition ha documentation to show to resident was informed, physician/designee conso resident's representative consistent with his or her authority. Notifications w the following: incident/ac significant change in the physical/mental or psyche status (that is a deteriorat health, mental, or psyche status in either life threat conditions or clinical complications), Need to treatment significantly (th need to discontinue an e form of treatment due to consequences, or to com new form of treatment) of	daily in the (CQI) for a o ensure eting r any gar less 100-unless ine Change iew Audit oted by the rmance e. The gnated Change of v, to t who has s he auted, and r ill include ccident, residents nosocial ation in osocial tening alter a nat is a existing adverse nmence a	e s e f s d

	T OF DEFICIENCIES DF CORRECTION	x1) provider/supplier/clia identification number 155494	FICATION NUMBER A. BUILDING <u>00</u>			(X3) DATE SURVEY COMPLETED 12/20/2021	
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TAG		R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE	DATE	
				decision to transfer of disch resident from the facility. Furthermore, this review will include validation that the re and the resident's represen if any, are notified of the foll change in room or roommat assignment, change in resid rights under federal or state regulations and validate per review of mailing addresses addresses and phone numb resident representative(s). Any concerns identified dur change of condition quality will be addressed at the tim the review and additional education will be completed that time. The Change of Co Quality Review Audit will be completed on five residents week for twelve weeks. The of the Audits will be submitt the Quality Assurance Performance Improvement Committee monthly. The Q/ Committee will determine if additional education or competencies are required, on the compliance reported the Quality Reviews. Follow initial twelve-week review, A minimum of 10 residents wi reviewed monthly until 1009 compliance has been detern by the QAPI committee. (A minimum of seven months r	I esident tative, owing: te dents' law or riodic s, email pers of ring the reviews e of at ondition a results ed to API based from ring the API based from ring the mined must		
				be completed). On 12/17/ A Referral Quality Review A was reviewed and accepted	Nudit		

	I OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155494	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 12/20/2021	
NAME OF PE	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
WATERS	OF SCOTTSBUF	RG, THE		TSBURG, IN 47170		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLETIO	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	Quality Assurance Performanc	DATE :	
				Improvement Committee. The Director of Nursing/Designated		
				Nursing will complete the Refe Quality Review Audit Tool, to		
				validate that any resident who a referral receives care and		
				and complete appointments an		
				validate that the Appointment Tracking Log is complete and		
				reviewed daily during the morn meeting. Furthermore, this revi	iew	
				will include validation that prog notes are being reviewed durin	ng	
				the morning clinical meeting (C to ensure no orders are there t	,	
				need to be processed for implementation including speci	ialty	
				referrals. Any concerns identi- during the referral quality review		
				will be addressed at the time of the review and additional	f	
				education will be completed at that time. The Referral Quality		
				Review Audit will be completed times a week for twelve weeks		
				(Including a 100% review of all appointments/referrals). 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 report		
				from the Quality Reviews. Following the initial twelve-wee		
				100% review, A minimum of 10		

	T OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155494	(X2) MULT A. BUILI B. WING	<u></u>	СОМ	'e survey pleted 20/2021
	ROVIDER OR SUPPLIE		1	TREET ADDRESS, CITY, STATE, ZIP CO 350 N TODD DR	DD	
WATERS	OF SCOTTSBUR	RG, THE	5	SCOTTSBURG, IN 47170		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	D PROVIDER'S PLAN OF CORF EFIX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETIC DATE
IAU		K LSC IDENTIFYTING INFORMATION		residents will be review until 100% compliance determined by the QAF committee. (A minimum months must be complet 12/17/21, a Glucose Me Quality Review Audit w and accepted by the Qu Assurance Performance Improvement Committee Director of Nursing/Des Nurse will complete the Monitoring Quality Rev Tool, to validate that ar who has abnormal gluc (above 400 or abnormation below 60-unless otherw specified by the physician nursing assessment an specialty referrals. A concerns identified duri Glucose Monitoring Qu reviews will be address time of the review and a education will be comp that time. The Glucose Quality Review Audit w completed five times a twelve weeks (Including review of all residents w monitoring). The results Audits will be submittee Quality Assurance Perf Improvement Committee The QAPI Committee w determine if additional or competencies are re based on the compliant	red monthly has been of seven eted). On onitoring ras reviewed uality e e. The signated e Glucose iew Audit by resident cose levels ally low vise ian) have ation with h/designee, nd review for ny ing the additional leted at Monitoring fill be week for g a 100% with glucose s of the d to the formance be monthly. vill education quired,	

	R MEDICARE & MEDI					MB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 12/20/2021	
	PROVIDER OR SUPPLIE		1350 N	ADDRESS, CITY, STATE, ZIP COD I TODD DR ISBURG, IN 47170		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DN BE PRIATE	(X5) COMPLETION DATE
				from the Quality Reviews. Following the initial twelve- 100% review, A minimum of residents will be reviewed r until 100% compliance has determined by the QAPI committee. (A minimum of months must be completed). Any patterns be identified. If needed, an Plan will be written by the O committee. Any written Ac Plan will be monitored by th Administrator until resolved member of the Regional Te attend the monthly QAPI m on site or remotely x 3 months Date of Complia 1/20/22	of 10 monthly been seven s will Action QAPI tion ne t. A eam will neetings	
F 0657 SS=D Bldg. 00	 §483.21(b)(2) A must be- (i) Developed without of the comprehending the comprehending the comprehending (ii) Prepared by a includes but is not (A) The attending (B) A registered the resident. (C) A nurse aide resident. (D) A member of staff. (E) To the extent the text of tex of text of t	g and Revision prehensive Care Plans comprehensive care plan hin 7 days after completion nsive assessment. an interdisciplinary team, that of limited to g physician. nurse with responsibility for with responsibility for the food and nutrition services				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN	IT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155494	A. BUILDING		COMI 12/2	e survey Pleted 0/2021
	PROVIDER OR SUPPLI		135	EET ADDRESS, CITY, STATE, ZIP CO 0 N TODD DR OTTSBURG, IN 47170	DD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIZ TAG	CROSS-REFERENCED TO THE AP	ECTION DULD BE PROPRIATE	(X5) COMPLETIO DATE
	included in a resperticipation of the representative is for the developming plan. (F) Other appropriation of the developming of the developming of the developming of the developming plan. (F) Other appropriation of the developming of the dev	team after each assessment, e comprehensive and assessments. eview and interview, the facility d update a care plan related y for 1 of 21 residents review for ent 51) d for Resident 51 was reviewed, et to, hemiplegia and wing cerebrovascular accident, - dominant side, weakness, scle left ankle and foot, and, dementia and traumatic DS (Minimum Data Set) 11/10/21, indicated the an was moderately impaired. He e assistance of two staff DL's (Activities of Daily Living). corative program was performed dar days. He received PROM Motion) for 5 days, AROM Motion) for 5 days and splint or	F 0657	 F657 Care Plan timing/ 1. On 12/17/21, resident care plan was reviewed revised by the MDS Coordinate the status of the statu	dent #51's and ordinator to splint. Director of ator and tified with orders at will be f the splint ently in use. wed and ng this <i>Director of</i> <i>tor</i> <i>nsive Care</i> es were	01/20/203

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	155494	B. WING		12/20/2021	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD		
WATER	S OF SCOTTSBUF	RG, THE	SCOTTSBURG, IN 4717			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	The physician's or	der, with a start dated of 8/21,		was re-educated on the Care Pla	n	
	indicated the resid			Assessment/Comprehensive Car	e	
	-	rapy evaluation and treat as		plan policy. This education was		
	indicated.			completed by the Director of Nursing.		
	The care plan, date	ed 8/9/14 and revised on		5		
	-	the resident had a contracture		The intradisciplinary team is		
		r, elbow, and left hand related to		responsible for validating new		
	hemiplegia. The re	esident will have no further		orders (including hold orders for		
	contractures. Inter	ventions include, but were not		splints) are reviewed daily in the		
	limited to, inform	the physician of any changes to		morning clinical meeting (CQI)		
	,	ave restorative for PROM and		Monday through Friday and that		
	therapy as needed.			care plans are revised as indicated.		
	The review of the	resident's Occupational notes,				
	dated 10/26/21, in	dicated therapy discussed with				
	the resident's nurse	e he had an area on the left		4. On 1/17/21, a Splint Care		
	hand in the crease.	The nurse assessed and		Plan Quality Review Audit was		
	trimmed the reside	ent's fingernails and applied		reviewed and accepted by the		
		in his hand. His splint was put		Quality Assurance Performance		
		while treatment was completed		Improvement Committee. The		
		ea was not caused from the		Director of Nursing/Designated		
	-	e resident's long fingernails		Nursing will complete the Splint		
	digging into the sk	tin due to contractures.		Care Plan Quality Review Audit		
				Tool , to validate that any resident	t	
		resident's care plan lacked		who has a splint or brace has a		
	hold.	resident's splint was placed on		care plan that reflects the current treatment.		
	During an intervie	w on 12/17/21 at 9:34 a.m., the		Any concerns identified during the	e	
	-	rapist indicated the resident was		Splint Care Plan Quality		
	_	again on 8/21 for modification of		reviews will be addressed at the		
	a new splint and se	elf-feeding. At that time the		time of the review and additional		
	staff had not been	trained to apply the new splint,		education will be completed at		
	and the old splint l	had been put on hold.		that time. The Splint Care Plan will be completed five times a		
	During an intervie	w on 12/18/21 at 4:10 p.m., LPN		week for twelve weeks (Including	a	
		tical Nurse) indicated the care		100% review of all residents with		
		lated or revised when there was		Splints/Braces. The results of the		
		ion, a change in medication,		Audits will be submitted to the		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(-)	E SURVEY PLETED	
	or conduction	155494	B. WING		-	12/20/2021	
NAME OF 1	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CO	D		
WATER	S OF SCOTTSBUR	RG, THE		N TODD DR TSBURG, IN 47170			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)	
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TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	any new orders, an	d any therapy changes.		Quality Assurance Perfe			
				Improvement Committe	•		
		w on 12/20/21 at 8:39 a.m., MDS		The QAPI Committee w			
		ted if a care plan was put on		determine if additional e			
		move the care area from the		or competencies are re-	-		
		e plan would be reinstated when		based on the compliance			
	therapy restarted the	ne splint.		from the Quality Review			
				Following the initial twe			
		0 a.m., the DON (Director of		100% review, A minimu			
		l a copy of the facility's current		residents will be review	ed monthly		
	policy titled Care I			until 100% compliance	has been		
	-	rehensive Care Plans" dated		determined by the QAP	1		
		f this policy included, but was		committee. (A minimum	of seven		
		The Comprehensive Care Plan		months must be comple	eted).		
	will further expand	l on the resident's risks, goals					
		using the "Person-Centered"		Any patterns will be ide	ntified. If		
	Plan of Care appro	ach for each resident that		needed, an Action Plan	will be		
	includes measurab	le objectives and timetables to		written by the QAPI con	nmittee.		
	meet the resident's	medical, nursing, physical		Any written Action Plan	will be		
	functioning mental	and psychosocial needs.		monitored by the Admir	nistrator		
	These needs will b	e defined from observations,		until resolved.			
	interviews, clinica	l medical record review and		A member of the Regio	nal Team		
	through assessmen	t and CAAs. The Physician		will attend the monthly			
	Orders, Change of	Condition Forms, MAR's and		meetings on site or rem			
	-	s of the Plan of Care."		months	,		
	3.1-35(a)						
	3.1-35(e)						
				Date of Compliance 1/2	0/22		
0050							
0658	483.21(b)(3)(i)						
SS=F		d Meet Professional					
Bldg. 00	Standards						
		mprehensive Care Plans					
		vided or arranged by the					
	-	d by the comprehensive					
	care plan, must-			1		1	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 12/20/2021 155494 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, THE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (i) Meet professional standards of quality. Based on observation, record review, and F 0658 F658 Professional Standards 01/20/2022 interview, the facility failed to ensure nursing services met professional standards of care for 1. Infection Control-LPN # 13 infection control practices, perineal care, quality was verbally educated by the DON of care, nursing assessments and monitoring, on 12/16/21 regarding proper PPE notification of change, and nursing knowledge of in isolation rooms. LPN # 14 was interventions. This deficient practice had the verbally educated by the DON on potential to affect all 71 residents residing in the 12/16/21 regarding proper PPE in facility. isolation rooms. Nurse Aide #15 was verbally re-educated on Findings include: completion of peri care and appropriate infection control 1. During the survey, multiple concerns were practices on 12/17/21 by identified related to infection control practices of administrative nursing staff. improper use of personal protective equipment in transmission based precautions rooms and Glucose Monitoring- On perineal care. 12/16/21 The Director of Nursing completed an RN assessment on Cross Reference F880 resident #46. The assessment 2. Resident 46 experienced unstable blood glucose included but is not limited to the levels. Nursing staff had not notified the following items: physical resident's physician each time his blood glucose assessment, vital signs, glucose levels were outside ordered parameters and failed monitoring (last seven days), to ensure an endocrinology appointment was set current medications to treat up as ordered by the physician. The physician did diabetes, and specialty referrals. not address continual unstable blood glucose On 12/17/21, a telehealth review levels, and the resident experienced several was completed with Reliant Health instances of high blood glucose levels with no Care. During the telehealth review treatment or modification to insulin orders. The licensed nursing staff reviewed the resident ultimately was hospitalized with RN assessment, the residents hyperglycemic hyperosmolar nonketotic coma and blood sugars (for the past seven diabetic ketoacidosis. Upon return to the facility days) and current treatment plan the resident continued to experience unstable for diabetes. New orders were blood glucose levels, which the physician had not received, and family notified. addressed with any sliding scale insulin coverage. Resident #46 was seen by an endocrinologist on 1/10/22 and Cross Reference F684 medication orders were adjusted. Cross Reference F580 Change of Condition-PL0011 Event ID: Facility ID: 000478 Page 18 of 82 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/20/2021
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD	
WATER	S OF SCOTTSBUF	RG, THE		N TODD DR TSBURG, IN 47170	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETI
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		veloped a skin tear. Nursing staff		Resident #54	
	had not adhered to	professional standards of		Resident #54 was assessed b	у
	notifying the phys	ician of a change in resident		licensed nursing staff on 12/20	0/21,
	condition and obta	ining treatment orders or		a change of condition was	
	complete any follo	ow-up monitoring or assessment		completed, and treatment orde	ers
	related to the new	area of skin impairment.		were clarified regarding skin to	
				on the rt. arm. Nail care was	
	Cross Reference F	684		completed by licensed nursing	, I
				staff. The physician and	,
	4. Resident 54 had	a fall on 12/15/21 resulting in a		responsible party were notified	das
		ead and complaints of right hip		indicated and residents plan o	
		was sent to the hospital for		care was revised.	
	·	return to the facility, the nursing			
	-	ted any neurological checks.		Resident #51	
	The resident was observed complaining of pain			On 12/20/21 the Clotrimazole	
		erved to not assess or address		order was clarified and rolled	
	the resident's com			pillowcase to be inserted follow	wing
				the application of	wing
	Cross Reference F	689		medication/cream was added	to
		ad not transcribed the		the treatment order. Resident	
	-	into the clinical record for a		responsible party was notified	
		riation to his contracted left		resident #51's care plan was	
		ere observed to be digging down		revised as indicated.	
		s palm, and moisture was		Tevised as indicated.	
		on. The physician ordered to		Incident/Accidents- On 12/20	101
	U	atment and a pillowcase to the		resident #54 was reviewed by	· ,
		ders were not transcribed and		intradisciplinary team. Reside	
		sident developed a fungal		#54's CT scan completed	ant l
	infection to his has			12/15/21 was reviewed and	
	infection to ms na	nd:			.1
	Cross Reference F	684		determined to be within norma	
	Closs Reference F	004		limits. A pain assessment was	
	During an internit			completed by licensed nursing	
	-	w, on 12/15/21 at 08:24 a.m., LPN		staff on 12/20/21 the resident	41
		ll Nurse) 6 indicated she would		reported no pain at the time of	ine
	-	in to locate nonpharmacological		assessment.	
		ehaviors, however, was unable			
	_	plan in the clinical record, she		Transcription of orders- On	
		to the signs and symptoms of		12/20/21 the Clotrimazole orde	
	psychotropic medi	ication.		was clarified and rolled pillowo	ase
				to be inserted following the	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		COMI	(X3) DATE SURVEY COMPLETED 12/20/2021	
	PROVIDER OR SUPPLIE		1350	ET ADDRESS, CITY, STATE, ZIP CO N TODD DR	DD		
NATER	S OF SCOTTSBUR	RG, THE	SCC	OTTSBURG, IN 47170			
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TAG	The Facility Assess provided on 12/14, included but was m following compete living nail and ha motion (upper or la control isolation, including use of po Resident assessme admission assessme injury assessment, observations of res assessment Carin or other dementia	R LSC IDENTIFYING INFORMATION sment Tool, dated 12/7/21, /21 at 10:00 a.m. by the ED, tot limited to, " Consider the encies Activities of daily air care perineal care range of ower extremity) Infection , standard universal precautions ersonal protective equipment nt and examinations - tent, skin assessment, pressure neurological check sponse to treatment, pain ng for persons with Alzheimer's Specialized care diabetic ing, oxygen administration"	TAG	application of medication was added to the treator Resident and responsite was notified and resider care plan was revised a indicated. 2. On 1/17/21 the II Nursing identified reside residing in the facility as potential to be affected facility provision of care professional standards. 3. On 1/17/22 the administrator and Direc Nursing were provided by the Regional Nurse via teleconference rega components of F658. Di teleconference a team took place to review all identified in the 2567 and corrective actions nece meet professional stand care. An Adhoc QAPI in was conducted on 1/17 review and adopt record education/competencie auditing tools for F580, F658, F684, F686, F68 F695, F697, F756, F83 and F886 to ensure that facility actions were con implementing services	on/cream ment order. ole party nt #51's as Director of ents s having a by the e that meets tor of education consultant arding the discussion items nd ssary to dards of meeting 7/22 to mmended as and F657, 8, F689, 8, F880 at the mpliant with	DATE	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155494	B. WING		12/20/2021
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
WATER	S OF SCOTTSBUF	RG, THE		TODD DR SBURG, IN 47170	
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETIO
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				 (Facility and Agency, License nursing staff will not be allowed work after 1/20/21 unless they have successfully completed assigned education). 4. An Adhoc QAPI meetind was conducted on 1/17/22 to review and adopt recommended education and auditing tools f F580, F657, F658, F684, F688, F689, F695, F697, F755 F838, F880 and F886 to ensurt that the facility actions were compliant with implementing services that meet appropriate standards of care. Any patterns will be identified needed, an Action Plan will be written by the QAPI committee Any written Action Plan will be monitored by the Administrate until resolved. A member of the Regional Te will attend the monthly QAPI meetings on site or remotely provides and the set of the remotely provides on site or remotely provides on site or	ed to / all g led for 6, 6, 6, if e e . If e e. or am
⁻ 0684 SS=J Bldg. 00		of care a fundamental principle that tment and care provided to		Date of Compliance 1/20/22	

