	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155556		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/09/2024	
	PROVIDER OR SUPPLIE S OF TIPTON SKILI	R LED NURSING FACILITY, THE		300 FAI	ADDRESS, CITY, STATE, ZIP COD IRGROUNDS RD I, IN 46072			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 0000								
F 0000 Bldg. 00	IN00424603, IN00-IN00425307. Complaint IN00422 the allegation are complaint IN00422 related to the allegation are complaint IN00422	5077 - Federal deficiencies ations are cited at F684 and 5288 - No deficiencies related to ited. 5307 - Federal deficiencies ations are cited at F684 and 529 and 9, 2024. 50505 55556 66350	F 00	000				
	Total: 104							
	These deficiencies accordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1.						
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE		TITLE		(X6) DATE	

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

Victoria Roe Administrator 02/13/2024

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155556	B. WI			01/09/	
					_		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
\4/4 TEDO	OF TIPTON OKU	ED AU IDOINO EA OU ITY THE			RGROUNDS RD		
WATERS	OF TIPTON SKILL	LED NURSING FACILITY, THE		TIPTON	I, IN 46072		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	ID PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	2024.	completed on January 18,					
F 0684	483.25 Quality of Care						
SS=G							
Bldg. 00	§ 483.25 Quality of						
	•	a fundamental principle that					
	• •	ment and care provided to					
	facility residents. I						
	-	ssessment of a resident, the					
		re that residents receive					
		e in accordance with					
		dards of practice, the					
		erson-centered care plan,					
	and the residents'		Б 0.	CO 4	D		02/05/2024
		and record review, the facility unlicensed staff notified a	F 06	084	Preparation and/or execution of this plan of correction in general,		02/05/2024
		per that a dependent resident			or this corrective action, does		
		efore transferring the resident			constitute an admission of	HOL	
	_	wheelchair. This deficient			agreement by this facility of the	Δ	
		the resident not being			facts alleged or conclusions se		
	_	ed for injury by a licensed			forth in this statement of	,	
		ent experienced bilateral femur			deficiencies. The plan of corre	ction	
	fractures. (Resident				and specific corrective actions		
		,			prepared and/or executed in		
	Finding includes:				compliance with State and Fed	deral	
	-				Laws.¿ Facility's date of allege		
	A document, titled	"Indiana State Department of			compliance is: 2/5/2024. Facil		
	Health Survey Repo	ort System," dated 12/30/23 at			is respectfully requesting pa	-	
	5:01 a.m., indicated	Resident 2 had a witnessed fall			compliance for all deficiencie	es	
	on 12/22/23. At the	time of the fall, the resident's			in this POC.		
	-	ssessed with no concerns.			It is the policy of the facility to		
		family were notified of the fall.			ensure that licensed nursing s	taff	
		oted to have increased pain on			are notified of residents falling	and	
	_	nysician was notified. X-rays			completing as assessed for inj	-	
		/29/23. The family and			prior to resident being transfer		
		are of the femur fracture and			What corrective action(s) wil	I	
		the emergency department			be accomplished for those		
	for evaluation.				residents found to have beer	1	

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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 COMPLETED 00 B. WING 01/09/2024 155556 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 300 FAIRGROUNDS RD WATERS OF TIPTON SKILLED NURSING FACILITY, THE **TIPTON. IN 46072** (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 affected by the deficient The record for Resident 2 was reviewed on 1/8/24 practice? at 2:55 p.m. Diagnoses included, but were not Resident 2 was sent to the limited to, hemiplegia and hemiparesis (paralysis hospital on December 30, 2023, and weakness) affecting the right side of the and has not returned to facility. body, cerebral infraction (stroke), and osteoporosis without a pathological fracture (low CNA 3 and QMA 2 were bone mass which increases the risk of bone terminated on January 5, 2024 fractures/breaks). Residents who reside in the A quarterly Minimum Data Set (MDS) facility have the potential to be assessment, dated 10/19/23, indicated the affected by this finding. Therefore, following: this plan of correction applies to a. The resident had a BIMS (Brief Interview for all residents in the facility. Mental Status) score of 15 which indicated she was cognitively intact. What measures will be put into b. The resident had an impairment on one (1) side place and what systemic to both her upper and lower extremities. changes will be made to c. The resident was dependent (helper did all the ensure that the deficient effort) to move from a lying position to sitting on practice does not recur? the side of the bed. At an in-service held by the A care plan, initiated on 08/05/2023 and Administrator/Designee on discontinued on 01/08/24, indicated the resident 1/29/2024 for all clinical staff the was a fall risk. following was reviewed: 1 **Incident and Accidents** There were no nursing notes found in the Policy resident's record to indicate the events which led Notifications in relation to to the resident having fell or being lowered to the Falls, Pain, and Changes in ground on 12/22/23. Condition 3 Hoyer/Mechanical Lift There was no nursing assessment found in the Policy resident's record to indicate the nurse had QMA – Scope of Practice assessed the resident after she fell or was lowered Pain Documentation in to the ground on 12/22/23. relation to including location of

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12/19/23 to 12/22/23.

