STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF TIPTON SKILLED NURSING FACILITY, THE	300 FAIRGROUNDS RD TIPTON, IN 46072

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00420312, IN00419935, IN00420123, IN00420049, IN00420051, IN00420061, IN00418007. Complaint IN00420312 - Federal/State deficiency related to the allegation is cited at F776. Complaint IN00419935 - Federal/State deficiency related to the allegation is cited at F550. Complaint IN00420123 - No deficiencies related to the allegation were cited. Complaint IN00420049 - No deficiencies related to the allegation were cited. Complaint IN00420051 - No deficiencies related to the allegation were cited. Complaint IN00420061 - No deficiencies related to the allegation were cited. Complaint IN00418007 - No deficiencies related to the allegation were cited. Survey dates: October 23, 24, 25 and 26, 2023 Facility number: 000505 Provider number: 155556 AIM number: 100266350 Census bed type: SNF: 28 SNF/NF: 81 Total: 109 Census payor type:	F 0000	Completion Date: 11/27/2023 Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission of 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.¿ Facility's date of alleged compliance is: 11/27/2023¿ ¿Facility is respectfully requesting paper compliance for all deficiencies in this POC.¿¿	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Victoria Roe	Administrator	11/19/2023

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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	Medicare: 28 Medicaid: 45 Other: 36 Total: 109 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on November 3, 2023.			
F 0550 SS=D 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 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			

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	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, interview and record review, the facility failed to ensure residents were treated with respect and dignity for 2 of 4 residents being reviewed for respect and dignity. (Residents B and F) Findings include: A document, titled "Indiana State Department of Health Survey Report System," dated 10/24/23, indicated Resident B voiced concerns regarding care provided to her by CNA 1 on 10/23/23. The five-day follow-up indicated the facility suspended CNA 1 while the investigation was being completed, but was unable to substantiate the specific incident, which occurred on 10/23/23. However, during the investigation, the facility discovered negative findings regarding CNA 1 and chose to move forward with her termination. During an interview, on 10/24/23 at 3:15 p.m., the Executive Director (ED) indicated CNA 1 was terminated for customer service after her investigation was completed. She had received more complaints regarding this staff member's customer service during the investigation and she	F 0550	It is the policy of the facility to ensure that all residents are treated with respect and dignity. Residents who reside in the facility have the potential to be affected by this finding. On 11/21/2023 an audit was completed by the SSD/Designee for all alert and interviewable residents to ensure no concerns related to interactions between them and care staff. At an in-service held by the ADM/Designee on 11/24/2023 for all staff the following was reviewed: 1. Resident Rights 2. Dignity/Respect during interaction/communication with residents 3. Customer Service	11/27/2023

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	thought it was best to terminate her. 1. During an interview, on 10/25/23 at 4:00 p.m., Resident B was observed sitting up in her chair. She indicated CNA 1 had been rough with her, on 10/23/23, while providing personal care for her, then again, the morning of 10/24/23, after serving her breakfast to her. She indicated she was not abused. She was given poor customer service. She felt CNA 1 was frustrated with her both times and took her frustrations out on her. CNA 1 came into her room, on 10/23/23, to change her and while providing incontinent care for her she roughly pushed her over onto her left side, so hard she thought she was going to fall out of the bed. After cleaning her, CNA 1 roughly turned her onto her right side, and she again thought she would fall out of the bed. The next day (10/24/23), CNA 1 brought Resident B's breakfast tray into her and sat it on her bedside table, then left the room before making sure she had everything she needed. The resident turned on her call light to ask for the items she had not received. CNA 1 answered her light and indicated she would bring them to her. She brought one item, so the resident turned her light on again. CNA 1 answered her call light and indicated she would bring the other two items. After waiting for a while, the resident turned on her light again. CNA 1 answered her light and again indicated she would bring her items to her. CNA 1 brought one of the two items and never returned with the third. Resident B indicated CNA 1 was frustrated with her because she kept turning on her call light and requested the same items repeatedly, but she was not bringing the items to her after she asked for them. 2. During an interview, on 10/25/23 at 4:30 p.m., Resident F was observed sitting in her chair. She indicated CNA 1 had been rude to a few of her		Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. SSD/Designee will interview 10 random residents weekly related to customer service for 4 weeks, then 5 random residents weekly for 4 months, and then 5 random residents monthly for 4 months. If the facility is within 95% compliance after the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring of the Communication Audit will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	