01/27/2022 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/20/2021 155494 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, THE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. A. Based on observation, record review, and F 0684 01/20/2022 F684 Quality of Care interview, the facility failed to address and manage unstable blood glucose levels for a resident with Diabetes Mellitus and to follow the 1.What corrective action(s) will physician recommendations for care for 1 of 21 be accomplished for those residents reviewed for Quality of Care. (Resident residents found to have been 46) affected by the deficient practice-B. Based on observation, record review, and interview, the facility failed to ensure the physician was notified and treatment orders were obtained for a new skin impairment for Resident 54. The facility also failed to ensure physician Resident #46 orders were transcribed into the clinical record and implemented for Resident 51. This deficient On 12/16/21 Resident #46's practice affected 2 of 21 residents reviewed for primary physician was contacted Quality of Care. by the Director of Nursing and notified that the endocrinologist The Immediate Jeopardy began on 11/10/21 when visit had not been scheduled. The the facility failed to follow physician primary physician recommended recommendations to refer the resident to an no changes in treatment at that endocrinologist related to unstable blood glucose time and scheduled a facility visit levels. The resident's blood glucose levels became on Saturday 12/18/21. progressively unstable. On 12/5/21 the resident was hospitalized due to a change in condition and Referral documentation was was hospitalized with the diagnoses of Diabetic scanned to Dr. Endocrinologist in Ketoacidosis and Hyperglycemic Hyperosmolar Sellersburg, IN on 12/16/21 and Nonketotic Coma. The resident returned to the the office was contacted for an facility and has continued to have unstable blood appointment. On 12/17/21 the glucose levels with no changes made in his office scheduled an appointment insulin treatment. The Executive Director, for resident #46 on January Assistant DON (Director of Nursing) and Nurse 10,2022 at 11AM. Residents Consultant were notified of the Immediate family (daughter) contacted and PL0011

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

Event ID:

Facility ID: 000478

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION X	(X3) DATE SURVEY COMPLETED 12/20/2021	
NAME OF 1	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
WATERS	S OF SCOTTSBUF	RG, THE	SCOT	TSBURG, IN 47170		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		/21 at 6:45 p.m. The immediate		agreed to appointment. On		
		oved on 12/18/21, but		1/10/22 resident #46 was seen b	у	
	-	nained at the lower scope and		the endocrinologist and		
		al harm with potential for more		medication adjustment was		
	than minimal harm	n that is not immediate jeopardy.		completed.		
	Findings include:			On 12/16/21 The Director of Nursing completed an RN		
	A During an obse	rvation on 12/15/21 at 10:53		assessment on resident #46. Th		
	-	was observed walking into the		assessment included but is not		
		dining room. There was a large		limited to the following items.		
	-	he dining room floor. CNA		A) Physical assessment		
(Certified	· ·	Aide) 8 indicated the resident		B) Vital Signs		
		cident and she had gotten him		C) Glucose monitoring review	v	
	-	ad happened for the third time		(last seven days)		
	-	is urinating quite frequently		D) Current medication orders	;	
	(common sign of c			to treat diabetes		
				E) Specialty referrals or		
	During a continuo	us observation, on 12/16/21		recommendations		
	from 10:15 a.m. to	11:15 a.m., Resident 46 was				
		l, walking about the memory		On 12/17/21 A telehealth review		
		om. He would sit for short		was completed with Reliant Hea	lth	
		ng room, and then get up and		Care. During the telehealth revie		
		oom. At 10:42 a.m. he sat down		licensed nursing staff reviewed t	he	
		's geriatric wheelchair in the		RN assessment, the residents		
		his eyes. CNA 9 assisted the		blood sugars (for the past seven		
	resident to his bed			days) and current treatment plan	1	
	The aliminations	l for Resident 46 was reviewed		for diabetes. New orders were		
				received, and family notified.		
		0 a.m. Diagnoses included, but o, cerebral infarction, alcohol		Now orders ressived for Desider	at	
		lcohol induced persisting		New orders received for Resider		
	-	prillation, altered mental status,		#46 include the following change Ø Discontinue Metformin 500m		
		pairment, cognitive			3	
		ficit, Type 2 diabetes mellitus		Ø Administer Metformin 1000m	a	
		ions, polyneuropathy,		BID and sliding scale insulin	5	
	hypertension, and			Ø Licensed nursing staff are		
	,			responsible for on-going		
	The Quarterly MD	S (Minimum Data Set)		monitoring of blood glucose leve	ł	
		11/5/21, indicated the resident		and will report blood sugars abo		

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155494	B. WING		12/20/2021
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
WATER	S OF SCOTTSBUR	G, THE	SCOT	TSBURG, IN 47170	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	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 COMPLET
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		itively impaired, had diabetes		400 or below 60 to the physicia	an/
	mellitus, and requi	red injections of insulin daily		nurse practitioner.	
	The hospital disch	arge summary, dated 4/9/21,		On 12/17/21 the intradisciplina	arv
	-	ent would need to continue		team completed an	,
	accuchecks (blood	glucose monitoring) after		intradisciplinary care plan mee	etina
		ne after discharged and would		to review resident #46 related	-
		ed on high dose sliding scale		diabetes management. (For fu	
		rsing home medical doctor to		reference the intradisciplinary	
		eded. Orders at the time of		team included the following	
	5	cility included, but were not		participants: Director of Nursin	na
	-	glargine 26 units every morning,		Assistant Director of Nursing,	' ' ,
		nits three times daily every 6		Dietary Manager, Director of	
	-	cale as ordered, after giving		Activities, Social Services,	
	-	nsulin) do not recheck finger or		Therapy, certified Nursing	
		l next scheduled check. Give		Assistant). The comprehensive	e
	-	based on blood glucose 70 to		review included but was not lin	
	-	insulin (none), 151 to 200 give 3		to the following items:	
		give 6 units, 251 to 300 give 9		A) RN assessment	
		ive 12 units, for blood sugars		B) Nurse	
	over 350 call the p	-		Practitioner/Physician	
				recommendations	
	The care plan, initi	ated on $6/14/21$, indicated the		C) Blood glucose levels	
	-	diabetes with risk for		D) Specialist/Referrals	
		hyperglycemia. Interventions		E) Current interventions for	~
		not limited to, administer		managing diabetes including	
	,	sulins per order, check blood		medication	
		l as needed, monitor labs as		medication	
		D (physician) of blood sugar		F) Resident/Family	
		cified parameters, and offer		preferences including	
	snacks as needed.	enter parameters, and orier		appointment/referral and curre	nt
	shucks us needed.			treatment of diabetes	ALC .
	The Blood Sugar S	Summary indicated the resident			
	e e	sugar levels above 350 on the			
	following dates:			Care Plan interventions were	
	iono wing dates.			reviewed and updated by licer	head
	- April 23 at 7.22	n.m., the resident's blood sugar		nursing staff as indicated durir	
	-	mg/dL (milliliters per deciliter).		this review to include diabetic	'9
		mg/aL (mininters per decinter).			
	- April 24 at 4:39 t	o.m. and 4:40 p.m., BS level was		management and specialty referrals.	
	1 1 1 2 2 1 10 10 2 1	· r ·····, = = •••••• ··••	1	1	

PARTMEN NTERS FO	NTERS FOR MEDICARE & MEDICAID SERVICES				FORM APPROVEI OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/20/2021	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD		
WATER	S OF SCOTTSBUF	RG, THE		N TODD DR TSBURG, IN 47170		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT		
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO	OPRIATE COMPLETION	
TAG		DR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	567 mg/dL; at 7:51	1 p.m., BS level was 384 mg/dL.				
	Mars 14 at 0:10 a	$DS_{1} = 207 \dots s/H$		Resident #46 will continue	to be	
		.m., BS level was 397 mg/dL; at ., BS level was 395 mg/dL; and at		monitored weekly by the	u dire a	
	7:44 p.m., BS leve	-		intradisciplinary team (incl	-	
	/.44 р.ш., БS leve	51 was 377 111g/UL.		the residents' physician) for minimum of four weeks to		
	- May 26 at 9.01 m	o.m., BS level was 558 mg/dL.		that the current interventio		
	101ay 20 at 9.01 p	, 25 iover was 556 mg/al.		effective for management		
	- June 7 at 10:08 a	.m., BS level was 406 mg/dL.		diabetes. During the four v		
		,		review the intradisciplinary		
	- June 8 at 9:30 a.r	m., BS level was 520 mg/dL; at		will complete a diabetic Mo		
		vel was 445 mg/dL; at 1:39 p.m.,		Compliance audit that inclu	-	
	BS level was 353 mg/dL; and at 3:54 p.m., BS level was 463 mg/dL.			following items-		
				J J		
			Ø Oral/injectable meds giv	ven as		
	- June 9 at 7:06 p.1	m., BS level was 482 mg/dL.		ordered		
				Ø Blood sugars are monit	ored as	
	- June 10 at 8:19 p	.m., BS level was 435 mg/dL.		ordered and MD is notified	of blood	
				glucose levels below 60 or	above	
	- June 11 at 4:40 p	o.m., BS level was 449 mg/dL.		400		
				Ø Interventions are initiate		
		.m., BS level was 589 mg/d; and		indicated to maintain blood	•	
	at 7:20 p.m., BS le	evel was 545 mg/dL.		between 60 -400 to include		
	Lune 15 (10.05	n m. DS local max 2/5 / H		medication management b	-	
	- June 15 at 12:05	p.m., BS level was 365 mg/dL.		physician/nurse practitione		
	- June 17 at 5.02 m	o.m., BS level was 353 mg/dL.		Any concerns identified wi communicated to the phys		
	- June 17 at 3.02 p	, 15 level was 555 llig/uL.		the time of the review.	iciail al	
	- July 1 at 11.35 a	.m., BS level was 513 mg/dL.				
	<i>u</i> ,	, 25 level was 515 mg/d2.		Resident #54		
	- July 2 at 9:44 a.n	n., BS level was 530 mg/dL; at		Resident #54 was assesse	ed by	
	8:40 p.m., BS leve	.		licensed nursing staff on 1	-	
		-		a change of condition was		
	- July 3 at 8:21 p.n	n., BS level was 364 mg/dL.		completed, and treatment		
		-		were clarified regarding rt.		
	- July 10 at 7:47 p.	.m., BS level was 430 mg/dL.		dressing change. Nail care		
				completed by licensed nur	sing	
	- July 11 at 8:14 p.	.m., BS level was 450 mg/dL.		staff. The physician and		
				responsible party were not		
	- July 26 at 11:55 a	a.m., BS level was 421 mg/dL.		indicated and residents pla	an of	

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NTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
	ENT OF DEFICIENCIES	x1) provider/supplier/clia identification number 155494	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION X3	(X3) DATE SURVEY COMPLETED 12/20/2021	
	PROVIDER OR SUPPLIE		1350 N	ADDRESS, CITY, STATE, ZIP COD I TODD DR I SBURG, IN 47170		
		6, me				
X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	- July 29 at 5:24 p.	m., BS level was 401 mg/dL.		care was revised.		
	- August 11 at 11:2	4 a.m., BS level was 391 mg/dL.		Resident #51 On 12/20/21 the Clotrimazole		
	- August 16 at 5:31	p.m., BS level was 442 mg/dL.		order was clarified and rolled pillowcase to be inserted followin the application of	g	
 September 3 at 10:49 a.m., BS level was 600 mg/dL. September 4 at 1:07 p.m., BS level was 371 mg/dL; and at 4:55 p.m., BS level was 347 mg/dL. 				medication/cream was added to the treatment order. Resident and		
				responsible party was notified an resident #51's care plan was revised as indicated.	d	
	- September 15 at 8:13 p.m., BS level was 382 mg/dL.			Infection Control LPN # 13 was verbally educated		
		3:26 p.m., BS level was 434		by the DON on 12/16/21 regardin proper PPE in isolation rooms. LPN # 14 was verbally educated	ıg	
	- September 20 at 8 mg/dL.	3:57 p.m., BS level was 369		by the DON on 12/16/21 regardin proper PPE in isolation rooms. Nurse Aide #15 was verbally		
	- September 21 at 1 mg/dL.	0:18 a.m., BS level was 569		re-educated on completion of per care and appropriate infection control practices on2/17/21 by administrative nursing staff.		
	- October 2 at 7:47	p.m., BS level was 378 mg/dL.		auministrative nursing stan.		
	- October 3 at 7:15	p.m., BS level was 500 mg/dL.		2. How other residents having the potential to be affected by		
	- October 7 at 10:5	1 a.m., BS level was 357 mg/dL.		the same deficient practice will be identified, and what		
	- October 10 at 7:56 p.m., BS level was 386 mg/dL.			corrective action(s) will be taken—		
	- October 11 at 10:	13 a.m., BS level was 416 mg/dL.				
		00 p.m., BS level was 457 mg/dL; S level was 490 mg/dL.		On 12/16/21 The Director of		
		5 p.m. and 8:46 p.m., BS level 3:38 p.m., BS level was 353		Nursing identified fifteen Residen requiring glucose monitoring and diabetes management.		

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NTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			-			OMB NO. 0938-03		
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	r í	JILDING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/20/2021		
155494			D. W.			12/20	J/2021	
NAME OF	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD			
WATER	S OF SCOTTSBUR	G, THE		SCOTI	TSBURG, IN 47170			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTIO	Ň	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF	BE	COMPLETI	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	mg/dL; and at 7:45	p.m., BS was 574 mg/dL.						
	O - t - 1 - 1 7 - t 9.00	$\mathbf{D}_{\mathbf{r}} = \mathbf{D}_{\mathbf{r}} $			On 12/16/21-12/17/21, The			
	- October 1 / at 8:00	p.m., BS level was 570 mg/dL.			Director of Nursing complet RN assessment on fifteen c			
	The physician's ord	er, dated 10/19/21 at 12:26			fifteen residents. The asses			
		scontinue the resident's			included but is not limited to			
	sliding scale insulir				following items.			
					F) Physical assessment			
	The physician's ord	er, dated 10/22/21, indicated			G) Vital Signs			
		eters were changed to notify			H) Glucose monitoring re	view		
	the physician of any	blood sugar levels below 60			(last seven days)			
	or above 400. The r	esident's Lantus was increased			I) Current medication o	rders		
	to 25 units twice da	ily. There were no other			to treat diabetes			
	medication changes	related to the resident's			J) Specialty referrals or			
	insulin.				recommendations			
	The Blood Sugar S	ummary indicated the resident			On 12/16/21-12/17/21, a tel	ehealth		
	had multiple blood	sugar levels above 400 on the			review was completed with	Reliant		
	following dates:				Health Care for fifteen of fift	een		
					residents. During the telehe	alth		
		a.m., BS level was 554 mg/dL;			review licensed nursing stat	f		
	and at 12:17 p.m., I	BS level was 471 mg/dL.			reviewed each resident's R			
					assessment, blood sugars (
		e, dated 10/25/21 at 8:28 a.m.,			past seven days) and curre			
		nt's Lantus was increased from			treatment plan for diabetes.			
	units at h.s. (bedtim	to 30 units in the a.m. and 35				- 411		
	units at n.s. (beddin	е).			Results-or recommendation blood sugars (for the last se			
	The physician's not	e, dated 10/26/21 at 12:15 a.m.,			days), most recent A1C lab			
		tian ordered a onetime dose of			results, and current diabetic	:		
	Novolog (fast actin				treatment plan reviewed by			
	6	. ,			for fifteen of fifteen resident			
	- October 27 at 9:17	p.m., BS level was 568 mg/dL.			telehealth.			
					n			
	The physician's not	e, dated 10/27/21 at 11:20 a.m.,						
		nt was discharged to the						
		d returned at 5:52 p.m. with no			clinician. All new orders red			
	new orders at that t	me.			by clinician were entered in			
					residents' clinical record an	d		
	On 10/27/21 at 10:2	2 p.m., the physician changed			reviewed by DNS.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 12/20/2021 155494 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, THE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the resident's p.m. Lantus dose to 30 units. The resident received 30 units of Lantus in the a.m. During the telehealth reviews, and at h.s. three of fifteen residents received medication adjustments and seven - October 30 at 4:28 p.m., BS level was 589 mg/dL. of fifteen residents received orders The physician was notified with no new orders for Hgb A1C. received. Ø (Resident 1 of 3)-New order for Metformin 500 mg QD - October 31 at 11:50 a.m., BS level was 459 mg/dL. Ø (Resident 2 of 3) New order for No physician notification documented. Metformin 500 mg BID Ø (Resident 3 of 3) New order for - November 1 at 8:14 p.m., BS level was 514 mg/dL. Metformin 500mg BID The physician was notified with no new orders Ø (7 of 15 residents) Hgb A1c lab received. Ø Licensed nursing staff will be - November 2 at 4:42 p.m., BS level was 483 mg/dL. required to monitor glucose results The physician was notified with no new orders as ordered each shift and report to received. the physician/nurse practitioner if blood glucose levels are below 60 - November 5 at 1:14 p.m., BS level was 566 mg/dL. or above 400 (unless otherwise No physician notification documented. specified by the physician. - November 6 at 6:05 p.m. and at 7:57 p.m., BS level was 500 mg/dL. The physician was notified with All Families notified of any new no new orders twice in the same day. orders pertaining to clinician review and documented in the - November 7 at 7:47 p.m., BS level was 484 mg/dL clinical record. For fifteen of fifteen No physician notification documented. residents, no referral request made at this time per telehealth - November 8 at 9:12 p.m., BS level was 560 mg/dL. clinician, following telehealth review. The physician's order, dated 11/8/21, indicated the resident's parameters were changed to notify the physician of any blood sugar levels below 60 or On 12/17/21 the intradisciplinary above 500. team completed an intradisciplinary care plan meeting The Blood Sugar Summary indicated the resident's for fifteen of fifteen residents. The blood sugar levels were at/or above 500 on the comprehensive review included but following dates: was not limited to the following items: PL0011 Facility ID: 000478