The resident's progress notes did not indicate a

change in the resident's mental condition from

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All unlicensed staff were educated

to notify a licensed nurse prior to

transferring a resident after a fall. Additionally, any staff who fail to

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/09/2024	
		155556	B. W	ING		01/09/	2024	
NAME OF F	PROVIDER OR SUPPLIEF	}			ADDRESS, CITY, STATE, ZIP COD			
					IRGROUNDS RD			
WATERS	S OF TIPTON SKILI	LED NURSING FACILITY, THE		TIPTON	N, IN 46072			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE	
		dated 12/22/23, indicated the			comply with the points of the			
		ne resident for complaints of			in-service will be further			
	_	(both knees) and shoulder pain.			educated/disciplined as			
	_	ed to the physician she had			indicated.			
		id off the bed and landed on her knee. The			How the corrective action(s)			
		hysician's finding was mild tenderness of both nees without significant effusion (fluid gathered			will be monitored to ensure	the		
					deficient practice will not			
	- '	ime of the physician's report			recur, i.e. what quality			
		specification of a.m./p.m.			assurance program will be p	ut		
		mentation of when the			into place?			
		ssed the resident only the time			The DON/Designee will audit			
	•	/22/23 at 10:28:13 and another			for completion of assessment			
	time/date stamp on	12/22/23 at 11:20:24.			resident was not transferred b	у		
					unlicensed staff after the fall,			
		lministration Record (MAR)			documentation, notification ar	nd		
	indicated the follow	_			incident report completion 5 ti	mes		
		complaints of 4/10 pain, on			a week x 4 weeks, then 3 time	es a		
		given acetaminophen 325			week x 4 weeks, then once a			
	milligrams x 2 table	-			week x 4 months.			
		complaints of 5/10 pain, on			The DON/Designee will audit	10		
	12/28/23, and was g	given acetaminophen 325 mg x 2			random residents pain			
	tablets at 9:56 a.m.				medications for documentatio	n of		
		complaints of 10/10 pain, on			location of pain x 4 weeks, the	en 5		
	12/29/23 at 7:40 a.r	_			random residents a week x 4			
	acetaminophen 325	-			weeks, then 5 random resider	nts a		
	-	as to where the resident was			month x 4 months.			
		noted in the Medication			If the facility is within 95%			
	Administration Rec	cord or notes.			compliance at the end of the 6			
					months, the monitoring will be	•		
		t, titled "Basic Investigation			stopped.			
		dicated Resident 2 had a			At the monthly QAPI meeting,			
		2/22/23, in her room. CNA 3			monitoring will be reviewed. A	•		
	was assisting the resident from bed. The CNA sat				concerns will have been corre			
	the resident on the side of the bed, turned her				as found. Any patterns will be			
	back to get the sit to stand mechanical lift and the				identified. If necessary, an Ad	ction		
	resident slid to the floor from the edge of the bed.				Plan will be written by the			
	,	2 assisted the resident from the			committee. Any written Actior	า		
		ir. The QMA did get the			Plan will be monitored by the			
	_	s and they were normal. The			Administrator weekly until			
	resident denied any	pain. The physician was			resolution.			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155556		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/09/2024	
	ROVIDER OR SUPPLIER	ED NURSING FACILITY, THE	300 FA	ADDRESS, CITY, STATE, ZIP COD IRGROUNDS RD N, IN 46072	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	notified while he wand did see the reside and QMA were sust investigation. The recomplaints of pain, obtained and the residence femur fractures. The hospital for evaluating was terminated for post of practice and the following facility post of performance, gray working outside of following facility post of following facility post of following facility post of facility documents form," dated 1/5/24 Executive Director indicated CNA 3 was violation of safety repolicy and /or proceedically mechanical incidents/accidents In a facility document with from the Director of a.m., CNA 3 indicated to grab the state back around Resided	as in the facility making rounds dent on 12/22/23. The CNA pended pending an esident had continued Orders for x-rays were sults of the x-ray were bilateral e resident was sent to the fon and treatment. The QMA practicing outside of her scope CNA was terminated for not olicy and procedure. The titled "Facility Separation and received from the facility oss violation of safety rules, ther scope of practice, not olicy and procedure. The titled "Facility Separation and received from the facility of practice, not olicy and procedure. The titled "Facility Separation and received from the facility of practice, not olicy and procedure. The titled "Facility Separation and received from the facility of practice, not olicy and procedure. The titled "Facility Separation and received from the facility of the faci			DATE
	entered the room, sl	nd for the QMA. When QMA 2 the asked Resident 2 she asked the resident told the QMA she			

