STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 00 B. WING	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00415219, IN00414917, and IN00414022. Complaint IN00415219 - Federal/State deficiencies related to the allegations are cited at F550. Complaint IN00414917 - No deficiencies related to the allegations are cited. Complaint IN00414022 - No deficiencies related to the allegations are cited. Survey dates: August 22 and 23, 2023 Facility number: 000178 Provider number: 155280 AIM number: 100273840 Census Bed Type: SNF/NF: 72 Total: 72 Census Payor Type: Medicare: 9 Medicaid: 50 Other: 13 Total: 72 This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 29, 2023.	F 0000	**DISCLAIMER STATEMENT:** **Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.** **We respectfully request a desk review to verify satisfaction of compliance with the alleged survey deficient practices.**	
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Vanessa Roll	Administrator	09/08/2023

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

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	existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, record review, and	F 0550	It is the policy of this facility to	09/21/2023

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	interview, the facility failed to ensure residents' rights to a dignified existence related to toileting and dining for 5 of 7 residents reviewed for Activities of Daily Living. (Residents B, C, E, F, and G) Findings include: 1. During an observation on 8/22/23 at 10:50 a.m., CNA (Certified Nurse's Aide) 2 and CNA 3 entered Resident B's room to check and change him and get him up for lunch. Resident B was in bed, eyes closed, and covered with a blanket. The CNAs did not identify themselves to the resident. CNA 2 told him, "Come this way," rolled him to the left, he grabbed the grab bar, then CNA 3 told him, "Come this way" and rolled him to the right. They checked him, he was clean and dry. They used the lift to transfer him to the wheelchair. Resident B never opened his eyes. The clinical record for Resident B was reviewed on 8/22/23 at 10:10 a.m. A Quarterly MDS (Minimum Data Set) assessment, dated 5/20/23, indicated the resident was severely cognitively impaired. The resident required two-person extensive assistance for toileting and one-person extensive assistance for eating. The diagnoses included, but were not limited to, dementia and depression. 2. During an observation on 8/22/23 at 11:08 a.m., CNA 2 and CNA 3 assisted Resident C to the bathroom to use the toilet. The CNAs placed his wheelchair in front of the toilet, placed a gait belt on him, and assisted him to stand. He said, "I need to sit". The CNAs stood him in front of the toilet, told him to step forward and told him to try to go to the bathroom. Resident C had a large		ensure each resident is treated with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility strives to protect and promote the rights of each resident. Resident #B, C, E, F, and G received no negative outcome as a result of the alleged deficient practice. All residents residing on the dementia care unit care plans have been reviewed and updated to reflect their dining and toileting choices. Any resident has the potential to be impacted by this alleged deficient practice. All residents have been reviewed 9/7/23 by the Administrator. Any concerns were addressed. No negative outcome has occurred due to the alleged deficit practice. Nursing staff were in-serviced by the Administrator and Social Service Director on 9/8/23 on the facility expectation to honor, protect and promote care in a dignified manner and resident's rights. Any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. ADON and Social Service Director have completed 100% audit of resident receiving toileting and	

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	bowel movement while standing. The clinical record for Resident C was reviewed on 8/22/23 at 1:25 p.m. An Admission MDS assessment, dated 8/17/23, indicated the resident was severely cognitively impaired. The resident required two-person extensive assistance for toileting. The diagnoses included, but were not limited to, metabolic encephalopathy, and urine retention. 3. During a continuous observation of the noon meal on 8/22/23 from 11:47 a.m. to 12:08 p.m., the following occurred: - At 11:47 a.m., Residents E, F, and G were seated together at one table. Residents B, D, and H were seated at another table with the Speech Therapist. - At 11:48 a.m., Resident F had a meal tray served, with a glass of milk. Resident F took a drink of the milk and placed the glass on the table. - At 11:49 a.m. Resident E was sitting at the table without food or drinks, he picked up Resident F's milk glass, took a drink, and placed the glass of milk back in front of Resident F. - At 11:50 a.m., Resident D was sitting at the table with Resident B. Resident D reached across the corner of the table and took Resident B's peaches. Resident B had his eyes closed and was not eating or being assisted with the meal. Resident D tried to get a bite of the peaches by placing the cup to her mouth. The Speech Therapist indicated Resident D should keep those peaches and they would get Resident B some more.		dining assistance to ensure care plans are in place. Administrator and or designee will utilize audit tool “resident rights and dignity” to ensure care is provided in accordance with facility expectations for care in a dignified manner that promotes resident rights. The competency tool will be used to monitor compliance and become part of the CQI agenda as part of the QAPI process. This audit will be completed on 3 residents five days a week for 4 weeks, then weekly for 4 weeks, then once a month for 4 months, quarterly thereafter until 95% compliance is achieved. Any concerns will be addressed as discovered. If any patterns are identified at the monthly QAPI meeting, an action plan will be written by the QAPI committee. Any written action plan will be monitored by the Administrator monthly until resolved and substantial compliance is achieved.	

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	- At 11:51 a.m., Resident F was sitting at the table with Residents E and G. Resident F took a drink of milk from her glass and placed it back on the table. Resident E and G did not have their meal trays. - At 11:53 a.m., the Speech Therapist indicated resident B required staff assistance with eating when he was sleepy. - At 11:56 a.m., Resident E was sitting at the table without a meal tray. He reached across the table and picked up Resident F's small bowl of peaches and tried to drink them. He was able to get a couple in his mouth, and then placed the bowl back in front of Resident F. - At 11:58 a.m., CNA 2 was observed standing on the right side of Resident G. The CNA asked Resident G if she wanted a drink and then began to feed the resident but did not ask if she wanted a bite of food. She just put the food to the resident's mouth. There were no available chairs for the CNA to sit on. - At 12:07 p.m., CNA 2 was still standing at the table with the Resident G. She did not ask the resident if she wanted a bite or a drink, she took the spoon, filled it with pureed food and stuck the spoon to the resident's mouth. - At 12:08 p.m. Resident E received his meal tray. CNA 3 sat down to assist him with eating. During an interview on 8/22/23 2:02 p.m., CNA 2 and CNA 3 indicated they looked at the computer system to know what each resident needed. If the resident was new, they could ask the nurse. They did not hear Resident C say he needed to sit down during toileting.			

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	During an interview on 8/22/23 at 2:12 p.m., RN (Registered Nurse) 4 indicated Resident B usually woke up in the afternoon and liked to move furniture, so someone had to be with him. She did not notice that at lunch, some of the residents at the same table had food and some did not. Resident E was usually the last one to be served because he liked to grab food and he required assistance with eating. She did not see Resident E take Resident F's milk or peaches. Resident E was a choking hazard. The current facility policy titled; "Resident Rights" was provided by the Administrator on 08/22/23 at 10:38 a.m. The policy indicated, "...As a resident of this facility, you have the right to a dignified existence ...Quality of Life - The facility must care for you in a manner and environment that enhances or promotes your quality of life ...Dignity - the facility will treat you with dignity and respect ...Accommodation of Needs - You have the right to receive services with reasonable accommodations to individual needs..." The current facility policy titled; "Meal Service" was provided by the Administrator on 08/22/23 at 3:01 p.m. The policy indicated, "...all residents be provided adequate supervision to meet each resident's nursing and personal care needs including meal service and assistance with eating ...Procedure: 3. Each table will be served in sequence to ensure that every resident at the table is eating at the same time..." This Federal Tag relates to Complaint IN00415219 3.1-3(t) 3.1-3(v)(1)			