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PRINTED:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

IES			IFICAT		PLIER/CLIA JMBER	4	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING				(X3) DATE SURVEY COMPLETED 12/20/2021							
	JRC	G, THE	Ξ				•	13	50 N	TOD	D D		γάτε, Ζι 170	P COD				
ЛАI	RY S	TATE	MENT (OF DEFI	CIENCIE			ID			p	PROVIDERS	S PLAN OF (ORRECTION	J		(X5)
FIC	IEN	CY MU	ST BE I	PRECEI	DED BY FU	ILL		PREF	IX	CR	EACH	I CORRECT	TVE ACTIO	N SHOULD B	E		COMPLE	TION
RY	OR	LSC IE	DENTIF	YING II	NFORMAT	ION		TA	G	011	.000	D	EFICIENCY				DATI	Ξ
0 a	ıt 8:	38 p.n	n., BS	level 5	500 mg/dl	L.				G)	F	RN ass	essmer	nt				
w	as n	otified	d, advi	sed the	e facility	to				H)	Ν	lurse F	ractitio	ner/Phy	sician			
oint	tme	nt witl	h endo	crinol	ogist, and	l				rec	omi	menda	tions					
ime	e do	se of (5 units	of No	volog.					I)	I	Blood g	glucose	levels				
										J)		Specia	alist/Re	ferrals				
1 a	ıt 10):04 p.	m., B	S level	600 mg/d	dL.				K)	(Current	t interve	entions f	for			
w	as n	otified	d and o	ordered	18 units o	of				ma	nag	jing dia	ibetes i	ncluding	9			
										me	dica	ation						
										L)	l	Reside	nt/Fam	ily				
3 a	it 8:	25 p.n	n., BS	level 5	500 mg/dl	L. No				pre	fere	ences i	ncludin	g				
ific	atio	n doci	ument	ed.						app	ooin	tment/	referral	and cu	rrent			
										trea	atm	ent of o	diabete	s				
4 a	ıt 8:	08 p.n	n., BS	level 5	500 mg/dl	L. No												
ific	atio	n doci	ument	ed.														
										Car	re F	Plan inte	erventi	ons wer	е			
5 a	ıt 10):05 p.	m., B	5 level	560 mg/d	dL.				rev	iew	ed and	update	ed by lic	ensed			
no	tific	ation	docum	nented.									-	ated du				
											-	-		e diabet	-			
		39 a.m			500 mg/dI	L. No				ma	nag	jement	, specia	alty refe	rrals.			
										Ead	ch r	esiden	t will co	ntinue t	o be			
7 a	ıt 10):09 p.	m., B	5 level	516 mg/d	dL.				mo	nito	ored we	ekly by	the				
no	tific	ation	docum	nented.						intra	adis	sciplina	ry tear	n (<i>inclu</i> o	ding			
										the	res	sidents	' physic	<i>ian)</i> for	a			
0 a	ıt 9:	20 p.n	n., BS	level 5	500 mg/dl	L. No				min	nimu	um of fo	our wee	eks to va	alidate			
ific	atio	n doci	ument	ed.						that	t the	e curre	nt inter	ventions	s are			
										effe	ectiv	ve for n	nanage	ment of				
1 a	it 8:	23 p.n	n., BS	level 5	500 mg/dl	L. No							-	follow u				
ific	atio	n doci	ument	ed.						refe	erra	ls are o	comple	ted as				
										indi	icat	ed. Du	ring the	e four we	eeks			
7 a	it 8:	52 p.n	n., BS	level 6	500 mg/dl	L. No							-	olinary t				
ific	atio	n doci	ument	ed.						will	cor	mplete	a diabe	etic Mon	itoring	I		
										Cor	mpl	iance a	audit th	at incluc	les the	;		
- December 4 at 8:34 p.m., BS level 500 mg/dL. No		No				follo	owii	ng item	IS-									
		n doci										•		eds give	en as			
										ord				5				
c th	e nı	ırsing	notes,	indica	ted the								ars are	monitor	red as			
					below 60),						•		otified c		d		
					following									/ 60 or a				
						-				Ŭ								
										glu	cos	e level	s below		above			

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/20/2021			
NAME OF	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 1350 N TODD DR					
WATER	S OF SCOTTSBUF	RG, THE		TSBURG, IN 47170				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION				
	 June 24 at 12:45 he required a gluca August 26 at 8:12 and he required tw September 23 at and he required a g September 29 at and he required a g 	a.m., BS level was 47 mg/dL, and		the physician. Ø Interventions are initiat indicated to maintain bloc between 60 -400 to includ medication management physician/nurse practition Any concerns identified w communicated to the phy the time of the review. On 12/20/21 the Director Nursing reviewed skin assessments for residents residing in the facility, no	od sugars de by the er vill be sician at of	DATE		
	staff due to unprec blood sugar levels two times during t floor, his bowel so blood sugar had be that same day. The notified twice and The nursing note,	lictable increases and drops in . The resident had gotten up he shift and urinated on the unds were hyperactive, his een reading "HI" since 4:00 p.m. e resident's physician had been had given no new orders. dated 11/10/21 at 8:44 a.m.,		residents were identified a dressings or skin treatme without a physician's orde On 12/20/21 a facility nail audit was completed by li nursing staff and resident were checked and trimme indicated) by licensed/cer	as having nts er. care censed : nails ed (if			
	and was not respond and was sent to hove report at 12:19 p.m returning to the fact arrived at the hosp 26. The nursing note, indicated the physical blood glucose level advised to set up a	he nursing note, dated 11/10/21 at 8:25 p.m., dicated the physician was contacted regarding a ood glucose level of "HI". The physician dvised to set up an appointment with an ndocrinologist, and a onetime dose of NovoLog		 staff. Residents residing in the on 12/20/21 were identified Director of Nursing Service having the potential to be by facility adherence to appropriate infection contexpractices. (See F880 for a interventions). 3. What measures will be place and what systemic will be made to ensure the systemic to ensure the systemic to ensure the systemic will be made to ensure the systemic will be systemi	ed by ces as affected additional put into changes			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 12/20/2021 155494 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, THE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE communication or appointments with an deficient practice does not recur endocrinologist following the physician's request on 11/10/21. The nursing note, dated 11/10/21 at 11:35 p.m., indicated the resident's blood sugar was 600 On 12/17/21, the procedure for mg/dL and the physician was notified at 8:03 p.m., scheduling referrals was reviewed with orders to administer 8 units of fast acting and revised by the QAPI insulin. The resident's sugar was rechecked at 9:35 Committee. (Participants involved p.m. and the resident's blood sugar level was 504 in the QAPI Committee on md/dL. 12/17/21 include the following participants Executive Director, The nursing note, dated 11/28/21 at 5:42 a.m., Activities Director, Rehab indicated the resident's blood glucose level Manager, Dietary Manager, reading was "HI". The physician was made aware, Business Office Manager, however, the clinical record lacked documentation Assistant Director of Nursing. of any new orders. Director of Nursing, Certified Nursing Assistant, staff The nursing note, dated 12/2/21 at 2:30 a.m., development coordinator and indicated the resident's blood glucose level Maintenance Director). Follow up reading was "HI". The physician was made aware, via phone will be conducted with however, the clinical record lacked documentation the medical director. of any new orders. The revised process for scheduling The nursing note, dated 12/5/21 at 1:36 a.m., referrals includes the followingindicated the resident was wandering in and out Licensed nursing staff will A) of his room with an unsteady gait and confusion, be required to document referrals his blood sugar level registered as "HI", fluids as a physician order were given, and vitals were obtained. The resident B) Physician orders will be had a tremor in his hand, and he would not answer reviewed daily Monday through questions. The physician was notified with new Friday in the morning clinical orders to send to the hospital. meeting C) A new Facility Appointment Log- this log will be The nursing note, dated 12/5/21 at 9:25 a.m., indicated the resident was admitted to the hospital completed by the for acute renal failure. transportation/scheduler daily to record all appointments and The hospital discharge summary, dated 12/7/21, referrals with tracking to include indicated the resident's current problems were scheduled appointmentsacute renal failure, dementia, elevated troponin residents will remain on the

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	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155494		(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/20/2021		
NAME OF	PROVIDER OR SUPPLIEF	ξ		ADDRESS, CITY, STATE, ZIP COD			
WATER	S OF SCOTTSBUR	G, THE		I TODD DR TSBURG, IN 47170			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	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 APPROPRIATE	COMPLETI		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
		mic hyperosmolar nonketotic		appointment log until the			
		a, and lactic acid acidosis. He		scheduled appointment has been			
	was treated with IV			completed			
		resident's insulin order for		D) The appointment tracking			
		ed to 25 units twice daily with		log will be reviewed daily Monday	/		
		nue to monitor and adjust		through Friday by the			
		The resident returned to the		administrator in the daily morning			
	facility on 12/7/21	in stable condition.		meeting with the department			
				managers			
	-	ummary indicated the resident		E) The DON/ADON will monitor	or		
		ted blood glucose levels		all progress notes since the			
	above 400 mg/dL upon return to the facility as			previous morning clinical meeting			
	follows:			(CQI) to ensure no orders are			
		· · · · · · · · · · · · · · · · · · ·		there that need processed for			
	- December 8 at 11:09 a.m., BS level was 405			implementation			
	mg/dL; and at $4:28$	p.m., BS level was 430 mg/dL.		F) Licensed nursing staff are			
				responsible for on-going			
	- December 9 at 8:3	31 p.m., BS level was 429 mg/dL.		monitoring of blood glucose level			
	D 1 11 44	22 DG 1 1 420		and will report blood sugars abov			
		:32 p.m., BS level was 428		400 or below 60 to the physician/			
	mg/dL; and at 8:55	p.m., BS level was 483 mg/dL.		nurse practitioner.			
	December 12 at 4	:19 p.m., BS level was 550		G) Administrative nursing staff			
		p.m., BS level was 418 mg/dL.		will communicate any delays in scheduling appointments with the			
	mg/uL, and at 0.37	p.m., D5 level was 416 mg/dL.		residents' primary care provider a			
	- December 13 at 6	:02 p.m., BS level was 465		indicated,	13		
		p.m., BS level was 409 mg/dL.					
	, and at 7.55	r, 22 te tet trub 107 mg/uL.					
	- December 15 at 1	1:38 a.m., BS level was 501 and		On 12/17/21, education was			
		ere documented at the same		initiated by executive director who			
		BS level was 500 mg/dL; and at		is also a licensed nurse),	-		
	7:43 p.m., BS level	-		regarding management of diabete	es		
		5		including writing orders for			
	The clinical record lacked documentation of any			specialty referrals and the revised	ł		
		ation for sliding scale insulin		process for scheduling			
		admission, on 12/7/21 until		appointments This education was	5		
		justments to the resident's		mandated for licensed and all			
		ween 12/7/21 and 12/16/21.		administrative managers. (For			
				future reference administrative			
	During an interview	v on 12/16/21 3:03 p.m., the		managers include the following:			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTERS FO	NTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039		
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	ILDING	00	COMPI	LETED	
		155494	B. WIN	NG		12/20	/2021	
NAMEOF))	I	STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	PROVIDER OR SUPPLIEF	ξ.		1350 N	I TODD DR			
WATER	S OF SCOTTSBUR	G, THE		SCOT	TSBURG, IN 47170			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	E	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	DON indicated she	believed someone had told her			Activities Director, Rehab			
	the SSD (Social Ser	rvices Director) had spoken			Manager, Dietary Manager,			
	with the family rega	arding a referral to an			Business Office Manager,			
	endocrinologist for	the resident and they didn't			Assistant Director of Nursing	7 ,		
	want him to see one	2.			Director of Nursing, Certified	1		
					Nursing Assistant, Director	of		
	During an interview	v on 12/16/21 at 3:10 p.m., the			Nursing, Administrator, Diet	ary		
	SSD indicated she l	had not spoken to the			Manager, Social Services, s	taff		
	resident's family un	til this date $(12/16/21)$ and the			Development, and Houseke	eping		
	daughter had indicated she did want him to see an				and Maintenance Director).			
	endocrinologist. If	it's clinical, it wouldn't be her						
	responsibility. She did not schedule the outside				As of 12/17/21, 11 of 11			
	appointments, the bus driver did that.				Administrative staff, and 8 o	f 13		
					licensed nursing staff have			
	During an interview	v on 12/16/21 at 3:18 p.m., the			received education regardin	g		
	DON and ED both	indicated the MDS coordinator			diabetic management and	•		
	was currently respo	nsible for scheduling			communication of physician			
	appointments, but p	prior to two weeks ago the bus			referrals. Each participant w			
	driver had been res	ponsible for it. Neither the ED			required to complete a post-			
	nor the DON person	nally had any conversations			validate competency. Knowl	edge		
		amily regarding his blood			was measured by a POST 1	-		
	sugar levels. If fam	ily were notified of things, it			that required 100% accurac	y of		
	would need to be do	ocumented. The DON had			the answers. (Facility and A			
	spoken with the res	ident's physician on this date			Licensed nursing staff will n	ot be		
	(12/16/21), and he l	had no changes and planned to			allowed to work after 12/17/			
	see the resident on	his next visit to the facility.			unless they have successful	lly		
	The ED indicated the	he resident had not had any			completed all assigned			
	endocrinologist app	pointments made for the			education).			
	resident at this time	2.						
					All blood sugars will be revie	ewed		
	During an interview	v on 12/17/21 at 1:58 p.m.,			daily in the morning clinical			
		cian indicated he had been			meeting (CQI) Monday throu	ugh		
	caring for the reside	ent for approximately four			Friday for a minimum of four			
	months. He had brit	ttle diabetes and bounced back			weeks to ensure licensed st	aff are		
	and forth from high	to low without any medicine.			completing physician notifica	ations		
	He decided last more	nth to send the resident to an			for any resident with a blood			
	endocrinologist. W	henever someone had brittle			less than 60 or greater than	-		
	diabetes, an endocr	inologist should be			400-unless otherwise specif	ied by		
		e an order last month for the			the physician/physician exte	-		
		ndocrinologist. He was at the						

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resident to see an endocrinologist. He was at the

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OMB NO. 0938-039

Facility ID: 000478

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	· /	LDING	00	COMPLETED		
		155494	B. WIN	IG		12/20	/2021	
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	PROVIDER OR SUPPLIE	ER			TODD DR			
WATER	S OF SCOTTSBUF	RG, THE		SCOTI	SBURG, IN 47170			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
REFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		PR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	-	ought it might be better to let the			On 1/17/22 Licensed nursing			
	-	blood sugars than to let him			were provided education rega	-		
		w blood sugar. He expected the			completion of change of cond	ition		
		endocrinologist and follow up			for skin changes, transcription	n of		
		l what they did, was call him			treatment orders and monitori	ng		
	-	ential realities. As a temporary			nail care.			
		ent's sugars were a " a little						
	-	vas the one holding back, but he			The process for monitoring na			
		nt needed to see an			care was revised to include ro	outine		
	-	e was not sure if he			monitoring with showers.			
		onversation. He did not adjust						
		in because he felt they needed			Infection Control			
		dn't go into diabetic			On 1/17/22, the Director of			
	ketoacidosis (DKA	A). The resident needed an			Nursing /Infection Control			
endoc	endocrinologist. H	e was going to decide on			Preventionist initiated education	on		
	12/18/21 how to p	roceed with his care. He			with facility licensed and certif	ied		
	indicated he could	control the resident's			nursing staff regarding the pro	oper		
	condition.				infection control procedures,			
					isolation precautions (includin	g		
	During an intervie	w, on 12/17/21 at 2:40 p.m.,			N95 masks) and PPE. This			
	Resident 46's phys	sician indicated when the			education included a PPE skil	ls		
	resident was hospi	talized on 12/5/21, it was most			observation and check-off to			
	important that it w	as not DKA. Even though his			validate competency with use	of		
	sugars were high,	it was not a DKA. The bad one			PPE, handwashing competen	су		
	that could kill pati	ents was DKA. He gave an			observation, and peri-care			
	-	staff had more information than			instruction.			
		ne needed to adjust his orders.						
		etween a doctor and a nurse was			On 12/17/21, the Director of			
		wasn't sure what he wanted to			Nursing reviewed the policy a			
		of the right direction. He			procedures for proper use of I			
		ent was on sliding scale insulin,			(Personal Protective Equipme	ent)		
	and he was to be n	otified any time the resident			and Peri Care. No revisions w	ere		
was		the resident was above 400, he			required.			
		receive fast acting insulin.						
There was a change in nurses, who did not know					On 1/17/22 the annual facility			
	the patients, so he	chose to use longer acting			infection control assessment	was		
	insulin because the	ere was less room for error.			reviewed and revised by the			
	Agency staff did n	ot know patients. He would			Director of Nursing/Infection			
	rather not give the	fast-acting insulin and would			control preventionist and the			
		have high blood sugar. He			Executive Director to include			