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155556	B. W	ING	_	01/09/	/2024
		<u> </u>	1	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			RGROUNDS RD		
WATERS	OF TIPTON SKILL	LED NURSING FACILITY, THE			I, IN 46072		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	• •	they moved the resident and					
		st. When the CNA was asked					
	-	ify the nurse she stated "I					
		I should of I thought [name of					
		The Assistant Director of A 3 why she was using the					
	-	nother staff, CNA 3 indicated "					
	i don t know, i kn	.I don't know, I know I am supposed to"					
	In a facility docume	ent, titled "Confidential					
	Witness Statement,	dated 12/29/23 and received					
		f Nursing on 1/9/24 at 10:26					
		ated, on 12/22/23, the CNA					
	-	hile she was passing					
		dicated Resident 2 was on the					
		into the resident's room,					
		esident 2 seemed okay. She					
	-	out the resident into her					
		ould go to breakfast. The					
		of Nursing asked QMA 2 if she					
		se on duty of the fall. QMA 2					
		ant Director of Nursing and					
	· ·	'No I got busy again with					
		orget to tell her" The					
		of Nursing asked QMA 2 why ident when it was outside of					
		e. QMA 2 indicated "I don't					
	know I had a lapse						
	Kilow i liau a lapse !	m juagement					
	A facility document	t, titled "Confidential Witness					
	· ·	2/31/23 and received from the					
		on 1/9/24 at 10:26 a.m.,					
		Assistant Director of Nursing					
		time the incident happened,					
		ought it was around 7:00 a.m.					
		went into the resident's room					
	to get her up. She cl	hecked the resident and set					
		f the bed. The resident was					
	_	lift to the side of the bed and					
	noticed Resident 2	was starting to slide. She					
			1				I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155556	B. WI	NG		01/09/	2024
				CTDEET A	DDDESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD RGROUNDS RD		
\//ATED	C OE TIDTON SKILI	LED NURSING FACILITY, THE			I, IN 46072		
WATERS	OF TIPTON SKILL	LED NORSING FACILITY, THE		TIFTON	1, IN 40072		
(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 APPROPRIA	ΓF	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	pulled the call light	and yelled for QMA 2 to help.					
	By the time QMA 2	2 got into the room, CNA 3 had					
	pushed the lift out of	of the way; if it had remained in					
	place, it would have	e hit the resident. Instead of					
	letting Resident 2 fall, she lowered her to the ground. The QMA came in and assessed the						
	resident, she asked	the resident if she was okay,					
	and Resident 2 said	yes. The QMA then helped					
		the wheelchair and the					
	resident said she wa	as fine. The Assistant Director					
	of Nursing asked th	e CNA what the resident's					
	position was after sl	he had been lowered to the					
	floor. CNA 3 indica	ated the resident was kind of					
	sitting up straight. I	Her back was straight, and her					
		nt of her. Her legs were not					
	_	way. When asked if the CNA					
	I -	rse; CNA 3 indicated "No I					
	didn't I'm sorry"						
	A facility document	t, titled "Confidential Witness					
	1	2/31/23 and received from the					
	Director of Nursing	g on 1/9/24 at 10:26 a.m.,					
	_	Assistant Director of Nursing					
		happened, she indicated she					
	was out on the med	• •					
		NA 3 came and got her. CNA 3					
		he had slowly put Resident 2					
		3 entered the room and asked					
		vas hurt. The resident denied					
		on her body. She did not					
		red marks or anything. The					
		then transferred her into the					
	1	ked the resident if she was					
		ent said yes. She then took the					
	i i	s. She could not recall the vital					
	_	her blood pressure was good					
		akfast. The resident did not					
		her about it the rest of the					
	1	oout the position of the					
	l ·	MA entered the room, she					
	1351delli Wileii tile Q	and room, one					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155556	B. W	ING		01/09/	/2024
				T			
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
					RGROUNDS RD		
WATERS	S OF TIPTON SKILI	LED NURSING FACILITY, THE		TIPTON	I, IN 46072		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWDERIC BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	indicated the reside	nt's knees were bent, she had					
		nd she was leaning against the					
		The QMA did not administer					
		the resident that day.					
	During a telephone interview, on 1/8/24 at 2:43 p.m., QMA 2 indicated she was working on the medication cart on the day Resident 2 fell or was						
		nd. She did not witness the					
		nformed by CNA 3. The					