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	neighbors. She did not bother CNA 1 anymore because all she received from her was an attitude. She did not ask her to do anything for her anymore. When CNA 1 answered her call light, she never came in the room, she would stand at her door and ask what she wanted, then she would take off and never do what she asked her to do. She would end up doing it for herself or trying to get help from someone else. She overheard CNA 1 being rude to her neighbors who were a husband and wife, and she did not like it. She also overheard her being rude to her neighbor on the other side of her. She did not consider it abuse, but a lack of respect or dignity for all three of these residents. She reported it when they were investigating CNA 1 after an incident which occurred with Resident B. A current policy, titled "Resident Rights," undated and provided by the ED on 10/24/23 at 11:05 a.m., indicated "...As a resident of this facility, you have the right to a dignified existence and to communicate with individuals and representatives of choice. The facility will protect and promote your rights as designated below...Dignity: The facility will treat you with dignity and respect in full recognition of your individuality...Accommodation of Needs: You have the right to receive services with reasonable accommodations to individual needs and interests...." This Federal tag relates to Complaint IN00419935. 3.1-3(t)			
F 0776 SS=D Bldg. 00	483.50(b)(1)(i)(ii) Radiology/Other Diagnostic Services §483.50(b) Radiology and other diagnostic services.			

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	§483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. Based on interview and record review, the facility failed to ensure a chest X-ray was completed for 1 of 3 residents being reviewed for diagnostic services. (Resident E) Finding includes: An "Intake Information" indicated Resident E had a raspy sore throat and a cough. An order was written for a chest X-ray. The resident was told the X-ray company was coming the evening of 10/9/23. The X-ray company called on 10/9/23 around 9 p.m., indicating the staff members car broke down and someone would be at the facility on Tuesday (10/10/23). The X-ray company did not come to do the chest X-ray until the morning of 10/13/23 and the resident had been sent to the hospital. During an interview, on 10/23/23 at 12:15 p.m., the Interim Director of Nursing (DON) indicated Resident E was admitted to the hospital on 10/13/23, for signs and symptoms of pneumonia. They received a phone call from the hospital, on 10/13/23, Resident E had Legionella.	F 0776	It is the policy of the facility to ensure that all residents receive radiology/diagnostic services timely. Residents who reside in the facility have the potential to be affected by this finding. On 11/17/2023 an audit was completed by the DON/Designee to ensure no Xray orders were missed or untimely. At an in-service held by the DON/Designee on 11/22/2023 for all staff the following was reviewed: ¿¿Physicians orders ¿¿Ancillary Services and Providers ¿¿Obtaining x-rays timely ¿¿Physician Notification	11/27/2023

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	The record for Resident E was reviewed on 10/24/23 at 2:15 p.m. Diagnoses included, but were not limited to, multiple myeloma, acute respiratory failure with hypoxia, pneumonia, muscle wasting and atrophy, and pain. A progress note, written on 10/11/23 at 3:55 p.m., indicated the resident's physician visited and ordered a chest X-ray as requested by the resident. A physician's order, written on 10/11/23 at 3:57 p.m., was for a two-view chest X-ray. A nursing progress note, written on 10/13/23 at 8:24 a.m., indicating the resident "insists" on going to the hospital due to shortness of breath. She had no signs of distress. Her speech was clear and normal, and she was able to speak with shortness of breath. The resident was sent to the Emergency Room (ER) for an evaluation and treatment as she requested. A nursing progress note, written on 10/15/23 at 6:39 a.m., indicating the resident was hospitalized on 10/13/23. There was a lack of documentation to follow-up on when the resident's chest X-ray was completed. During an interview, on 10/26/23 at 3:30 p.m., the Regional Nurse Consultant indicated the resident had a chest X-ray ordered on 10/11/23, but she was unable to find an X-ray result. She was unsure why there was no result. A document, titled "Mobile Imaging Services Agreement," dated 11/1/22, indicated the X-ray		Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. DON/Designee will review the 24-hour report, and previous days orders 5 times weekly for 4 weeks, 3 times weekly for 4 weeks, and once a week for 4 months to ensure compliance. This monitoring will continue for a minimum 6 months, if the facility is within 95% compliance after the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring of the X Ray Monitoring will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	

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	company and the facility entered a contract on that date. The contract included, but was not limited to, the following: The provider provided mobile imaging services to residents whose conditions and plans of care required medically necessary mobile imaging services and the facility desired the provider to perform certain mobile imaging services for its residents. The provider would provide imaging services to residents upon the order of a qualified medical professional. The Provider would render services through appropriately qualified personnel. The Provider will provide portable diagnostic X-ray services where available, that have been ordered by a qualified MD, DO or NPP. The Provider will respond to a request for service for STAT within four hours, ASAP within six hours and routine within eight hours. The turnaround times (response) will include providing the report and results back to the facility. This Federal tag relates to Complaint IN00420312. 3.1-49(g) 3.1-49(j)(4)			