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATI	E SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED 12/20/2021		
155494		B. WING		12/20/2021			
NAME OF	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP COD N TODD DR			
NATER	S OF SCOTTSBUR	RG, THE		TTSBURG, IN 47170			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE OPRIATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	-	in making a determination is		infection control education			
		by tomorrow when I come there,		facility and agency license			
		ity of direction. It won't be I		certified nursing staff inclu	ıding		
	-	oblem; it will be I will have		PPE and handwashing			
	decided how I hop	e to solve the problem."		competencies.			
	• •	erosmolar Hyperglycemic		On 1/17/22 the facility QA			
		(Updated 5/12/21), was obtained		Committee adopted a wee	•		
		the National Institutes of Health		infection control rounding			
website. The guidance included, but was not				will be conducted weekly	by the		
limited to, "Hyperosmolar hypergly syndrome (HHS) is a clinical cond			infection control				
			preventionist/designee. The				
from a complication of diabetes mellitus HHS is a serious and potentially fatal complication of type 2 diabetes. The mortality rate in HHS can be				will be completed weekly			
			determine compliance wit				
			infection control and ident	•			
	-	ich is about 10 times higher		opportunities for education	n.		
	-	seen in diabetic ketoacidosis					
		formerly called					
		erglycemic non-ketotic		4. What quality assurance			
	-	is a serious and potentially fatal		program will be put in pl			
		pe 2 diabetes If diabetes is		and by what date the sys			
		e chance of developing HHS is		changes for each deficie	ncy		
	-	cose level in HHS is usually		will be completed.			
	-	. Dehydration is usually more					
		compared to DKA, and there is					
		ovascular collapse particular e focused on the insulin		On 40/47/04 A D 5	al		
				On 12/17/21, an A Referr			
		oses of oral hypoglycemic		Quality Review Audit wa			
		nption of carbohydrate-rich		reviewed and accepted by			
		us use of medications that can		Quality Assurance Perform			
		mia or cause dehydration		Improvement Committee.			
Treatment of HHS requires a multidisciplinary approach. Consultations with an endocrinologist and an intensive care specialist are recommended.				Director of Nursing/Design			
		-		Nursing will complete the			
				Quality Review Audit To validate that any resident			
	to improve patient outcome, an interprofessional approach with good care			a referral receives care ar			
	-	d coordination between the					
	Intensivist, nurse,			services necessary to sch			
	endocrinologist are			and complete appointmer validate that the Appointm			
		e necessary		Tracking Log is complete			
				I HAUKING LOG IS COMPLETE	anu	1	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155494	A. BUILDING B. WING	00	COMPLETED 12/20/2021	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R	1350 N	I TODD DR		
WATER	S OF SCOTTSBUR	G, THE	SCOTT	TSBURG, IN 47170		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLET	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	Guidance for NIH	Hyperglycemic crises: Diabetic		reviewed daily during the morn	ing	
		Iyperglycemic Hyperosmolar		meeting. Furthermore, this revi	ew	
	State (Updated 5/9	/21), was obtained on 12/17/21		will include validation that prog	ress	
		Institutes of Health website.		notes are being reviewed durin	g	
		ided, but was not limited to, "		the morning clinical meeting (C	QI)	
		sis (DKA) and hyperglycemic		to ensure no orders are there the	nat	
		(HHS) are acute metabolic		need to be processed for		
	· ·	iabetes mellitus that can occur		implementation including speci	alty	
	-	th type 1 and 2 diabetes		referrals.		
	-	agnosis, comprehensive clinical				
		valuation, and effective		Any concerns identified during		
		to the successful resolution of		referral quality reviews will be		
		ritical components of the		addressed at the time of the		
		ses' management include		review and additional education		
	-	resuscitation, insulin therapy,		will be completed at that time.		
		lacement along with the		Referral Quality Review Audit		
	-	monitoring using available		will be completed five times a		
	-	predict the resolution of the		week for twelve weeks (Includin	ng a	
		bis The mortality rate of HHS		100% review of all		
		10-20% depending on		appointments/referrals). The		
		idities and severity of the initial		results of the Audits will be		
		ared with DKA and is		submitted to the Quality		
	-	th DKA+ [and] HHS The two		Assurance Performance		
	-	ripitating factors in the KA or HHS are inadequate		Improvement Committee month	niy.	
	-	-		The QAPI Committee will		
		nether omitted or insufficient the presence of infection		determine if additional education		
	e ,	the presence of infection ts have features of both DKA		or competencies are required,	tod	
	-	t recent evidence confirming		based on the compliance repor from the Quality Reviews.	ieu	
		4 patients will have both		Following the initial twelve-wee	k	
		me of presentation with		100% review, A minimum of 10		
		is The cornerstone of DKA		residents will be reviewed mon		
		s insulin in physiologic doses		until 100% compliance has bee	•	
		resolved, patients who are able		determined by the QAPI	///	
		d on a multiple dose insulin		committee. (A minimum of seve	n	
		acting insulin and short/rapid		months must be completed).		
		n before meals as needed to				
		cose Several studies				
		omission of insulin is one of		On 12/17/21, a Glucose		
		precipitating factors of DKA		Monitoring Quality Review		
		pre-priming metors of Divis				

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 2	K3) DATE SURVEY COMPLETED 12/20/2021
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
	S OF SCOTTSBUF		1350 N TODD DR SCOTTSBURG, IN 47170		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
TAG	,	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
		and HHS as potentially fatal		Audit was reviewed and accept	
	-	burdensome complications of		by the Quality Assurance	
		ort for diminishing the possible		Performance Improvement	
	risk factors is wor			Committee. The Director of	
				Nursing/Designated Nursing wil	1
	The immediate jec	pardy, that began on $11/10/21$,		complete the Glucose	
	-	2/18/21 when the DON		Monitoring Quality Review	
	completed a review	w of the resident's vitals,		Audit Tool, to validate that any	
	glucose monitorin	g review for the last 7 days, and		resident who has abnormally high	
	current medication	orders to treat diabetes, the		(above 400 or abnormally low	
	physician adjusted	the medication regimen for		below 60-unless otherwise	
	Resident 54, and t	he appointment for the resident		specified by the physician) bloo	d
	to see an endocrin	ologist was scheduled, but		sugars have appropriate	
	noncompliance ren	mained at the lower scope and		communication with the residen	ťs
	severity of isolated	d, no actual harm with potential		physician/designee, nursing	
	for more than min	imal harm that is not Immediate		assessment and review for	
		the facility would need to nonitoring of Resident 46,		specialty referrals.	
	diabetic monitorin	g compliance audits would need		Any concerns identified during t	he
	to be conducted, d	iabetic residents would need		Glucose Monitoring Quality	
	continued monitor	ing, and further staff education		reviews will be addressed at the	e
	would need to be j	provided.		time of the review and additiona	al
				education will be completed at	
	B.1. During an ob	servation, on 12/14/21 at 9:46		that time. The Glucose	
	a.m., Resident 54	was sitting in his recliner in his		Monitoring Quality Review	
	room. His right ar	m was observed to have a large,		Audit will be completed five time	es
	-	essing which had a moderate		a week for twelve weeks (Includ	ling
		laking reddish-brown staining.		a 100% review of all residents v	vith
		g was a approximately 2 inch by		glucose monitoring. The results	
	·	ct tape. His pants and shirt were		the Audits will be submitted to t	
		ave dried reddish brown		Quality Assurance Performance	
	-	The resident indicated he had		Improvement Committee month	ly.
		ff had not done anything about		The QAPI Committee will	
		as worn and stained, with the		determine if additional education	n
	gauze fabric pillin	g and fraying.		or competencies are required,	
				based on the compliance report	ed
		tion, on 12/14/21 at 1:47 p.m.,		from the Quality Reviews.	
		ut to the dining room. He		Following the initial twelve-week	<
		rse on the unit and asked her if		100% review, A minimum of 10	
	she was going to h	elp fix his arm. The nurse did	1	residents will be reviewed mont	hiv I

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATI	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155494	A. BUILDING B. WING			PLETED 0/2021
		155494				0/2021
NAME OF	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP (O N TODD DR	COD	
WATER	S OF SCOTTSBUR	RG, THE		DTTSBURG, IN 47170		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE	SHOULD BE APPROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		ident's question or assess his		until 100% compliance		
	arm. She assisted l	nim to sit down at a table.		determined by the QA		
				committee. (A minimu		
		tion on 12/15/21 at 9:13 a.m., the		months must be comp	oleted).	
		g in his recliner in his room. The				
	-	onger in place on the resident's		Any patterns will be id		
		bordered gauze dressing		needed, an Action Pla		
	-	with dried, flaking reddish		written by the QAPI co		
		the gauze. The resident stated,		Any written Action Pla		
	-	t! I asked them to fix it and they		monitored by the Adm	ninistrator	
	wouldn't do it!"			until resolved.		
				A member of the Reg		
	-	tion, on 12/15/21 at 1:00 p.m.,		will attend the monthly		
		tting in his recliner in his room.		meetings on site or re	motely x 3	
	The dressing to the unchanged.	e resident's right arm remained		months		
				On 1/17/21 a Change	of	
	-	tion, on 12/17/21 at 8:15 a.m.,		Condition Quality Re		
		tting in his recliner in his room.		was reviewed and acc		
	-	e right forearm was no longer in		Quality Assurance Pe		
	· ·	abbed area to the arm was		Improvement Commit		
	observed where the	e dressing had been.		Director of Nursing/De	-	
				Nursing will complete	-	
	The clinical record	l for Resident 54 was reviewed		of Condition Quality		
		40 a.m. Diagnoses included, but		validate that any resid		
		o, muscle weakness, heart failure,		a change in condition		
		nic obstructive pulmonary		documentation to sho		
	-	ce on supplemental oxygen,		resident was informed	,	
		ence of cardiac defibrillator,		physician/designee co		
		of right wrist, unspecified		resident's representat		
		ity, osteoarthritis, lack of		consistent with his or		
		other abnormalities of gait and		authority. Notifications		
	mobility.			the following: incident		
				significant change in t		
	· ·	S assessment, dated 10/9/21,		physical/mental or psy		
		ent's cognition was moderately		status (that is a deteri		
	impaired and he ha	ad no skin impairments.		health, mental, or psy		
				status in either life thr	eatening	
	-	ed 8/29/19, indicated the		conditions or clinical		
	resident was at ris	k for self-abusive acts, and had		complications), Need	to alter a	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION	COMP	e survey leted)/2021
NAME OF	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP COD N TODD DR		
WATER	S OF SCOTTSBUF	RG, THE		TTSBURG, IN 47170		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO	D BE OPRIATE	COMPLETI
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		ning and picking at his skin.		treatment significantly (tha	it is a	
		ided, but were not limited to,		need to discontinue an exi	sting	
		nd family as needed of any		form of treatment due to a	dverse	
	treatment or medic	cations as ordered for any injury.		consequences, or to comr	nence a	
				new form of treatment) or	а	
	-	ed 4/12/21, indicated the		decision to transfer of disc	harge a	
		c for bleeding related to the use		resident from the facility.		
	-	lication. Interventions included,		Furthermore, this review w	/ill	
	but were not limite	ed to, document abnormal		include validation that the	resident	
	findings and notify	the physician.		and the resident's represe	ntative,	
				if any, are notified of the fo	ollowing:	
	The physician's or	ders, dated 12/4/21, indicated		change in room or roomm	ate	
	the resident receiv	ed aspirin 81 mg daily and		assignment, change in res	idents'	
	Plavix 75 mg daily	7.		rights under federal or stat	te law or	
				regulations and validate pe		
	The nursing note,	dated 12/12/21 a 2:30 p.m.,		review of mailing addresse		
	indicated the resid	ent appeared to have a small 0.1		addresses and phone num		
	cm (centimeter) by	0.5 cm skin tear on his right		resident representative(s).		
	elbow. Initially he	would not allow staff to treat,				
	but when the resid	ent was calm, the area was		Any concerns identified d	uring the	
	cleansed with wou	nd cleaner and a border gauze		change of condition qual	ity	
	was applied. The r	esident could not recollect how		reviews will be addressed	at the	
	he obtained the sk	in tear.		time of the review and add	litional	
				education will be complete	ed at	
	The clinical record	l lacked documentation of any		that time. The Change of		
	notification to the	family, physician, or of any		Condition Quality Review	/ Audit	
	treatment orders for	or the skin tear.		will be completed five time	s a	
				week for twelve weeks (th	is audit	
	During an intervie	w on 12/20/21 at 12:10 p.m., the		will include monitoring for	change	
	DON (Director of	Nursing) indicated she had seen		of condition with abnormal	-	
	the note about the	resident's skin tear. When a		levels and skin treatment		
	resident had a new	skin impairment, they should		changes). The results of the	ne	
	open a change in c	ondition note, notify the family		Audits will be submitted to	o the	
	and doctor, and en	sure treatment orders are in		Quality Assurance Perform	nance	
	place.			Improvement Committee r	nonthly.	
				The QAPI Committee will	-	
	2. During an obser	vation, on 12/13/21 at 10:36		determine if additional edu	ication	
		was observed with long jagged		or competencies are requi	red,	
	fingernails to his l	eft hand. His left palm and his		based on the compliance		
	hand appeared red			from the Quality Reviews.		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION (X. 00	3) DATE SURVEY COMPLETED
		155494	B. WING		12/20/2021
NAME OF	PROVIDER OR SUPPLIE	CR		ADDRESS, CITY, STATE, ZIP COD	
NATER	S OF SCOTTSBUF	RG, THE		I TODD DR TSBURG, IN 47170	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	The alinical record	l for Resident 51 was reviewed,		Following the initial twelve-week review, A minimum of 10 residen	
	on 12/18/21 at 1:3			will be reviewed monthly until	115
		d, but were not limited to,		-	
	-	miparesis following		100% compliance has been determined by the QAPI	
		cident, affecting left		committee. (A minimum of sever	
		e, weakness, contracture of		months must be completed).	'
		and foot, and contracture left			
	hand	,		On 1/17/22, an Infection Contro	a l
				Quality Review Audit Tool was	
	The Quarterly MD	S assessment, dated 11/10/21,		reviewed and accepted by the	
	indicated the resid	ent's cognition was moderately		Quality Assurance Performance	
	impaired. He requ	ired extensive assistance of two		Improvement Committee. The	
	staff members wit	h ADL's (Activities of Daily		Director of Nursing/Infection	
	Living).			Control Preventionist and	
				Administrative staff will complete	•
	The physician's ve	rbal orders, dated of 10/26/21,		random PPE observations, using	1
	indicated to apply	a prescription barrier cream to		the Infection Control Quality	
	the resident's butto	ocks and groin topically every		Review Audit Tool, to validate the	at
	shift for redness. A	Apply to palm left hand topically		infection control procedures are	
	every shift for exc	oriation and a rolled pillowcase		followed. This audit will also	
	to be placed in pal	m after cream applied.		include monitoring for proper per	i
				care (by licensed observer),	
		lated 10/26/21 at 12:31p.m.,		following isolation guidelines,	
		are the resident had excoriated		handwashing and use of	
		f his left hand, which was		appropriate masks. Any concern	s
		s currently working with		identified during the infection	
		on brace for the contracture.		control observations will be	
		notified with new orders for		addressed at the time of the	
		r cream to area and apply rolled		observation and additional	
	pillowcase to area	every shift.		education will be completed at	
				that time. The Infection Control	
		l lacked documentation		Quality Review Audit will be	
	-	er for a rolled pillowcase to be		completed five times a week for	
	-	ent's left palm was transcribed		twelve weeks. The results of the	•
	into the resident's	cimical record.		Audits will be submitted to the	
	During inter	12/17/21 at 0.20 I DN		Quality Assurance Performance	
		w on 12/17/21 at 9:30 a.m., LPN		Improvement Committee monthly	у.
		tical Nurse) indicated the		The QAPI Committee will	
	resident had a roll	that he was supposed to wear	1	determine if additional education	

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155494	A. B	IULTIPLE C UILDING /ING	ONSTRUCTION 00	COMI	e survey pleted D/2021
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP C	OD	
WATER	S OF SCOTTSBUR	RG, THE			TSBURG, IN 47170		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE NPPROPRIATE	(X5) COMPLETION DATE
F 0686 SS=D Bldg. 00	all the time for his left hand holds moverbal order, it shows record at the time I On 12/20/21 at 8:3 copy of the facility Physician Orders (Review of this politor, "It is the politor orders of the physic the facility must have resident's immedia orders to provide et consistent with the status upon admiss completed, orders physician to addre assessment." 3.1-37(a) 3.1-37(b) 483.25(b)(1)(i)(ii) Treatment/Svcs to Ulcer §483.25(b)(1) Pro- Based on the cor a resident, the fa (i) A resident reco- professional stand pressure ulcers a pressure ulcers a pressure ulcers a pressure ulcers a condition demons- unavoidable; and (ii) A resident wit necessary treatmer with professional	contracture and moisture. His isture. When a doctor gives a ould be added to the clinical he gave the order. 0 a.m., the DON presented a 's current policy titled Following Physician Orders)." icy included, but was not limited cy of the facility to follow the cian. At the time of admission, ave physician's orders for the te care. The facility will have essential care to the resident, resident's mental and physical tion2. As assessments are will be received from the ss significant findings of the o Prevent/Heal Pressure Integrity essure ulcers. nprehensive assessment of cility must ensure that- eives care, consistent with dards of practice, to prevent and does not develop unless the individual's clinical strates that they were			or competencies are re- based on the complian from the Quality Review Following the initial two review, A minimum of * will be reviewed month 100% compliance has determined by the QAF committee. (A minimum months must be compl Date of Compliance 1/2	ce reported ws. elve-week 10 residents ily until been Pl n of seven leted).	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE O A. BUILDING		DATE SURVEY OMPLETED
IND I LAN	of conduction	155494	B. WING		2/20/2021
NAME OF 1	PROVIDER OR SUPPLIE	CR .		ADDRESS, CITY, STATE, ZIP COD	
WATER	S OF SCOTTSBUR	RG, THE		TSBURG, IN 47170	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE
	new ulcers from a	eview and interview, the facility	F 0686	F686 Tx/Services to	01/20/2022
		e implementation of	1 0080	Prevent/Heal pressure Ulcers	01/20/2022
		in place to prevent the			
		pressure ulcer for 1 of 5			
		for pressure ulcers. (Resident		1. On 1/17/21, resident #36's	
	36)	-		care plan, wound	
				evaluation/assessment and	
	Findings include:			physician orders were reviewed	
				and revised by the Director of	
		l for Resident 36 was reviewed		Nursing Services and MDS	
		7 a.m. The diagnoses included,		Coordinator to address current	
		ed to, type 2 diabetes mellitus,		care and services necessary for	
		muscle weakness,		prevention of pressure ulcers.	
		osteoarthritis, encephalopathy,		Resident #36 does not have any	
	viral infections.	ce, schizophrenia, obesity, and		current pressure ulcers and has	
	viral infections.			been provided a pressure reduction wheelchair cushion.	
	The Quarterly MD	S (Minimum Data Set)		Resident #36's care plan has been	
	· ·	10/15/21, indicated the resident		reviewed and revised to include	
	was cognitively in			potential for skin breakdown.	
	-	ed 7/14/21, indicated the		2. On 1/17/21-1/18/22,	
		e to lie flat due to becoming		residents residing in the facility	
		h. The resident required the		that are determined to be at risk	
		be elevated due to shortness of		for pressure ulcers were identified	
		flat, related to chronic		by the Director of Nursing as	
	-	nary disease. The intervention evation of the head of the bed		having the potential to be affected	
		ing and prevent shortness of		by appropriate treatments to prevent/heal pressure ulcers.	
	breath.	ing and prevent shortness of			
				On 1/17-1/18/22, the Director of	
		l lacked documentation of any		Nursing and MDS Coordinator	
		event the development of		reviewed the identified residents to	
	pressure ulcers.			validate that current skin	.
	The group is the	lated 9/21/21 at 2:25		conditions have appropriate wound	1
		lated 8/31/21 at 3:35 p.m.,		evaluations/assessments,	
	-	ound rounds the resident		treatments, pressure reducing	
	-	ouched. The resident reported		surfaces/equipment and care plans that reflect current physician	