	incident happened b	between 7:00 and 8:00 a.m. The					
	CNA told her, she h	nad sat the resident up on the					
	side of the bed, wer	nt to get the stand-up lift, and					
		the floor. QMA 2 retrieved the					
	vital sign machine a	and then went to the room. The					
	resident was found	on the floor with her legs					
	extended out in from	nt of her, in a sitting position,					
	with the CNA supp	orting her. The resident told					
	QMA 2 she was fin	e. A few minutes later, the					
	CNA took the resid	ent to the dining room. The					
	resident seemed fin	e. QMA 2 indicated she did tell					
	the nurse of the fall	when the nurse came to the					
	unit to administer in	nsulin. She did not know if the					
	nurse assessed the r	resident. The nurse					
	administered insuli	n, returned the insulin pens to					
	the medication cart	, and then left the unit.					
	Resident 2 used the	sit to stand lift for transfers.					
		interview, on 1/8/24 at 2:46					
	p.m., CNA 3 indica	ted the day of the fall was a					
	normal morning. Re	esident 2 used a sit to stand					
	·	transfers, and she had not ever					
		e resident using the lift before.					
		on the side of the bed and					
		was starting to slip. She					
		ght and yelled for the QMA in					
		ed the resident very gently to					
	the floor as soft as s	she could. The QMA came,					
	looked at the reside	nt, and all was okay. The CNA					
	and QMA transferr	ed Resident 2 into her					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	l	
		155556	B. W	ING		01/09/	2024
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
WATERS	S OF TIPTON SKILI	LED NURSING FACILITY, THE			RGROUNDS RD I, IN 46072		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION resident was fine. She		TAG	DEFICIENCY		DATE
		reported the fall to the nurse.					
		ssess the resident from the					
		when Resident 2 was					
	transported to the d	ransported to the dining room. She understood					
		be a one person assist using					
		out was informed after the					
	incident the resident required two (2) staff to use						
	the lift.						
	During an interview	v, on 1/8/24 at 2:57 p.m., the					
	_	indicated QMA 2, nor CNA 3					
		rse of the fall. The QMA					
	cannot assess. The	facility policy had not been					
		he CNA and QMA had been					
	terminated from em	nployment.					
	During an interview	v, on 01/8/24 at 3:01 p.m., the					
	_	indicated the reason there was					
	not an assessment i	n the resident's record was					
		NA nor the QMA had					
	reported the fall to						
		interview, on 1/9/24 at 9:45					
	l ·	ted she had not been informed g Resident 2 until she returned					
	_	3. She did go to the unit, look at					
		g scale, administer her insulin,					
		ck to the medication cart, and					
		unit she was working on that					
	day. During the tim	e she spent with Resident 2 on					
	I	ent, the resident did not					
	mention she had fal	llen.					
	During an interview	v, on 1/9/24 at 10:04 a.m., the					
	_	indicated insulin was					
	administered to Res	sident 2, by LPN 1, on 12/22/23					
	at 9:01 a.m.						
	During an interview	v, on 1/9/24 at 1:02 p.m., the					
	_	indicated the facility found out					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	r í	JILDING	nstruction <u>00</u>	(X3) DATE : COMPL 01/09/	ETED
	PROVIDER OR SUPPLIER S OF TIPTON SKILI	LED NURSING FACILITY, THE		300 FAI	DDRESS, CITY, STATE, ZIP COD RGROUNDS RD I, IN 46072		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY 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)		(X5) COMPLETION DATE
	reported pain to QM were then interview physician's note rel the physician did no During a telephone p.m., Physician 8 ir in the facility and a wanted to see him be having knee pain and day. He did assess suspicions of any firmild injury. He indighted she was lowered to During an interview Executive Director refer to the QMA and A facility documen undated and received on 1/9/24 at 10:26 a responsibility was to under the supervision to include assessing A facility policy, the Stand Lift," undate Executive Director "The operation of one trained operator indicated she was 2 transfers. A facility policy, the Reporting Policy," Executive Director indicated "Any and the physician state of the physician policy," Executive Director indicated "Any and the physician state of the physician policy," Executive Director indicated "Any and the physician ph	w, on 1/9/24 at 2:08 p.m., the indicated the physician did s a nurse. t, titled "Job Description," ed from the Executive Director a.m., indicated the QMA o administer medications on of a licensed nurse. It did					
	person designated t	o be in chargeIf a resident is					