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	E SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMP	LETED
		155494	B. WING		12/20)/2021
JAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
	S OF SCOTTSBUR			I TODD DR FSBURG, IN 47170		
						1
X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION	TAG			DATE
	-	ea and it had been there for a		orders and wound care need		
		easured 1.6 cm (centimeters) by		(including actual and potenti		
		The wound was dry with no		skin breakdown intervention		
		a pinkish red wound bed, with a		care plans). Care plans wer		
		The resident indicated she had		reviewed and revised to ens		
	-	ace when she was at home, and		care plans reflect actual and		
	-	ed frequently. The area was		potential risk for skin injuries		
	-	dry. The doctor was notified,		based on each resident's ris		
		re obtained for Medihoney and		Any discrepancies were revi	sed if	
	8/31/21 and discor	he evening shift, started on tinued on 9/7/21.		indicated during this review.		
	The telehealth visi	t, dated 9/4/21 at 9:32 a.m.,		3. On 1/17/22, the Directo	or of	
	indicated the reside	ent was seen for a pressure		Nursing /Incensed nurse		
	wound on the left	outtocks. The Stage II wound		designee-initiated education	with	
	measured 1 cm lor	g by 4 cm wide by 0.2 cm deep		licensed nursing staff regard	ing	
	and was identified	on 8/31/21.		treatment and services to pro-	event	
				and heal pressure ulcers. Th	nis	
	The Treatment Ad	ministration Record for		education included verification	on of	
	September 2021 in	dicated an order to apply		pressure reduction surfaces	and	
	Medihoney, skin p	rep to the peri-wound, cover		implementation of at risk for	skin	
	with a foam dressi	ng every day shift, started on		breakdown care plans for at	risk	
	9/8/21 and discont	inued on 9/21/21.		residents.		
		t, dated 9/19/21 at 9:05 a.m.,				
	· ·	ure wound on the left buttocks		On 12/20/21, Director of Nur	sing	
		ong by 2.9 cm wide, by 0.2 cm		reviewed the procedure for		
	-	o tunneling, undermining or		"Baseline Care Plan		
		vas scant, thin, and watery		Assessments/Care Plan "pol	-	
		id made up of cells, proteins,		and procedure and found the	e	
) observed. The wound tissue		policy to be acceptable.		
		d red and was warm to the				
	touch.					
				(Facility and Agency,		
		t, dated 10/2/21 at 10:41 a.m.,		Licensed nursing staff will no		
		for silver sulfadiazine cream 1%		allowed to work after 1/20/21		
		o the left gluteal fold topically,		unless they have successful	ly	
		wound healing. Cleanse the		completed all		
		l cleanser, pat dry, skin prep		assigned education).		
	peri-wound, and co	over with dressing. The Stage				

PL0O11 Facility ID: 000478

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If continuation sheet F

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATI	E SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	G <u>00</u>	COMP	PLETED
		155494	B. WING		12/20	0/2021
		-	STR	EET ADDRESS, CITY, STATE, ZIP C	COD	
NAME OF 1	PROVIDER OR SUPPLIE	R	135	50 N TODD DR		
WATER	S OF SCOTTSBUR	RG, THE	SC	OTTSBURG, IN 47170		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREF	X (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAC	DEFICIENCY)		DATE
	-	measured 1.2 cm long by 2.7 cm		4. On 1/17/22, an A		
	-	ep. There was a small amount of		Ulcer Treatment/Prev	ention	
	-	nguineous drainage. The		Quality Review Audit	was	
		and red in color. The		reviewed and accepted	d by the	
	surrounding tissue	was warm.		Quality Assurance Per	formance	
				Improvement Committe		
		t, dated 10/9/21 at 10:44 a.m.,		Director of Nursing/De	signated	
		for Medihoney wound/burn		Nursing will complete r	andom	
	dressing gel. The d	lirections indicated to apply to		pressure ulcers review	s using the	
	the left dorsoglutes	al fold topically every shift for		Pressure Ulcer		
	wound healing and	l cover with a dry dressing.		Treatment/Prevention	Quality	
	The start date was	10/09/21. The Stage II pressure		Review Audit Tool, to	validate	
	injury to the left bu	attocks measured 0.8 cm long		that resident(s) receive	e treatments	
	by 1.8 cm wide by	0.3 cm deep. There was a small		and Services to prever		
	amount of thin/wa	ter sanguineous exudate with		pressure ulcers and to	validate	
	no odor. There was	s 0% epithelial tissue, 100%		wound care plans are		
	granulation, 0% sl	ough, 0% necrotic tissue. The		and implemented as in	-	
	wound was red in	color. The wound margins were		meet the needs of the		
		surrounding tissue was warm.		based on wound		
	The current treatm	ent was Medihoney per order.		evaluations/assessme	nts and risk	
		tative interventions were a		for pressure ulcers. An	y concerns	
	-	tion mattress and a wheelchair		identified during the pr	•	
	cushion.			ulcer/treatment/preve		
				quality reviews will be		
	The telehealth visi	t, dated 10/30/21 at 11:40 a.m.,		at the time of the revie		
		of Medihoney wound/burn		additional education w		
		lirections indicated to apply to		completed at that time		
		al fold, topically every shift for		Pressure Ulcer		
	e	l cover with a dry dressing,		Treatment/Prevention	Quality	
	-	10/09/21. The Stage II pressure		Review Audit will be c		
		uttocks, measured 0.2 cm long		on five residents a wee		
	by 0.7 cm wide by	-		weeks. The results of t		
				will be submitted to the		
	The nurse's note. d	ated 11/10/21 at 10:11 a.m.,		Assurance Performance	•	
		to the left buttock was noted as		Improvement Committee		
		ad pink intact skin with no		The QAPI Committee	•	
		esident denies any pain to area.		determine if additional		
				or competencies are re		
	During an intervie	w on 12/20/21 at 11:10 a.m., LPN		based on the complian	-	
		1 Nurse)19 indicated the		from the Quality Revie	-	

1350 N	ADDRESS, CITY, STATE, ZIP COD I TODD DR TSBURG, IN 47170 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) Following the initial twelve-wee 100% review, A minimum of 10 residents will be reviewed mon until 100% compliance has bee determined by the QAPI committee. (A minimum of sever	k thly	(X5) DMPLETION DATE
ID PREFIX	TSBURG, IN 47170 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) Following the initial twelve-wee 100% review, A minimum of 10 residents will be reviewed mon until 100% compliance has bee determined by the QAPI	k thly	OMPLETION
PREFIX	Following the initial twelve-wee 100% review, A minimum of 10 residents will be reviewed mon until 100% compliance has bee determined by the QAPI	k thly	OMPLETION
	100% review, A minimum of 10 residents will be reviewed mon until 100% compliance has bee determined by the QAPI	thly	DATE
	months must be completed).	en	
		- Date of Completion—1/20/22	- Date of Completion—1/20/22

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	î /	JILDING NG	<u>00</u>	X3) DATE : COMPL 12/20/	ETED
	PROVIDER OR SUPPLIE			1350 N	address, city, state, zip cod I TODD DR ISBURG, IN 47170		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	Ē	(X5) COMPLETIC DATE
	resident's clinical that a reduction in unavoidable; and §483.25(c)(2) A r motion receives a services to increa prevent further de §483.25(c)(3) A r receives appropriassistance to ma with the maximur unless a reduction demonstrably una Based on observative review the facility therapy services w decrease in range of residents reviewed 51 and 28) Findings include: 1. The clinical recorreviewed, on 12/18 included, but were hemiparesis follow affecting left non-of contracture of mus contracture left hat The Quarterly MD assessment, dated resident's cognition required extensive members with AD	esident with limited range of appropriate treatment and ase range of motion and/or to ecrease in range of motion. esident with limited mobility fate services, equipment, and intain or improve mobility in practicable independence n in mobility is avoidable. fon, interview and record failed to ensure restorative ere provided to prevent a of motion for 2 out of 3 for range of motion. (Residents	F 06	588	 F688 Increase/Prevent Decrease in Range of Motion/Mobility 1. On 1/18/22, resident #51' therapy recommendations and physician orders will be reviewed and revised by the Director of Nursing Services, therapy and MDS Coordinator to validate appropriate interventions for the left ankle, left foot and left hand including passive range of moti and application of boot/splint. Resident 51's care plan and restorative documentation will b reviewed and revised as indicat during the review. On 1/18/22, resident #28's ther recommendations and physicia orders will be reviewed and rev by the Director of Nursing 	ed I on ted apy n	01/20/20

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	(X2) MULTIPLE A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 12/20/2021
NAME OF	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP COD N TODD DR	
WATER	S OF SCOTTSBUF	RG, THE		TTSBURG, IN 47170	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	an OT (Occupation	nal Therapy) evaluation and to		Services, therapy and MDS	
	treat as indicated.			Coordinator to validate approp	oriate
				interventions for the left fingers	s,
	-	ed 8/9/14 and revised on		wrist and shoulder including	
		the resident had a contracture		passive range of motion and	
		, elbow, and hand related to		application of splint. Resident	#
		ntervention was to inform the		28's care plan and restorative	
		hanges to his contracture,		documentation will be revised	as
		storative for PROM (Passive		indicated during the review	
	Range of Motion)	and therapy as needed.			
				2. On 1/18/22 residents	
		sident's clinical record lacked		residing in the facility that have	
		a restorative therapy program in		contractures, splints or braces	
	place and PROM	for contractures.		be identified by the Director of	
	D · · · · ·			Nursing and Therapy.	
	-	w on 12/17/21 at 9:01 a.m., LPN			
		tical Nurse) indicated the n PT (Physical Therapy) at this		On 1/18/22, each resident	ha
		etting OT. The resident did not		identified will be reviewed by t	
	-	splints that nursing applied.		intradisciplinary team (includin nursing and therapy) to validat	-
		if PROM was required by		appropriate treatment and ser	
	nursing staff.	in income was required by		to increase ROM and/or preve	
	nurbing sturi.			further decline in ROM. Splinti	
	During an intervie	w on 12/17/21 at 9:34 a.m., The		and Range of motion program	•
	-	apist indicated Resident 51 was		be reviewed during this proces	
	picked up for OT	again on 8/21. The therapy was		ensure necessary documentat	
		f a splint and self-feeding. He		is being recorded, splints are	
		left ankle. Staff were trained to		being applied as indicated and	ł
	apply the boot. Th	e staff have been trained to		range of motion /restorative	
	provide daily PRC	M with care to prevent		programs are documented. A	ny
	worsening of the c	ontractures.		discrepancies will be revised it	-
				indicated during this review.	
	During an intervie	w on 12/20/21 at 8:39 a.m., The		_	
	Restorative Nurse	indicated therapy recommends			
	how often the resid	dent would have restorative		3. On 1/17/22, the Director	of
	therapy and what t	ype. Resident 51 should have		Nursing /Incensed nurse	
		d passive range of motion 7		designee-initiated education w	vith
	days per week.			licensed and certified nursing	staff
				regarding nursing restorative,	
	During an intervie	w on 12/17/21 at 3:10 p.m., the		range of motion, splinting and	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUIL		DNSTRUCTION	· · ·	E SURVEY LETED
		155494	B. WIN	G		12/20)/2021
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
NATER	S OF SCOTTSBUR	RG, THE			TODD DR SBURG, IN 47170		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PI	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		Nursing) indicated they could ative documentation on this			documentation.		
					On 12/20/21, Director of Nurs	ing	
		ord for Resident 28 was			reviewed the procedure for		
		7/21 at 2:00 p.m. The diagnoses			"Restorative Nursing "and fou		
		not limited to, hemiplegia and ving cerebral infarction affecting			the policy to be acceptable. The policy to be acceptable.		
	-	ant side, contracture of muscle			protocol for monitoring restora programs was revised to inclu		
		tracture of the left wrist, muscle			weekly restorative review by t		
		wasting and atrophy, and lack			MDS Coordinator/or licensed		
	of coordination.	······································			nursing designee. The weekly	,	
					review will be completed to		
	The Quarterly MD	S (Minimum Data Set)			validate completion of necess	ary	
	assessment, dated	10/4/21, indicated the resident			documentation and revisions	•	
	was rarely or never	r understood. He required			restorative programs if indicat	ed.	
	extensive assistance	e of two staff members with					
	ADL's (Activities	of Daily Living).			(Facility and Agency, License		
					nursing staff will not be allowe		
		der, dated 12/6/18, indicated the			work after 1/20/21 unless they		
		eive passive ROM (Range of			have successfully completed	all	
	Motion) for left fir	ngers, wrist, and shoulder.			assigned education).		
	-	ed 8/9/14 and revised on					
	,	the resident required PROM of			4. On 1/17/22, a		
		lower extremities. Staff were to			ROM/Splinting Quality Revie		
	-	ons daily, prior to wrist/hand The resident required a			Audit was reviewed and acce	hrea	
		n for splint/brace to prevent			by the Quality Assurance Performance Improvement		
		zement and ensure proper limb			Committee. The Director of		
	alignment.	and ensure proper mile			Nursing/Designated Nurse wil	1	
					complete random ROM and S		
	A review of the cli	nical record lacked			reviews using the ROM/Splint	-	
	documentation of a	a restorative therapy program in			Quality Review Audit Tool, to	-	
	place and the resid	ent receiving PROM for			validate that range of motion a	and	
	contractures.				splinting are completed and		
					documented as indicated and		
	-	w on 12/17/21 at 9:34 a.m., the			weekly nursing review is		
	-	apist indicated the resident was			completed. Any concerns		
	not on OT at this t	ime. He had met his goals. He			identified during the quality		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	· /	JILDING	DNSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 12/20/2021	
	PROVIDER OR SUPPLIE		-	1350 N	address, city, state, zip coi TODD DR SBURG, IN 47170	D		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE	
	During an intervie DON indicated she documentation on The current Restor and Procedure, pro- by the DON, inclu The facility is resp maintenance and r not only maintain, the resident's comp achieve, and mainto outcome. The facili residents receive c are able to perform independently. The the resident reached highest level of Ra	tance with all ADL's. w on 12/17/21 at 3:10 p.m., the e could not find any restorative this resident. ative Nursing Program Policy wided on 12/20/21 at 8:30 a.m. ded, but was not limited to, " onsible for providing estorative programs that will but improve, as indicated by orehensive assessment to ain the highest practicable ity is responsible to ensure that are and services needed if they a their own ADL care e facility must also ensure that s and maintains his or her nge of Motion and to prevent n Range of Motion."			reviews will be addresse time of the review and a education will be comple- that time. The ROM/Spli Quality Review Audit w completed on five reside week for twelve weeks. of the Audits will be sub the Quality Assurance Performance Improveme Committee monthly. The Committee will determin- additional education or competencies are requir on the compliance repor the Quality Reviews. Fol initial twelve-week 100% minimum of 10 residents reviewed monthly until 1 compliance has been de by the QAPI committee. <i>minimum of seven montu- be completed</i>).	dditional ted at nting ill be ents a The results mitted to ent e QAPI e if ed, based ted from lowing the o review, A s will be 00% termined (A		
F 0689 SS=D Bldg. 00	remains as free of possible; and §483.25(d)(2)Ead	ents. ensure that - e resident environment of accident hazards as is ch resident receives ision and assistance devices			Date of Completion—1/2	20/22		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/20/2021 155494 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, THE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE F 0689 F689 Incidents/Accidents 01/20/2022 Based on observation, interview, and record review, the facility failed to ensure residents were free of accidents and had the appropriate On 12/20/21, resident #54 1. follow-up assessments after a fall for 1 of 5 was reviewed by the residents reviewed for accidents. (Resident 54) intradisciplinary team. Resident #54's CT scan completed Findings include: 12/15/21 was reviewed and determined to be within normal During a continuous observation of the Memory limits. A pain assessment was Care unit, on 12/16/21 from 10:10 a.m. to 11:12 a.m., completed by licensed nursing LPN (Licensed Practical Nurse) 10 was sitting at staff on 12/20/21 the resident the desk in the corner of the dining room. reported no pain at the time of the Resident 54 was sitting in the dining room. He assessment. indicated "I fell last night. I hurt myself." He would not indicate where he hurt but stated he fell in his room. Activities Aide 11 approached the 2 On 1/18/22, residents resident and he told her his head and his knee residing in the facility that have were hurting, she told the resident, "Yea, they're fallen in the last 30 days will be taking care of you." At 10:13 Activities Aide 11 identified by the Director of told LPN 10 she was going to get the resident Nursing. batteries for his hearing aids but did not discuss the resident's complaints of pain. LPN 10 did not On 1/18/22, the identified assess the resident during this continuous residents will be reviewed by the observation, including any vital signs, intradisciplinary team to validate assessment of pain or skin, or any neurological fall risk assessments, fall care assessment. LPN 10 remained at the desk plans, completion of neuro-checks throughout the continuous observation. and pain assessments were completed as indicated at the time The clinical record for Resident 54 was reviewed of the event. Any discrepancies on 12/15/21 at 10:40 a.m. Diagnoses included, but identified will be reviewed by the were not limited to, muscle weakness, heart failure, IDT team and recommendations hypertension, chronic obstructive pulmonary will be implemented at the time of disease, dependence on supplemental oxygen, the review. Care plans will be chronic pain, presence of cardiac defibrillator, reviewed and revised as indicated. dementia, fracture of right wrist, unspecified intellectual disability, osteoarthritis, lack of coordination, and other abnormalities of gait and 3. On 1/17/22, the Director of mobility. Nursing /Incensed nurse designee-initiated education with Event ID: PL0011 Facility ID: 000478 Page 50 of 82 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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NAME OF F		identification number 155494	A. BUILDING <u>00</u> B. WING STREET ADDRESS, CITY, STATE, ZIP COD		(X3) DATE SURVEY COMPLETED 12/20/2021	
	ROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP COD N TODD DR		
WATERS	OF SCOTTSBUR	RG, THE		TTSBURG, IN 47170		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	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 DEFICIENCY)	ATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION	TAG			DATE
		S (minimum data set)		licensed and certified nursing		
		10/9/21, indicated the resident's		regarding fall prevention, pair		
	-	lerately impaired, he required		assessments, completion of i		
	-	valking, locomotion, and		checks for unwitnessed falls	and	
	transfers, used a w	alker, and had a history of falls.		head injuries, and completior	n of	
				change of condition for		
	-	ed $4/12/19$, indicated the		accidents/incidents.		
		c for falls, due to a recent fall.				
	The interventions	were to have the bed against				
	the wall (dated 7/2	6/21); to educate the resident to		On 12/20/21, Director of Nurs	sing	
	use a walker with ambulation (dated 6/29/20);			reviewed the procedure for		
	pathway cleared ir	room (dated 4/22/19); attempt		"Accident/Incident Reporting	"and	
	to keep all areas fr	ee of clutter, keep call light in		found the policy to be accept	able.	
	reach, notify and u	pdate physician as needed, and		Licensed nursing staff are		
	therapy screen as i	ndicated, quarterly, and as		responsible for completing		
	needed (dated 4/12	2/19).		incident/accident documentat	tion	
				including neuro checks for		
	The physician's or	ders, dated 12/4/20, indicated		unwitnessed falls and post fa	11	
	the resident took a	spirin 81 mg one time daily and		pain evaluations.		
	Plavix (blood thin	ner) 75 mg 1 time daily.				
				Falls will be reviewed daily du	uring	
	The nursing note,	dated 1/21/21 at 5:25 p.m.,		the morning CQI meeting M-I		
	indicated the resid	ent was sitting on the floor in		intradisciplinary team will rev		
	his room yelling for	or help. He indicated he had not		each event to validate that ne		
		d no pain. A CNA (certified		checks are completed per		
	nurse aide) assiste	d the resident to his recliner.		protocol, documentation of a		
		ated he was trying to get pants		change of condition is comple	ete,	
	from his closet and	l his knee gave out. Staff		MD and family notifications a		
		ent to use the call light when		complete, preventive measur		
		, and the resident understood.		implemented, 72-hour nursin		
	C			documentation post event, pa	-	
	The clinical record	l lacked documentation of any		evaluations and care plans w		
		ts for the unwitnessed fall.		revised as indicated. Any		
	Ű			concerns identified will be		
	The nursing note.	dated 7/25/21 at 1:46 p.m.,		addressed at that time and		
		ent had been found on the floor		additional education will be		
		been trying to reach his hat and		initiated as indicated by the		
		dside table. The resident had a		Director of Nursing.		
		ft side of his forehead,				
		.3 to 0.4 cm. The physician was		(Facility and Agency, License	ed and	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 12/20/2021 155494 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, THE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE notified with orders to send the resident to the nursing staff will not be allowed to hospital. neurological checks were initiated. work after 1/20/21 unless they have successfully completed all The nursing note, dated 7/25/21 at 5:09 p.m., assigned education). indicated the resident would be returning. He had received glue to the laceration. The nursing note, dated 7/25/21 at 5:48 p.m., 4. On 1/17/22, a Fall Quality indicated the resident returned. He complained of Review Audit was reviewed and a headache and had received Tylenol. He had a accepted by the Quality medium hematoma to the left side of the head. Assurance Performance Improvement Committee. The The clinical record did not include any Director of Nursing/Designated documentation of neurological checks continuing Nursing will complete random Fall upon return from the hospital. reviews using the Fall Quality Review Audit Tool. to validate The nursing note, dated 9/23/21 at 4:15 p.m., that documentation is complete indicated the resident was found sitting in his including change of condition, shower. There was bruising from the top to down MD/RP notification, pain the back of the resident's head. The resident assessments, 72-hour clinical indicated he lost his balance and fell backwards documentation post event and hitting his head on the shower wall. neuro checks if indicated. Any concerns identified during the The nursing note, dated 9/23/21 at 4:40 p.m., quality reviews will be addressed indicated the resident had been sent to the at the time of the review and hospital for evaluation. additional education will be completed at that time. The Fall The nursing note, dated 9/23/21 at 11:53 p.m., Quality Review Audit will be indicated the resident returned to the facility with completed on five days a week for a diagnoses of minor head injury. Neurological twelve weeks. The results of the checks were resumed per facility policy. The Audits will be submitted to the resident indicated his head did hurt and it was **Quality Assurance Performance** sore. Improvement Committee monthly. The QAPI Committee will The nursing note, dated 12/15/21 at 9:50 p.m., determine if additional education indicated the resident had an unwitnessed fall in or competencies are required, his bathroom and complained of left hip and head based on the compliance reported pain. He had a contusion to the back of his head. from the Quality Reviews. Following the initial twelve-week The Change in Condition note, dated 12/15/21 at 100% review, A minimum of 10 PL0011 Facility ID: 000478

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/20/2021	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD		
WATER	S OF SCOTTSBUF	RG, THE	1350 N TODD DR SCOTTSBURG, IN 47170			
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR(ION D BE OPRIATE	(X5) COMPLETIC
TAG	9:55 p.m., indicate	OR LSC IDENTIFYING INFORMATION ed the resident was being sent to	TAG	residents will be reviewed	monthly	DATE
		d lacked any documentation of t or ongoing neurological		until 100% compliance has determined by the QAPI committee. (A minimum of months must be complete	f seven	
	10 indicated Resid He went to the hor reported to work. resident and had d morning. She had 8:00 a.m. and 10:3 documented it. Sh checks on the resid knowledge, and it report. Neurologic a physician ordered injury, or if the resid where no one saw and hit their head, checks. On 12/16/21 at 12 handwritten paper name, along with	w on 12/16/21 at 11:52 a.m., LPN lent 54 had fallen the night prior. spital and came back before she She had been observing the one his vitals twice that obtained a full set of vitals at 30 a.m., but she had not yet e was not doing neurological dent, he was not on them to her had not been told to her in eal checks would be completed if d it, if the resident had a head sident had an unwitnessed fall anything. If a resident had a fall she would start neurological :05 p.m., LPN 10 presented which indicated the resident's a full set of vitals which she n completed at 7:00 a.m., and		- Date of Completion—1/20	/22	
	10:40 p.m. She we the clinical record During an intervie DON indicated the resident had a fall condition note, as physician and fam intervention in pla be initiated with a have expected the	ould be putting these values into				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/20/2021 155494 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, THE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 12/15/21. During an interview on 12/20/21 at 3:04 p.m., the ED indicated staff would be educated on neurological checks, they were to be initiated even upon going out to the hospital and would continue upon return. Staff would also be educated on monitoring the resident's pain, and to notify the nurse when the resident complained of pain. The most current, undated, Accident Incident Reporting Policy, provided on 12/17/21 at 4:03 p.m. by the DON, included, but was not limited to, " ... Any accident/incident will be reported immediately to the nurse or appropriate person designated to be in charge ... 10. Documentation of the resident's physical and mental status will be completed each shift following the incident for a minimum of 72 hours or until the condition symptoms improve. Neurochecks will be completed after each unwitnessed fall or head trauma according to policy ..." Policy 3.1-45(a)(1) F 0695 483.25(i) SS=D Respiratory/Tracheostomy Care and Bldg. 00 Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. PL0011

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/20/2021 155494 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, THE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Based on observation, record review, and F 0695 F695 Respiratory/Trach 01/20/2022 interview, the facility failed to ensure oxygen tubing and humidification were changed weekly and maintained for 1 of 3 resident's reviewed for On 12/20/21 resident #54's 1. respiratory care. (Resident 54) oxygen tubing and humidifier were changed and dated by licensed Findings include: nursing staff. During an observation, on 12/13/21 at 2:20 p.m., Resident 54 was sitting in his recliner in his room. 2. On 12/20/21 residents He had a nasal cannula in place, with oxygen residing in the facility with oxygen, running at 2 liters per minute (lpm). The tubing mini-nebs and/or CPAP/BiPAP and pre-filled humidification bottle were dated equipment were identified by the 12/5/21. The humidification bottle was empty. Director of Nursing. A facility tour was completed to ensure that During observation, on 12/14/21 at 9:17 a.m., the tubing, masks, and humidifiers resident was sitting in his recliner in his room. His were appropriately dated, and oxygen tubing remained unchanged, and the humidifiers were functioning humidification bottle was still empty. The date on appropriately. the tubing and humidification bottle was 12/5/21. During an observation, on 12/14/21 at 9:46 a.m., On 1/17/22, the Director of 3. the resident was sitting in his recliner in his room. Nursing /Incensed nurse His oxygen tubing remained unchanged, and the designee-initiated education with humidification bottle was still empty. The date on licensed staff regarding oxygen the tubing and humidification bottle was 12/5/21. and respiratory tubing/equipment. Licensed nursing staff are required During an observation on 12/15/21 at 9:13 a.m., the to maintain humidifiers and resident was sitting in his recliner in his room. His dating/labeling respiratory tubing. oxygen tubing remained unchanged, and the humidification bottle remained empty. The date on On 12/17/21, Director of Nursing the tubing and humidification bottle was 12/5/21. reviewed the procedure for "Oxygen Therapy "policy and During an observation, on 12/15/21 at 1:00 p.m., procedure and found the policy to the resident was sitting in his recliner in his room. be acceptable. Licensed nursing The oxygen tubing remained unchanged, and his staff are responsible for humidification bottle remained empty. The date on maintaining oxygen and the tubing and humidification bottle was 12/5/21. respiratory equipment. Oxygen and respiratory treatment During an observation, on 12/17/21 at 8:15 a.m., masks/tubing will be changed PL0011

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

Event ID:

Facility ID: 000478

If continuation sheet

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D PLAN OF CORRECTION IDENTIFICATION NUMBER 155494	A. BUILDING	00	(X3) DATE SURVEY COMPLETED	
		B. WING	<u></u>	12/20/2021
R SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
TTSBURG, THE			TSBURG, IN 47170	
SUMMARY STATEMENT OF	IMARY STATEMENT OF DEFICIENCIE		PROVIDER'S PLAN OF CORRECTION	(X5)
H DEFICIENCY MUST BE PR	ECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
LATORY OR LSC IDENTIFY	NG INFORMATION	TAG	DEFICIENCY)	DATE
ent's humification bottle v id been changed.	vas full and the		weekly by nursing staff.	
			(Facility and Agency, Licensed	
cal record for Resident 54			nursing staff will not be allowed	l to
on 12/15/21 at 10:40 a.m. included, but were not limited to, muscle weakness, heart failure,			work after 1/20/21 unless they	
			have successfully completed a	//
sion, chronic obstructive			assigned education).	
lependence on supplement				
ain, presence of cardiac				
, fracture of right wrist, u	•		4. On 1/17/22,	
al disability, osteoarthriti			anOxygen/Respiratory	
tion, and other abnormali	ties of gait and		Treatment Quality Review	
			Audit was reviewed and accep	ted
	4 1 10/0/21		by the Quality Assurance	
rterly MDS assessment, d			Performance Improvement	
the resident was modera, was short of breath whe			Committee. The Director of	
and had no skin impairme			Nursing/Designated Nurse will	of
and had no skin impairing	filts.		complete random observations oxygen equipment including	
plan, dated 2/12/21, indi	cated the		humidifiers, oxygen/respiratory	
was at risk for alteration i			treatment tubing and	
ated to COPD and refusin			BIPAP/CPAP equipment using	the
t times. Interventions inc	-		Oxygen/Respiratory Quality	
not limited to, oxygen as ordered.			Review Audit Tool, to validate	
			that weekly documentation is	
ician's order, dated 12/6/2	20, indicated the		completed for tubing/masks an	d
used oxygen continuously	v at 21pm via		humidifiers changes. This audit	
nula, and to change the o			will also include a visual	
e weekly on night shift or	n Sundays.		inspection of oxygen	
			tubing/masks and humidifiers to	o
ew of the MAR indicated			validate that dating on the	
ubing and bottle were last	t changed on		equipment matches the	
			documentation. Any concerns	
	-			
				ai
	as needed for			
ness.				•
				۰
to ng 1 ne	administer nasal spray nostrils every 4 hours a ss.		administer nasal spray solution in nostrils every 4 hours as needed for	administer nasal spray solution in nostrils every 4 hours as needed for ss. time of the review and addition education will be completed at that time. The Oxygen/respiratory Treatmen

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155494	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 12/20/2021
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	-
WATER	S OF SCOTTSBUR	G, THE		I TODD DR TSBURG, IN 47170	
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION
TAG	DON (Director of prefilled humidific would expect it to oxygen tubing she During an intervie Executive Director orders to change o humidification bot Sunday morning. T to make sure all re tubing changed an The most current, policy, provided o DON, included, bu for daily care of o humidifier bottle o sterile distilled wa bottle or use prefil	tle were for Saturday night into They would need to do an audit sidents on oxygen had their	TAG	completed on five residents a week for twelve weeks. The r of the Audits will be submittee the Quality Assurance Performance Improvement Committee monthly. The QAR Committee will determine if additional education or competencies are required, b on the compliance reported fr the Quality Reviews. Followin initial twelve-week review, A minimum of 10 residents will reviewed monthly until 100% compliance has been determ by the QAPI committee. (<i>A</i> <i>minimum of seven months mube completed</i>). - Date of Completion—1/20/22	esults d to Pl ased rom ng the be ined <i>ust</i>
F 0697 SS=D Bldg. 00	require such serv professional stan comprehensive p and the residents Based on observat interview, the facil non-pharmalogical and implemented t	Management. ensure that pain provided to residents who vices, consistent with dards of practice, the erson-centered care plan, of goals and preferences. ion, record review, and ity failed to ensure interventions were developed o address residents with pain, s reviewed for pain	F 0697	F697 Pain 1. 12/20/21, resident #55 v reviewed by the intradisciplina team and non-pharma logical	ary

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	СОМ	e survey pleted 0/2021
	PROVIDER OR SUPPLIE		1350 N	address, city, state, zip (I TODD DR ISBURG, IN 47170	COD	
	1					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
TAG	Findings include: 1. During an obser Resident 55 walke her walker with a s her bed. During th indicated her knee During an intervie resident indicated b but it could be bett and had been hurti been hurting her fo soon for her to tak used to have an or- treatment, and that a lot better. She ha have any orders fo about it a day or tv like to have it agai pain. The clinical record on 12/14/21 at 2:00 included, but were difficulty in walkin The Quarterly MD assessment, dated was cognitively in management regin pain medication, a non-medication im resident reported p rated it as moderat medication daily The care plan, date	vation, on 12/15/21 at 9:48 a.m., d out of the bathroom, utilizing slow gait, to ambulate towards e observation the resident was hurting. w on 12/15/21 at 10:00 a.m., the she was having a decent day, er. Her knee was hurting her ng for years. It had currently or about an hour, but it was too e any medication for it. She der for a topical menthol felt good, it made her pain feel d told the staff, but she did not r it at this time. She'd asked vo ago and had told staff she'd n. Resting also helped her knee for Resident 55 was reviewed 2 p.m. The resident's diagnoses not limited to, anxiety disorder, ng, and osteoarthritis. S (minimum data set) 10/29/21, indicated the resident tact, had a scheduled pain nen, did not receive terventions for pain. The ain presence frequently and e. The resident received opioid	TAG	 DEFICIENCY) interventions were addresident plans of care, assessment was compresident #55 on 12/20 physician was contact 1/17/22 to determine i analgesic gel or crean approved per resident On 1/17/21, resident # reviewed by the intradicteam and non-pharma interventions were addresident plans of care, assessment was completions were addresident plans of care, assessment was completion of Nursing. Eawas reviewed by the intradisciplinary team completion of pain assess care plans and effective management including non-pharma logical infiniterview able resident score 8 and above) we interviewed by adminiterviewed by a	A pain pleted on /21. The ted on f an n would be t's request. 464 was lisciplinary a logical ded to the . A pain pleted on ursing staff actory pain 18/22 he facility ain htified by the ach resident to validate sessments, ve pain g terventions. ts (BIMS ere strative staff nts were	DATE
	-	ntial for pain related to chronic		3. On 1/17/22, the	Director of	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 12/20/2021	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD		
WATER	S OF SCOTTSBUF	RG, THE		TSBURG, IN 47170		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	.D BE OPRIATE	COMPLETIC
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		chronic bilateral knee pain.		Nursing /Incensed nurse		
		ided, but were not limited to;		designee-initiated educati		
		lered, notify physician of		licensed staff regarding pa		
	-	observe for effectiveness of		management. This education		
		rve for signs and symptoms of		included a education rega	-	
	· · ·	essment upon admit, quarterly,		non pharma logical interve		
	and as needed (dat	ted 4/26/19).		and resident involvement	with plan	
				of care.		
	-	not contain any resident				
		armacological interventions for		On 12/20/21, Director of N	•	
	pain.			reviewed the procedure for		
	TTI 1' 1			Management "and found t		
		mary from the hospital, dated		to be acceptable. License		
		a muscle rub had been added to		nursing staff are responsil		
		rs and had been helpful for her ning of 2018, the pain was more		completing pain assessme		
		erate, and she began using a		implementing non pharma	-	
	wheelchair for lon			and pharma logical interve for pain management.	enuons	
	The physician's or	der, dated 4/25/19, indicated the		(Facility and Agency, Lice	nsed	
	resident had receiv	ved menthol-methyl salicylate		nursing staff will not be all	lowed to	
		d elbows three times daily, but		work after 1/20/21 unless	they	
	it had been discon	tinued on 7/13/19. The order did		have successfully comple	ted all	
	not list a discontin	uation reason.		assigned education).		
	. .	dated 6/30/21 at 4:10 p.m.,				
		ician was notified of the				
	-	nt that ibuprofen was ineffective			0	
	-	v order was received for Norco		4. On 1/17/22, a Pain	-	
	5/325 mg every 6	hours for moderate pain.		Review Audit tool was re		
	The residently are	ent nhusicion's orders		and accepted by the Qual Assurance Performance	цу	
		ent physician's orders, ent received the following:		Improvement Committee.	Tho	
		ne tablet every 6 hours for		Director of Nursing/Design		
	-	ted 6/30/21), Tylenol 325 mg		Nurse will complete rando		
	· · ·	y 12 hours as needed for pain		reviews using the Pain Qu		
		a pain monitoring with a verbal		Review Audit Tool, to val	-	
		very shift (dated $2/15/21$).		the following: documentat		
	lumentur boure ev			regarding pain evaluations		
	The pursing note	dated 7/11/21 at 5:36 p.m.,		non-pharma logical interve		