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/09/2024	
	ROVIDER OR SUPPLIER	ED NURSING FACILITY, THE	300 FA	ADDRESS, CITY, STATE, ZIP COD NIRGROUNDS RD N, IN 46072		
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
F 0689 SS=G Bldg. 00	involved in an accidance assessment of the reaction of the reaction of the Qualified Medication of the Qualified M	dent/incident an immediate esident will be completed" ment of Health (IDOH) on Aide (QMA) Training Manual, dated 1/2/24, in 1: Role and Responsibilities dication AideTasks the TED from Performing 1. Assess in" attes to Complaints IN00425077 dion/Devices ents. ensure that - eresident environment faccident hazards as is in resident receives sion and assistance devices ents. and record review, the facility quate supervision and staff at falls was provided to a ed the use of a mechanical lift of two staff during transfers. dice resulted in Resident 2 evitnessed fall and bilateral esident 2)	F 0689	Preparation and/or execution of this plan of correction in general or this corrective action, does reconstitute an admission of agreement by this facility of the facts alleged or conclusions seforth in this statement of deficiencies. The plan of correct and specific corrective actions prepared and/or executed in compliance with State and Federal	of 02/05/2024 al, not ext	
	A document, titled '	'Indiana State Department of	1	Laws.¿ Facility's date of allege	a	

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 $C3RF11 \qquad {\tt Facility\ ID:} \quad 000505$

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SUR	VEY
	OF CORRECTION	IDENTIFICATION NUMBER	î í	ЛLDING	00	COMPLETE	
		155556	B. W	ING		01/09/202	24
				CTD DET	ADDRESS CITY STATE 7IB COD		
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
\\/\\TEDG	S OE TIDTON SKILL	LED NURSING FACILITY, THE			IRGROUNDS RD 1, IN 46072		
VVATERS	OF HEION SKIL	LLD NUNSING FACILITY, THE		115101	N, IIN 40012		
(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	ATE CO	OMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ort System," dated 12/30/23 at			compliance is: 2/5/2024.¿ Fac	-	
	·	d Resident 2 had a witnessed fall			is respectfully requesting pa	-	
		e time of the fall, the resident's			compliance for all deficienci	es	
	_	assessed with no concerns.			in this POC.¿¿		
		family were notified of the fall.			10.00		
		oted to have increased pain on			It is the policy of the facility to		
	_				ensure that all residents recei		
	. •				adequate supervision and sta	IT (O	
	physician were aware of the femur fracture and resident was sent to the emergency department				prevent falls and two staff members for mechanical lift		
	resident was sent to the emergency department for evaluation.				members for mechanical lift transfers.		
	for evaluation.				แสทอเซาอ.		
	The record for Resident 2 was reviewed on 1/8/24				What corrective action(s) wi	.	
	at 2:55 p.m. Diagnoses included, but were not				be accomplished for those	"	
		gia and hemiparesis (paralysis			residents found to have bee	n	
		cting the right side of the			affected by the deficient		
	body, cerebral infra				practice?		
	-	ut a pathological fracture (low			Resident 2 was sent to the		
	-	ncreases the risk of bone			hospital on December 30, 202	23	
	fractures/breaks).				and has not returned to facility		
	,						
	A quarterly Minim	um Data Set (MDS)			CNA 3 and QMA 2 were		
		0/19/23, indicated the			terminated on January 5, 202	4	
	following:						
		a BIMS (Brief Interview for			All residents have the potentia		
	· · · · · · · · · · · · · · · · · · ·	re of 15 which indicated she			be affected. Therefore, this pl		
	was cognitively int				correction applies to all reside	ents	
		an impairment on one (1) side			of the facility.		
		nd lower extremities.					
		dependent (helper did all the			How other residents having		
	· ·	m a lying position to sitting on			potential to be affected by the		
	the side of the bed.				same deficient practice will		
	A comp m1=== !==!*	od on 0/7/17 and disti			identified and what corrective	e	
	-	ed on 9/7/17 and discontinued			action(s) will be taken?		
	·	the resident had late loss			At on in comice held buttle		
		iving (ADL) and needed total			At an in-service held by the		
		s due to hemiplegia. ded, but were not limited to,			Administrator/Designee on 1/29/2024 for all clinical staff t	ho	
		to see the CNA assignment			following was reviewed:	.i iC	
		the staff assist needed. The			1 Incident and Accidents		
	sincer for details off	the start assist needed. The	1		i incidentand Accidents	I	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	00	COMPLETED	
		155556	B. W	ING	_	01/09/2024	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			IRGROUNDS RD		
WATERS	OF TIPTON SKILL	LED NURSING FACILITY, THE			N, IN 46072		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)	DATE	
		ecify how many staff were			Policy		
		istance with transfers or the			2 Notifications in relation to		
	use of the mechanic	eal lift.			Falls, Pain, and Changes in		
					Condition		
		ed on 8/5/23 and discontinued			3 Hoyer/Mechanical Lift		
		I the resident was a fall risk and			Policy		
		2 people with the mechanical			4 QMA – Scope of Practice	•	
		to stand lift, and do not leave the resident			5 Pain Documentation in		
	while sitting on the	side of the bed.			relation to including location.		
					All unlicensed staff were		
		, dated 11/24/19, indicated			educated to notify a licensed		
		May use mechanical lift for			nurse prior to transferring a		
	transfers"				resident after a fall.		
					Additionally, any staff that fails	s to	
		ing notes found in the			comply with the points of this		
		indicate the events which led			in-service will be further		
		ng fell or being lowered to the			educated/disciplined as indica		
	ground on 12/22/23	•			How the corrective action(s)		
					will be monitored to ensure t	the	
		ress notes did not indicate a			deficient practice will not		
	_	ent's mental condition from			recur, i.e. what quality		
	12/19/23 to 12/22/2	3.			assurance program will be p	ut	
		1 4 1 1 2 / 2 2 / 2 2 2 3 3 3 4 3 4 3 4 3			into place?		
		dated 12/22/23, indicated the			The DON/Designee will audit		
	1 ^ -	re resident for complaints of			for completion of assessments	I	
	_	(both knees) and shoulder pain.			resident was not transferred b	У	
	•	ed to the physician she had			unlicensed staff after the fall,		
		landed on her knee. The			documentation, notification an		
		was mild tenderness of both			incident report completion 5 til	I	
	_	ficant effusion (fluid gathered			a week x 4 weeks, then 3 time	es a	
		me of the physician's report			week x 4 weeks, then once a		
		specification of a.m./p.m. nentation of when the			week x 4 months.	6	
					The DON/Designee will audit		
		sed the resident only the time			random staff members a week		
		/22/23 at 10:28:13 and another			2-person mechanical lift trans		
	ume/date stamp on	12/22/23 at 11:20:24.			x 4 weeks, then 4 random state	"	
	The Madiastics A 1	ministration Decord (MAD)			members x 4 weeks, then 2	the	
		ministration Record (MAR)			random staff a month x 4 mon		
	indicated the follow				The DON/Designee will audit	10	
	a. The resident had	complaints of 4/10 pain, on	1		random residents pain		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155556	B. W	NG		01/09/	2024
				·			
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					IRGROUNDS RD		
WATERS OF TIPTON SKILLED NURSING FACILITY, THE				TIPTON	N, IN 46072		
(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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	1.2	DATE