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CON	STRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	identification number 155494	A. BUILE B. WING		00	COMPLETED 12/20/2021	
NAME OF	PROVIDER OR SUPPLIE	R			DRESS, CITY, STATE, ZIP CO	D	
WATER	S OF SCOTTSBUR	RG, THE			ODD DR BURG, IN 47170		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	D	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE PROPRIATE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCY)		DATE
		ent came out of the bathroom		1	resident/responsible par	ty	
		in pain. The nurse offered pain		i	involvement with the trea	atment	
		formed the resident it was a		1	plan and revisions as ne	ed with	
	narcotic pain medi	cation. The resident began to		1	the plan of care as indica	ated	
		all she needed was Tylenol, and			(including non-pharma lo	•	
		narcotic. The nurse explained		i	interventions on the care	e plan).	
		Tylenol and ibuprofen were not			Any concerns identified	during the	
	working and the re	sident was still complaining of			quality reviews will be a	addressed	
	a lot of pain. The r	esident yelled, "No more". The			at the time of the review	and	
	nurse left the room	and came back at 6:00 p.m. to			additional education will	be	
	offer the narcotic p	pain medication, which the			completed at that time. T	The Pain	
1	resident accepted v	without issue.			Quality Review Audit w	ill be	
					completed on five reside	ents a	
	The clinical record	lacked documentation of any		,	week for twelve weeks.	The results	
	implementation of	non-pharmacological			of the Audits will be sub	mitted to	
	interventions to ad	dress the resident's pain.		1	the Quality Assurance		
					Performance Improveme	ent	
	During an intervie	w on 12/20/21 at 9:06 a.m., LPN			Committee monthly. The	e QAPI	
	12 indicated the re	sident complained of chronic			Committee will determin	e if	
	back pain, which v	vas treated with routine pain			additional education or		
	medication. He had	d provided interventions at			competencies are requir	ed, based	
	times such as distr	acting with activities,			on the compliance repor	ted from	
	redirection, encour	aging her to stretch, but he		1	the Quality Reviews. Fol	llowing the	
	could not locate an	y non-pharmacological		i	initial twelve-week review	w, A	
	interventions on th	e resident's care plan, and			minimum of 10 residents	s will be	
	could not locate an	y orders for any type of muscle			reviewed monthly until 1	00%	
	rub or other non-pl	harmacological interventions.			compliance has been de	etermined	
					by the QAPI committee.	(A	
	2. During an obser	vation, on 12/13/21 at 11:36			minimum of seven mont	hs must	
	AM, Resident 64 a	sked LPN 12 for pain			be completed).		
	medication. The L	PN assessed the resident's pain					
	using a verbal pair	scale, which he rated at a 7 or			_		
	9. The LPN then o	btained the resident's pain			_		
	medication and pro	ovided it to him. No other		1	Date of Completion—1/2	20/22	
	interventions for p	ain were offered at this time.					
		for Resident 64 was reviewed					
		0 p.m. Diagnoses included, but					
		, idiopathic peripheral					
	autonomic neuropa	athy, angina pectoris, peripheral					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/20/2021 155494 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, THE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE vascular disease, type 2 diabetes with diabetic neuropathy, osteoarthritis, weakness, and cognitive communication deficit. The Annual MDS assessment, dated 10/28/21, indicated the resident was cognitively intact, was on a scheduled pain medication regimen, received as needed pain medications, and non-medication intervention for pain. The resident reported the presence of pain frequently, rating it at an 8 on a numerical scale of 1 to 10. The care plan, dated 5/14/18, indicated the resident had a potential for pain related to acute general pain, chronic pain, osteoarthritis of bilateral ankles, feet, peripheral vascular disease, and neuropathy. Interventions included, but were not limited to, will be free of pain with intervention as needed, Cymbalta per order for pain and depression, medications as ordered, notify physician of uncontrolled pain, observe for signs and symptoms of pain, pain assessment upon admit, quarterly and as needed. The care plan did not contain any resident specific or non-pharmacological interventions for pain. The resident's current physician's orders, indicated the resident received the following: Norco 5/325 mg every 8 hours as needed, Tylenol 325 mg 2 tablets every 6 hours as needed for pain, gabapentin 400 mg three times daily for pain (dated 10/28/20); Cymbalta 60 mg daily at bedtime for pain (dated 11/4/21); and pain monitoring with a verbal numerical pain scale every shift (dated 2/15/21). The clinical record lacked documentation of any non-pharmacological interventions to address the PL0011 Event ID: Facility ID: 000478 Page 61 of 82 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/20/2021 155494 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, THE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE resident's pain. During an interview on 12/20/21 at 9:19 a.m., LPN 12 indicated the resident was on opioid pain medication and gabapentin. His care plan did not seem to include any additional interventions, such as distraction, repositioning, activities. He could not locate any non-pharmacological interventions, only pharmacological interventions. During an interview on 12/20/21 at 12:22 p.m., the ADON (Assistant Director of Nursing) indicated nursing staff were to document what interventions were tried prior to medication, but she did not know if they developed resident specific interventions for pain. During an interview on 12/20/21 at 12:27 p.m., the MDS coordinator indicated if there was something specific, they would put it into the care plan, such as specific types of pain, orders for certain things to do, and non-pharmacological interventions. Before pain medication could be given, they were supposed to try non-pharmacological interventions, but some of the patients just wanted medications. There were many nursing measures they could do, and the nurses were supposed to try resident specific interventions if they give a medication. It should be done before starting a new medication. If it was specific to a person, it would be care planned like that, it was really just using the nonpharmacological interventions one could come up with, like turning, repositioning, offering ice water, and toileting. The most current, undated, Management of Pain policy, provided on 12/20/21 at 2:15 p.m., included, but was not limited to, " ... Our mission is to facilitate resident independence, promote resident PL0011 Event ID: Facility ID: 000478 Page 62 of 82 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT 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 12/20/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, THE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE comfort and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. We will achieve these goals through ... Using non-pharmacological and complementary and alternative medicine when appropriate ... 8. Plan of care Initiate an interdisciplinary plan of care based on the initial assessment and development of pain relieving strategies. Include both pharmacological and complimentary interventions in the care plan." 3.1-37(a) F 0756 483.45(c)(1)(2)(4)(5) SS=D Drug Regimen Review, Report Irregular, Act Bldg. 00 On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the PL0011 Event ID: Facility ID: 000478 Page 63 of 82 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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NAME OF	PROVIDER OR SUPPLIE	ĒR			ADDRESS, CITY, STATE, ZIP COD I TODD DR		
WATER	S OF SCOTTSBUF	RG, THE		SCOT	TSBURG, IN 47170		
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETIO DATE
	attending physici director and direct minimum, the rest drug, and the irre- identified. (iii) The attending in the resident's fi identified irregulat what, if any, action address it. If there- medication, the ar- document his or medical record. §483.45(c)(5) The maintain policies monthly drug reg- are not limited to steps in the proo- pharmacist must identifies an irreg- action to protect. Based on record re- failed to ensure the recommendations attending physician medication regime 12) Findings include: 1. The clinical reco- on 12/14/21 at 1:5 was not limited to, hyperglycemia. On 10/20/21, the O- following recomm [physician]This	an and the facility's medical ctor of nursing and lists, at a sident's name, the relevant egularity the pharmacist g physician must document medical record that the arity has been reviewed and on has been taken to re is to be no change in the attending physician should her rationale in the resident's e facility must develop and and procedures for the imen review that include, but , time frames for the different ess and steps the take when he or she gularity that requires urgent the resident. eview and interview, the facility e consultant pharmacist were addressed with the n for 2 of 5 residents' ens reviewed. (Residents 6 and ord for Resident 6 was reviewed 6 p.m. Diagnosis included, but , Type 2 diabetes mellitus with	F 0'		F756 Drug Regimen Review 1. On 12/16/21, resident #6 was assessed by the Director Nursing and diabetic medicati and labs were reviewed with telehealth. New order was rec for HGB A1c every three mon On 12/30/21, resident #12's pharmacy recommendation fo work was reviewed and accep by psych to include CMP and CBC every three months. On 1/17/22 resident #12 was revie by the Director of Nursing and psych services to ensure	of ons eived ths. r lab oted ewed	01/20/202

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT 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 12/20/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, THE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE blood sugar of 209 on 10/4/21. Current Diabetes appropriate psychiatric meds: Lantus 60 units BID (twice daily); Humalog medications diagnoses and 20 units TID (three times daily). I recommend to behavior monitoring. increase the Lantus to 66 units BID [twice a day]." Documentation lacked the pharmacist On 1/17/22-1/18/22, 2 recommendation being addressed by the residents residing in the facility resident's physician. were identified by the Director of Nursing as having a potential to be During an interview with the Assistant Director of affected by completion of Nursing (ADON) on 12/16/21 at 2:30 p.m., she pharmacy recommendations. The indicated she could not find the signed copy Director of Nursing contacted the where the physician addressed the pharmacist and reviewed the last recommendation but was sure the nurses called 30 days of pharmacy the physician, and he made the changes recommendations. Any recommended. recommendation identified as not completed was communicated to the physician during the review. During an interview with LPN 20 on 12/17/21 at 8:55 a.m., she indicated when the pharmacy recommendations came in, they would go to the nurse who was taking care of the resident and On 1/17/22, the Director of 3. they would text the doctor and got new orders if Nursing /licensed nurse they agreed with the recommendation. We would designee-initiated education with then put the form in the doctor's file for them to licensed nursing staff regarding review and sign when they came in. medication drug reviews. 2. The clinical record for Resident 12 was reviewed The protocol for drug regimen on 12/16/21 at 10:00 a.m. Diagnoses included, but reviews was revised to include were not limited to, schizophrenia, unspecified emailing pharmacy reviews to the paranoid personality disorder, anxiety disorder, director of nursing. The Director of bipolar disorder, major depressive disorder, and Nursing will be responsible for panic disorder. tracking completion of pharmacy recommendations and maintaining On 10/18/21 the Consultant Pharmacist made a documentation of the completed recommendation for a specific diagnosis to be reviews and physician given to the resident's medication Fluphenazine response(s). (for schizophrenia) which the physician addressed on 11/10/21. The Consultant Pharmacist made the On 1/17/22, Director of Nursing following recommendation: "Justification: reviewed the procedure for Diagnosis alone does not warrant the use of "Consultant Pharmacy Services PL0011

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 12/20/2021 155494 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, THE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE antipsychotic medications. The clinical condition "and found the policy to be must also meet at least one of the following acceptable. criteria. Please check at least one of the following: behavioral symptoms present a danger to the (Facility and Agency, Licensed resident and others; expressions or indications of nursing staff will not be allowed to distress cause significant distress to the resident; work after 1/20/21 unless they If not clinically contraindicated, multiple have successfully completed all non-pharmacological approaches have been assigned education). attempted, but did not relieve the symptoms which are presenting a danger or significant distress." Documentation lacked the physician addressed 4. On 1/17/22, a **Pharmacy** the recommendation. Quality Review Audit was reviewed and accepted by the On 12/17/21 at 4:00 p.m., the Director of Nursing **Quality Assurance Performance** (DON) presented a copy of the facility's current Improvement Committee. The policy titled Consultant Pharmacy Services Executive Director/Designated Provider Agreement. Review of this policy Nursing will complete random drug included but was not limited to, "...Services:...8. regimen reviews using the Submitting a written report of findings and Pharmacy Quality Review recommendations resulting from the review of Audit Tool, to validate the medications regimen and nursing documentation following: completion of the records to the attending physician and the pharmacy reviews and proof of director of nursing " supporting documentation including the physicians response 3.1-25(i) to the pharmacy review. 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 Pharmacy Quality Review Audit will be completed on five residents a week for twelve weeks. The results of the Audits will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will PL0011 Page 66 of 82 Event ID: Facility ID: 000478 If continuation sheet FORM CMS-2567(02-99) Previous Versions Obsolete

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	R MEDICARE & MEDIO	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CO	NSTRUCTION		MB NO. 0938-039 E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII B. WIN	.DING	00	COM	MPLETED 20/2021	
	PROVIDER OR SUPPLIE			1350 N	NDDRESS, CITY, STATE, ZIP COD TODD DR SBURG, IN 47170			
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)		O BE OPRIATE	(X5) COMPLETION DATE		
F 0838 SS=D Bldg. 00	facility-wide asser- resources are ne- residents compet operations and e- must review and necessary, and a- must also review assessment whe plans for, any cha- substantial modif assessment. The address or includ §483.70(e)(1) Th population, includ (i) Both the numb facility's resident (ii) The care requi population consid	ty assessment. conduct and document a ssment to determine what cessary to care for its tently during both day-to-day mergencies. The facility update that assessment, as t least annually. The facility and update this never there is, or the facility ange that would require a ication to any part of this facility assessment must e: e facility's resident ding, but not limited to, per of residents and the			determine if additional edu or competencies are requi based on the compliance of from the Quality Reviews. Following the initial twelve 100% review, A minimum residents will be reviewed until 100% compliance has determined by the QAPI committee. (A minimum of months must be completed - Date of Completion—1/20.	red, reported -week of 10 monthly s been f seven d).		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/20/2021 155494 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, THE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. PL0011 Event ID: Facility ID: 000478 Page 68 of 82 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT 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 12/20/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, THE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Based on interview and record review the facility F 0838 F838 Facility assessment 01/20/2022 failed to update their Facility Assessment Tool when concerns with agency staffing were identified. This deficient practice had the potential 1. On 1/17/22, the facility to affect all 71 residents residing in the facility. assessment was reviewed by the administrative team and revised to Findings include: include agency orientation. The review of the Facility Assessment Tool, on 12/20/21 at 4:30 p.m., lacked documentation the 2. All residents residing in the Facility Assessment Tool was updated to address facility have the potential to be agency staffing concerns at the time they were affected by the accurate identified. completion of the facility assessment During an interview on 12/16/21 at 10:33 a.m., the DON indicated the facility used a high number of 3. On 12/20/21, the Executive agency staff. The facility had just rolled out a new reviewed the procedure for "Facility training packet since they were aware of an issue Assessment "and the process for with agency staff members and orientation to the reviewing the facility assessment facility. She did not know much about agency. was revised to include a monthly She had scanned through the packet when an team review by administrative staff agency staff started. during the QAPI committee meetings monthly for a minimum During an interview, on 12/20/21 at 5:35 p.m., the of seven months. Executive Director indicated she checked the (Facility and Agency, Licensed Facility Assessment on a monthly basis for nursing staff will not be allowed to changes. She indicated the Facility Assessment work after 1/20/21 unless they would be updated annually. have successfully completed all assigned education). During an interview, on 12/20/21 at 5:40 p.m., the RDCO (Regional Director Clinical Operations) indicated in the current facility assessment listed On 1/17/22, a **Facility** 4 contracted nurses. Updating the facility Assessment Audit tool was assessment just to add a specific area to address reviewed and accepted by the agency nurses would not change the Facility Quality Assurance Performance Assessment Tool. Improvement Committee. The Department Managers will The Facility Assessment Tool lacked a specific complete random facility plan to ensure the agency staff were oriented to assessment reviews using the Facility Assessment Quality the facility and all packet information was PL0011

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION 00	r í	E SURVEY PLETED	
AND PLAN	OF CORRECTION	155494	A. BUILDING B. WING	00	_	/20/2021	
NAME OF	PROVIDER OR SUPPLIE	ER		ET ADDRESS, CITY, STATE, ZIP (COD		
WATER	S OF SCOTTSBUF	RG, THE) N TODD DR TTSBURG, IN 47170			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COI	RRECTION	(X5)	
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE APPROPRIATE	COMPLETIC DATE	
	completed.			Review Audit Tool, to			
	The current "Feeil	ity Assessment," provided on		if the facility assessme			
		.m. by the E.D., included, but was		addresses the followin resident population, fa	-		
	-	e facility must conduct and		capacity, types of	onity		
		y-wide assessment to determine		diseases/conditions/pl	nysical and		
	what resources are	necessary to care for its		cognitive disabilities, c	-		
	-	ntly during both day-to-day		acuity, other pertinent			
	-	ergency. The facility must		affect the population, s			
	-	that assessment, as necessary,		competencies, physica			
		ly. The facility must also review ssessment whenever there is,		environment, equipme cultural or religious fac			
	-	s for, any changes that would		may affect the care (Ir			
		al modification to any part of		not limited to dietary fo	-		
	this assessment."			and activities). Any co			
				identified during the q	uality		
				reviews will be addres			
				time of the review and			
				education will be comp			
				that time. The Pharma Review Audit will be o			
				on five times a week fe	•		
				weeks. The results of			
				will be submitted to the	e Quality		
				Assurance Performan	се		
				Improvement Commit	-		
				The QAPI Committee			
				determine if additional			
				or competencies are r based on the compliar			
				from the Quality Revie			
				Following the initial tw			
				department manager i			
				facility assessment wil	ll be		
				reviewed by the depar			
				managers monthly un			
				compliance has been			
				by the QAPI committe minimum of seven mo			
				be completed).	11113 111131		
				,,		1	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING STREET ADDRESS CITY STATE ZIP COD		CON	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 12/20/2021	
	PROVIDER OR SUPPLIER			1350 N	address, city, state, zip (I TODD DR ISBURG, IN 47170	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
= 0880 SS=D Bldg. 00	infection prevention designed to provid comfortable environ the development a communicable dis §483.80(a) Infection program. The facility must de prevention and commust include, at a elements: §483.80(a)(1) A s identifying, report controlling infection diseases for all re- visitors, and other services under a de based upon the fac conducted accord following accepted §483.80(a)(2) Wri and procedures for include, but are no- (i) A system of su- identify possible of infections before to persons in the fac	on & Control Control establish and maintain an on and control program de a safe, sanitary and onment and to help prevent and transmission of seases and infections. on prevention and control establish an infection ontrol program (IPCP) that minimum, the following ystem for preventing, ng, investigating, and ons and communicable sidents, staff, volunteers, individuals providing contractual arrangement acility assessment ing to §483.70(e) and d national standards; tten standards, policies, or the program, which must ot limited to: rveillance designed to ommunicable diseases or hey can spread to other			- Date of Completion—	1/20/22	