	12/24/23, and was g	given acetaminophen 325			medications for documentation	n of	
	milligrams x 2 table	ets at 3:09 p.m.			location of pain x 4 weeks, the	n 5	
	b. The resident had	complaints of 5/10 pain, on			random residents a week x 4		
	12/28/23, and was g	given acetaminophen 325 mg x 2			weeks, then 5 random residen	ıts a	
	tablets at 9:56 a.m.				month x 4 months.		
	c. The resident had	complaints of 10/10 pain, on			If the facility is within 95%		
	12/29/23 at 7:40 a.r	n., and was given			compliance at the end of the 6	;	
	acetaminophen 325	mg x 2.			months, the monitoring will be		
					stopped		
	There was no entry	as to where the resident was			Any staff who fail to comply wi	th	
	experiencing pain n	oted in the Medication			the points of the in-service will	be	
	Administration Rec	ord or notes.			further educated and or		
					progressively disciplined as		
	_	t, titled "Basic Investigation			indicated.		
		licated Resident 2 had a			At the monthly QAPI meeting,	the	
		2/22/23, in her room. CNA 3			monitoring will be reviewed. A	Any	
	_	sident from bed. The CNA sat			concerns will have been corre	cted	
		side of the bed, turned her			as found. Any patterns will be	:	
	T	stand mechanical lift and the			identified. If necessary, an Ac	tion	
		floor from the edge of the bed.			Plan will be written by the		
	· · · · · · · · · · · · · · · · · · ·	assisted the resident from the			committee. Any written Action	1	
		ir. The QMA did get the			Plan will be monitored by the		
	_	s and they were normal. The			Administrator weekly until		
	_	pain. The physician was			resolution.		
		as in the facility making rounds			By what date the systemic		
		dent on 12/22/23. The CNA			change for the deficiency wil	II	
	and QMA were sus				be completed?		
	1	esident had continued			Date of Compliance: February	5,	
		Orders for x-rays were			2024		
		sults of the x-ray were bilateral					
		e resident was sent to the					
		ion and treatment. The QMA					
		practicing outside of her scope					
		CNA was terminated for not					
	tollowing facility p	olicy and procedure.					
	A facility documen	t, titled "Facility Separation					
		and received from the					
	· ·	on 1/9/24 at 10:26 a.m.,					
		vas terminated from the facility					
	×1711 2 W		l .		İ		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY		
AND PLA	AN OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	A. BUILDING <u>00</u>			COMPLETED	
		155556	B. WING	3		01/09/	2024	
				CTDEET A	DDDESC CITY STATE ZIR COD			
NAME O	F PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP COD			
WATERS OF TIRTON SKILLER NUIDSING FACILITY THE								
WATERS OF TIPTON SKILLED NURSING FACILITY, THE				TIPTON	I, IN 46072			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PR	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	for performance, gr	ross violation of safety rules,						
	working outside of	her scope of practice, not						
	following facility p	olicy and procedure.						
	A facility documen	t, titled "Facility Separation						
	Form," dated 1/5/2	4 and received from the						
	Executive Director	on 1/9/24 at 10:26 a.m.,						
		vas terminated for performance,						
	1	rules, violation of company						
		edure. CNA did not follow						
	-	lift policy or reporting						
	incidents/accidents	policy.						
	1	ent, titled "Confidential						
		" dated 12/29/23 and received						
		of Nursing on 1/9/24 at 10:26						
		ated, on 12/22/23, Resident 2 was						
	_	of the bed. CNA 3 turned her						
	_	and-up lift; when she turned						
		ent 2 was starting to fall. CNA 3						
		t, so the resident did not fall on						
		ed for the QMA. When QMA 2						
		he asked Resident 2 she asked						
		ne resident told the QMA she they moved the resident and						
	•	st. When the CNA was asked						
	1 *	tify the nurse she stated "I I should of I thought [name of						
		~ -						
		The Assistant Director of A 3 why she was using the						
	_	nother staff, CNA 3 indicated "						
		now I am supposed to"						
	don't know, I ki	iow i am supposed to						
	In a facility docum	ent, titled "Confidential						
	1	" dated 12/29/23 and received						
		of Nursing on 1/9/24 at 10:26						
		ated, on 12/22/23, the CNA						
		while she was passing						
	_	ndicated Resident 2 was on the						
		t into the resident's room,						
			1				i	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155556		A. BU	A. BUILDING 00 B. WING			COMPLETED 01/09/2024	
NAME OF PROVIDER OR SUPPLIER WATERS OF TIPTON SKILLED NURSING FACILITY, THE				300 FAI	ADDRESS, CITY, STATE, ZIP COD RGROUNDS RD I, IN 46072		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	assessed her, and R assisted CNA 3 to p wheelchair so she ce Assistant Director of had notified the nur stated to the Assistant the Administrator, 'my med pass and for Assistant Director of she assessed the resher scope of practice know I had a lapse. A facility document Statement dated 12 Director of Nursing indicated when the asked CNA 3 what she indicated she the CNA 3 told her she to get her up. She cher up on the side of fine. She pulled the noticed Resident 2 pulled the call light By the time QMA 2 pushed the lift out of place, it would have letting Resident 2 fa ground. The QMA resident, she asked and Resident 2 said put Resident 2 into resident said she war of Nursing asked the position was after statisting up straight. I legs were out in fro	esident 2 seemed okay. She but the resident into her ould go to breakfast. The of Nursing asked QMA 2 if she are on duty of the fall. QMA 2 ant Director of Nursing and 'No I got busy again with orget to tell her" The of Nursing asked QMA 2 why ident when it was outside of e. QMA 2 indicated "I don't					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155556		ì í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 01/09/	ETED	
NAME OF PROVIDER OR SUPPLIER WATERS OF TIPTON SKILLED NURSING FACILITY, THE				300 FAI	DDRESS, CITY, STATE, ZIP COD RGROUNDS RD I, IN 46072		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY 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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	didn't I'm sorry"						
	Statement," dated I Director of Nursing indicated when the asked QMA 2 what was out on the med medication when C had informed her; son the floor. QMA the resident if she w pain at any location appear to have any QMA and the CNA wheelchair. She ask okay, and the reside about the position centered the room, si knees were bent, she was leaning agar	NA 3 came and got her. CNA 3 he had slowly put Resident 2 3 entered the room and asked vas hurt. The resident denied on her body. She did not red marks or anything. The then transferred her into the ted the resident if she was ent said yes. When asked of the resident when the QMA he indicated the resident's e had boots on her feet, and tinst the bed on her bottom. ddminister pain medication to					
	p.m., QMA 2 indica medication cart on lowered to the grou incident. She was in incident happened be CNA told her, she has side of the bed, were the resident slid to the found on the floor of front of her, in a sit supporting her. The fine. A few minutes	interview, on 1/8/24 at 2:43 ated she was working on the the day Resident 2 fell or was nd. She did not witness the nformed by CNA 3. The between 7:00 and 8:00 a.m. The had sat the resident up on the nt to get the stand-up lift, and the floor. The resident was with her legs extended out in ting position, with the CNA resident told QMA 2 she was stater, the CNA took the					
		ng room. The resident seemed ted she did tell the nurse of the					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155556		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/09/2024			
NAME OF PROVIDER OR SUPPLIER WATERS OF TIPTON SKILLED NURSING FACILITY, THE			STREET ADDRESS, CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
TAG	fall when the nurse insulin. She did not the resident. The nure turned the insulin and then left the unstand lift for transfer During a telephone p.m., CNA 3 indica normal morning. Remechanical lift, for had trouble with the She sat the resident noticed the resident turned on the call lift the hall. She lowere the floor as soft as a looked at the reside and QMA transferred wheelchair and the	came to the unit to administer know if the nurse assessed rse administered insulin, pens to the medication cart, it. Resident 2 used the sit to rs. interview, on 1/8/24 at 2:46 ted the day of the fall was a esident 2 used a sit to stand transfers, and she had not ever e resident using the lift before. on the side of the bed and was starting to slip. She ght and yelled for the QMA in d the resident very gently to the could. The QMA came, int, and all was okay. The CNA and Resident 2 into her resident was fine. She	TAG	DEFICIENCY)	DATE			
	She understood the person assist using	reported the fall to the nurse. resident was to be a one the sit to stand lift but was neident the resident required the lift.						
	Executive Director had notified the nur policy had not been	y, on 1/8/24 at 2:57 p.m., the indicated QMA 2, nor CNA 3 se of the fall. The facility followed and both the CNA terminated from employment.						
	a.m., LPN 1 indicat of the fall involving to work on 12/27/22 the resident's sliding return the items bac then returned to the	interview, on 1/9/24 at 9:45 ed she had not been informed Resident 2 until she returned She had go to the unit, look at g scale, administer her insulin, k to the medication cart, and unit she was working on that e she spent with Resident 2 on						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED		
155556		B. WI			01/09/		
NAME OF PROVIDER OR SUPPLIER WATERS OF TIPTON SKILLED NURSING FACILITY, THE			300 FAI	ADDRESS, CITY, STATE, ZIP COD RGROUNDS RD I, IN 46072			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	Τ	ID			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX PROVIDERS PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		COMPLETIO	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the day of the incidemention she had fal	ent, the resident did not llen.					
	Executive Director about the fall, on 12 reported pain to QN were then interview physician's note relative physician did not the physician did not During a telephone p.m., Physician 8 in the facility and a wanted to see him behaving knee pain af day. He did assess t suspicions of any fr	w, on 1/9/24 at 1:02 p.m., the indicated the facility found out 2/29/23, when Resident 2 MA 2. Both QMA 2 and CNA 3 wed about the fall. There was a atted to the fall on that day, but notify the facility of the fall. interview, on 1/9/24 at 2:00 adicated he was making rounds nurse informed him Resident 2 because the resident was after a fall which occurred that the resident and had low ractures and thought it was a ficated Resident 2 did not fall, the ground.					
	_	y, on 1/9/24 at 2:08 p.m., the indicated the physician did s a nurse.					
	to Stand Lift," unda Executive Director "The operation o one trained operator	teled "Policy and Procedure Sit ated and received from the on 1/9/24 at 3:39 p.m., indicated f the lift requires a minimum on r" The resident's care plan-person mechanical lift for					
	Reporting Policy," Executive Director indicated "Any ac reported immediate person designated to	elled "Accident Incident undated and received from the on 1/9/24 at 10:26 a.m., ecident/incident will be ly to the nurse or appropriate to be in chargeIf a resident is dent/incident an immediate					

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Event ID:

C3RF11 Facility ID: 000505

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155556	B. WING			01/09/2024	
NAME OF PROVIDER OR SUPPLIER WATERS OF TIPTON SKILLED NURSING FACILITY, THE			3	00 FAI	DDRESS, CITY, STATE, ZIP COD RGROUNDS RD I, IN 46072	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	П	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE		TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY)		DATE
		esident will be completed" ates to Complaints IN00425077					
	3.1-45(a)(2)						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: C3RF11 Facility ID: 000505 If continuation sheet Page 20 of 20