	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONCEDUCEION	OMB NO. 0938-0 (X3) DATE SURVEY
	NT OF DEFICIENCIES	IDENTIFICATION NUMBER	A. BUILDING	<u>00</u>	COMPLETED
155494		155494	B. WING		12/20/2021
NAME OF	PROVIDER OR SUPPLII	ER		ADDRESS, CITY, STATE, ZIP COD	
	S OF SCOTTSBU			N TODD DR TSBURG, IN 47170	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E COMPLETI
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DATE
	communicable d	isease or infections should			
	be reported;				
		d transmission-based			
		e followed to prevent spread			
	of infections;				
	(iv)When and ho	w isolation should be used			
	for a resident; in	cluding but not limited to:			
	(A) The type and	l duration of the isolation,			
	depending upon	the infectious agent or			
	organism involve	ed, and			
		nt that the isolation should be			
	the least restricti	ve possible for the resident			
	under the circum				
		ances under which the facility			
	must prohibit em				
		isease or infected skin			
		ct contact with residents or			
		ct contact will transmit the			
	disease; and				
		jiene procedures to be			
	-	involved in direct resident			
	contact.				
	§483.80(a)(4) A	system for recording			
		ed under the facility's IPCP			
		e actions taken by the			
	facility.				
	§483.80(e) Liner	IS.			
		handle, store, process, and			
		so as to prevent the spread			
	of infection.				
	§483.80(f) Annu	al review			
	,	onduct an annual review of			
		late their program, as			
	necessary.	ate their program, as			
		ion and interview, the facility	F 0880	F880 Infection Control	01/20/20
		aff applied the proper PPE	1 0000		01/20/20
		ve Equipment) in the yellow		1. LPN # 13 was verbally	,

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	E SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COM	PLETED
		155494	B. WING		12/2	0/2021
NAME OF	PROVIDER OR SUPPLIE	² P		EET ADDRESS, CITY, STATE, ZIP C	COD	
				50 N TODD DR		
WATER	S OF SCOTTSBUF	RG, THE	SC	OTTSBURG, IN 47170		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COL	RECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFI	CROSS-REFERENCED TO THE	HOULD BE APPROPRIATE	COMPLETION
TAG		DR LSC IDENTIFYING INFORMATION	TAC	,		DATE
		atient care for 3 of 5		educated by the DON		
		nfection control. (Residents 68,		regarding proper PPE		
	70, and 25)			rooms. LPN # 14 was	•	
	Findings include:			educated by the DON regarding proper PPE		
	Findings include.			rooms. Nurse Aide #1		
	1 During an obset	rvation on 12/16/21 at 9:22 a.m.,		verbally re-educated o		1
	-	actical Nurse) 13 entered the		of peri care and appro		1
		68 without a gown, N-95 mask,		infection control practi	-	
		left the room and returned from		12/17/21 by administra		
	-	ed the door, and started to enter		staff.	anvo haroling	
	-	n again. She was entering the		2. Residents residi	na in the	
		ying an N-95 mask, gloves, or a		facility on 12/20/21 we	-	
		Director of Nursing) stopped the		by Director of Nursing		
		d the room. The resident was in		having the potential to		
		m (transmission based		by facility adherence to		
	precautions).			appropriate infection c		
	-			practices.		
	During an intervie	w at that time, the DON		3. On 1/17/22, the	Director of	
	indicated the LPN	should have worn the proper		Nursing /Infection Con	itrol	
	PPE of an N-95 m	ask, gloves, and gown when		Preventionist initiated	education	
	entering a yellow :	zone room.		with facility staff regard	ding the	
				proper infection control	bl	
	2. During an obser	rvation, on 12/16/21 at 9:30 a.m.,		procedures, isolation p	precautions	1
		esident 70's room to deliver ice		(including N95 masks)) and PPE.	1
		N-95 mask. She had the door		This education include		1
		ping into the room when the		skills observation cheo		
	**	and indicated she needed an		validate competency v		
	N-95 mask on.			PPE, handwashing co		
				and peri-care education		
	e	w on 12/16/21 at 9:46 a.m., the		On 12/17/21, the Direc		
		opment Coordinator) indicated		Nursing reviewed the		1
		education on infection		procedures for proper		1
	control/hand hygie	ene was conducted on 12/9/21.		(Personal Protective E		
	Duning · · ·	12/16/21 - 410.22		and Peri Care. No revi	isions were	
		w on 12/16/21 at 10:33 a.m., the		required.	f = =:114 -:	
		iff should have a gown, gloves,		On 1/17/22 the annual	-	
		ce shield to enter the yellow zone		infection control asses		
	leaving the room a	ld remove the N-95 mask upon		reviewed and revised	by the	1

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATI	E SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMP	LETED		
		155494	B. WING		12/20	12/20/2021		
NAME OF	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP CO	DD			
	VATERS OF SCOTTSBURG, THE			1350 N TODD DR SCOTTSBURG, IN 47170				
	-							
X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORE	RECTION	(X5)		
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	PPROPRIATE	COMPLETION		
TAG	1	R LSC IDENTIFYING INFORMATION	TAG			DATE		
		ervices for the donning and		control preventionist an	id the			
	-	re performed. The LPN was new		Executive Director.				
	-	e came from an agency		On 1/17/22 the facility a	-			
		own training, and they just		weekly infection control	-			
		aining packet. She did not know y. She had scanned through the		tool that will be conduct infection control	led by the			
					4			
	packet when agence	cy stari started.		preventionist/designee				
	During on interview	12/16/21 at 10.45 a m I DN		compliance with infection				
	-	w on 12/16/21 at 10:45 a.m., LPN ad no in-services on PPE		and identify opportunitie	es lor			
	-			education.				
	-	ng from the agency company ugh. She had worked at other			innend			
		facility she worked at, did an in		(Facility and Agency, Li				
		go on donning and doffing of		nursing staff will not be				
		acility she had worked at didn't		work after 1/20/21 unle	•			
		She had not received any		have successfully comp	bieled all			
		training at this facility. She did		assigned education).				
	-	for PPE use at the facility. She						
	-	the facility, but they did not		4. On 1/17/22, an In	faction			
	show her where to			,				
	show her where to	get her I I E.		Control Quality Review Tool was reviewed and				
	During on interview	w on 12/16/21 at 11:09 a.m.,		by the Quality Assurance				
	-	Director of Nursing) indicated		Performance Improvem				
		ny did the background checks		Committee. The Directo				
	and training.	ly die die blekground eneeks		Nursing/Infection Contr				
	und trunning.			Preventionist and Admi				
	During an intervie	w on 12/16/21 at 3:03 p.m., the		staff will complete rand				
	Ũ	e facility followed the CDC		observations, using the				
		se Control and Prevention)		Control Quality Review				
		no facility policy for PPE to be		to validate that infection				
	worn in the yellow			procedures are followed				
				will include monitoring f				
	The signage for the	e yellow zone isolation		peri care (observation b				
		required was a N95 mask or an		staff only), following is	•			
		niversal eyewear (face shield or		guidelines, handwashir				
	goggles), single go			of appropriate masks. A	-			
		-		concerns identified duri	•			
	On 12/16/21 at 3:0	3 p.m., the DON provided the		infection control observ	-			
		for Compliance with Infection		be addressed at the tim				
	Control policy and	procedure. The policy		observation and addition	nal			

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155494	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 12/20/2021	
NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG, THE			STREET ADDRESS, CITY, STATE, ZIP COD 1350 N TODD DR SCOTTSBURG, IN 47170			
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	(X5) COMPLETIC DATE
	will be implement facility policy" 3. During an obser CNA (Certified N perineal care on R washcloths into th them wet. The nei the bathroom was resident was in iso spectrum betalacta moved the floor m perineal care with the groin area and 3 swipes cleaned t washcloth and wit the entire labial ar rinsed the soap fro fresh wet washclor rinsed again. She a changed her glove to roll onto her lef washcloth and app the anal area with the washcloth and buttock and anal a washcloth. She ob rinsed the buttock area of the washcl The bathroom sink clean washcloths b The clinical record on 12/17/21 at 2:3 but were not limite breast cancer, Alz	x was not cleaned prior to the being placed in the sink. I for Resident 25 was reviewed 2 p.m. The diagnoses included, ed to, epilepsy, hypertension, neimer's disease, osteoarthritis, avioral, dehydration, stage 3		education will be comp that time. The Infection Quality Review Audit completed will be com times a week for twelv The results of the Aud submitted to the Qualit Assurance Performand Improvement Committe determine if additional or competencies are re based on the complian from the Quality Revie Following the initial two 100% review, A minim residents will be review until 100% compliance determined by the QA committee. (A minimul months must be comp Date of Completion-1/2	n Control will be apleted five ve weeks. dits will be ity ce tee monthly. will education equired, nce reported ews. relve-week num of 10 wed monthly e has been Pl m of seven oleted).	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/20/2021 155494 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, THE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE malnutrition, palliative care, urinary tract infection, urinary and bowel incontinence, anxiety, adult failure to thrive, obesity, and physical debility. The care plan, dated 11/3/21, indicated the resident was incontinent of bladder and bowels, chronic problem related to diagnosis. The interventions indicated pericare after every incontinent episode. Staff to assist to toileting as needed. The care plan, dated 11/17/21, indicated the resident required assistance with ADL'S (Activities of Daily Living). The interventions included, but were not limited to, assist the resident as needed to keep clean and dry. During an interview on 12/17/21 at 9:39 a.m., CNA 15 indicated she would clean the perineal area top to bottom and front to back. She would wash her hands before and after the care and apply gloves. The gloves would be changed when soiled and in between procedures. She failed to mention she would use different areas of the washcloth to clean the perineal area. During an interview on 12/17/21 at 2:32 p.m., the DON indicated staff should not soak the washcloths in the sink to get them wet, especially in a shared bathroom with a resident on transmission based precautions. The CNA should have folded the washcloth between swipes, during perineal care. The staff should change out gloves after touching items, such as the floor mat, before beginning perineal care. The review on 12/17/21 at 2:44 p.m., the DON provided a copy of the Perineal/Incontinence Care policy, last reviewed 1/1/20. The policy included, but was not limited to, "Procedure Purpose...To PL0011 Page 76 of 82 Event ID: Facility ID: 000478 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT 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 12/20/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, THE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE prevent infection ... " 3.1-18(b) 3.1-18(1) F 0886 483.80 (h)(1)-(6) SS=D COVID-19 Testing-Residents & Staff Bldg. 00 §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner PL0011 Page 77 of 82 Event ID: Facility ID: 000478 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		x1) provider/supplier/clia identification number 155494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 12/20/2021	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
WATER	S OF SCOTTSBUR	G, THE		TSBURG, IN 47170		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETI	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	that is consistent practice for conducting COVI	with current standards of D-19 tests:				
	(i) Document that the results of eac (ii) Document in t testing was offere appropriate to the resident's t results of each te §483.80 (h)((4) U individual specifie symptoms consistent with C	he resident records that ed, completed (as esting status), and the st. pon the identification of an ed in this paragraph with OVID-19, or who tests D-19, take actions to prevent				
	addressing reside individuals provic services under a	ave procedures for ents and staff, including ing rangement and volunteers, g or are unable to be tested.				
	emergencies due shortages, conta and local health o	lepartments to assist in ch as obtaining testing				
	Based on record re failed to ensure ap practices were foll pandemic related t residents for 2 of 3	view and interview the facility propriate infection control owed during the COVID-19 testing of a symptomatic residents reviewed for Residents 51 and 28)	F 0886	F886 Covid Testing 1. On 10/7/21, 10/18/21,10/25/21 and 1/10/2 resident #51 was tested for C		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 12/20/2021		
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CO	D		
WATERS OF SCOTTSBURG, THE			1350 N TODD DR SCOTTSBURG, IN 47170				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APF DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETIC DATE	
	reviewed, on 12/18 included, but were sepsis, contact with other viral commu The Quarterly MD assessment, dated resident's cognition required extensive members with AD The physician's or non-symptomatic to record TPR (Temp blood pressure, ox symptoms. Staff w temperature of 99. shortness of breath test as needed for 0 The care plan, date 3/26/21, indicated	ord for Resident 51 was 3/21 at 1:31 p.m. The diagnoses not limited to, bacteremia, n and suspected exposure to nicable disease. S (Minimum Data Set) 11/10/21, indicated the n was moderately impaired. He assistance of two staff L's (Activities of Daily Living). ders, dated 5/3/21, indicated for non positive COVID residents erature, Pulse, and Respiration), ygen saturation and signs and ere to report immediately any 1 degrees or higher, cough, , and sore throat. COVID-19 COVID-19 screening. ed 10/23/20 and revised on the resident was at risk for mission based infection		 All results were negative reviewed and revealed the resident #28's clinical represented to reviewed and revealed the resident #28 was tested 19 on 9/1/21, 9/8/21 9/14 9/21/21. All results were No other residents identified. On 1/17/22, the Dimensional transmission of the resident initiated ed with licensed nursing states regarding monitoring resisting residents who had symptoms that could be associated with Covid. (Facility and Agency, Licenturing staff will not be a work after 1/20/21 unless have successfully compliances and supplementation.) On 1/17/22, a Cov 	ecord was hat for COVID 4/21 and negative. were rector of lucation aff sidents for Covid and ve censed allowed to s they leted all		
	(COVID-19) which could result in untoward outcomes such as pneumonia, and/or acute respiratory distress. The resident had the following co-morbidities which can increase the risk for developing a serious illness from COVID-19. Interventions include, but were not limited to, laboratory testing for COVID-19 per		Testing Quality Review Audit was reviewed and accepted by the Quality Assurance Performance Improvement Committee. Administrative Nursing staff will complete random facility Covid symptom screening				
	physician's order and report abnormal results to the physician.The nurse's note, dated 6/9/2021at 11:53 p.m., indicated the resident's lung sounds were diminished with a low grade-temperature. Tylenol			documentation reviews u Covid Testing Quality F Audit Tool, to determine nursing staff completed Testing on residents with signs or symptoms docu	Review e if Covid n active		

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	CTION IDENTIFICATION NUMBER		ING <u>00</u>	СОМ	PLETED	
		155494	B. WING		12/2	0/2021	
NAMEOE	PROVIDER OR SUPPLIE	D	ST	REET ADDRESS, CITY, STATE, ZIP O	COD		
				350 N TODD DR			
WATER	S OF SCOTTSBUR	RG, THE	S	COTTSBURG, IN 47170			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II	PROVIDER'S PLAN OF COL	RRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PRE	FIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE APPROPRIATE	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TA	10		DATE	
	was given to allevi	ate headache and temperature.		on the covid screening			
				or clinical record. Any			
		lated 6/10/2021 at 8:00 a.m.,		identified during the q	-		
		51 had a temperature of 100.7		reviews will be addres			
		ed to his catheter bag. As		time of the review and			
		as administered as per order and notified with new orders to		education will be com			
		liately) CBC (Complete Blood		that time. The Covid 1	-		
		nprehensive Metabolic Panel),		Review Audit will be on five residents -five			
		s) with culture if indicated.		for twelve weeks. The			
		s) with culture if indicated.		the Audits will be sub			
	The clinical record	l lacked documentation of		Quality Assurance Per			
		related to symptoms.		Improvement Commit			
		5 1		The QAPI Committee	•		
	During an intervie	w on 12/18/21 at 4:10 p.m., LPN		determine if additional			
	-	ctical Nurse) indicated if a		or competencies are r	equired,		
	resident was runni	ng a temperature or having		based on the compliar	-		
	symptoms, he wou	ld assess the resident and do a		from the Quality Revie	WS.		
	rapid COVID test.	He would isolate the resident		Following the initial tw	elve review,		
	and call the physic	ian for orders.		A minimum of 10 resid			
				reviewed monthly unti			
	U U	w on 12/20/21 at 8:30 a.m., LPN		compliance has been			
		sident was having symptoms of		by the QAPI committe			
		ident would be moved to an		minimum of seven mo	onths must		
	would be informed	OVID tested, and the physician		be completed).			
	would be informed	1.					
	2. The clinical reco	ord for Resident 28 was		-			
	reviewed, on 12/17	7/21 at 2:00 p.m. The diagnoses		Date of Completion—	1/20/22		
	included, but were	not limited to, hemiplegia and					
	hemiparesis follow	ving cerebral infarction affecting					
		ant side, contracture of muscle					
	~ ~	tracture of the left wrist, muscle					
		wasting and atrophy, and lack					
		nronic obstructive pulmonary					
		et with and suspected exposure					
	to other viral com	nunicable disease.					
	The Quarterly MD	S (Minimum Data Set)					
		10/4/21, indicated the resident					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/20/2021 155494 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, THE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE was rarely or never understood. He required extensive assistance of two staff members with ADL's (Activities of Daily Living). The physician's orders, dated 9/3/20, indicated COVID-19 test as needed for COVID-19 screening. Non-symptomatic non positive COVID residents record TPR, blood pressure oxygen saturation and signs and symptoms. Report immediately any temperature of 99.1 degrees or higher, cough, shortness of breath, and sore throat. Dated 1/21/21, COVID-19 test as needed for COVID-19 screening. The clinical record lacked documentation that the resident was COVID-19 tested when the resident presented with respiratory symptoms. The nurse's note, dated 9/8/21 at 2:21a.m., indicated the resident previously had phlegm and was unable to cough it up. He was wheezing throughout all lung lobes. He vomited coffee ground emesis, diaphoretic, respirations of 38, and oxygen saturation on room air was at 83% (percent). His wheezing worsened. During an interview on 12/13/21 at 1:51 p.m., the DON indicated staff would monitor resident for symptoms and they would be tested. The staff were to report any oxygen saturation below 90% and any temperatures above 99.0. The current "Guidelines for Compliance With Infection Control," provided on 12/16/21 at 3:03 p.m. by the DON, included, but was not limited to, "...3. The facility must have a system to identify infections and communicable diseases for resident, ... Change of condition with potential for infection, Lab results suggesting the potential for possible infection."... PL0011 Event ID: Facility ID: 000478 Page 81 of 82 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR	R MEDICARE & MEDICA	AID SERVICES				OM	B NO. 0938-039
STATEMEN	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(2) MULTIPLE CONSTRUCTION		(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155494	B. WING			12/20/2021	
	NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG, THE			1350 N	T ADDRESS, CITY, STATE, ZIP COD N TODD DR TTSBURG, IN 47170		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
	3.1-18(b)						

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