| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155556 | A. BUILDING 00<br>B. WING | 01/09/2024 |

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

| (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<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00424603, IN00425077, IN00425288 and IN00425307.<br><br>Complaint IN00424603 - No deficiencies related to the allegation are cited.<br><br>Complaint IN00425077 - Federal deficiencies related to the allegations are cited at F684 and F689.<br><br>Complaint IN00425288 - No deficiencies related to the allegation are cited.<br><br>Complaint IN00425307 - Federal deficiencies related to the allegations are cited at F684 and F689.<br><br>Survey dates: January 8 and 9, 2024.<br><br>Facility number: 000505<br>Provider number: 155556<br>AIM number: 100266350<br><br>Census Bed Type:<br>SNF/NF: 77<br>SNF: 27<br>Total: 104<br><br>Census Payor Type:<br>Medicare: 16<br>Medicaid: 48<br>Other: 40<br>Total: 104<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. | F 0000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| 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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155556 | A. BUILDING 00<br>B. WING | 01/09/2024 |

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

| (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 |
|---|---|---|---|---|
| | Quality review was completed on January 18, 2024. | | | |
| F 0684<br>SS=G<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to 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.<br>Based on interview and record review, the facility failed to ensure an unlicensed staff notified a licensed staff member that a dependent resident experienced a fall before transferring the resident from the floor to a wheelchair. This deficient practice resulted in the resident not being immediately assessed for injury by a licensed nurse and the resident experienced bilateral femur fractures. (Resident 2)<br><br>Finding includes:<br><br>A document, titled "Indiana State Department of Health Survey Report System," dated 12/30/23 at 5:01 a.m., indicated Resident 2 had a witnessed fall on 12/22/23. At the time of the fall, the resident's skin and pain was assessed with no concerns. The physician and family were notified of the fall. The resident was noted to have increased pain on 12/29/23 and the physician was notified. X-rays were ordered on 12/29/23. The family and physician were aware of the femur fracture and resident was sent to the emergency department for evaluation. | F 0684 | 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: 2/5/2024. **Facility is respectfully requesting paper compliance for all deficiencies in this POC.**<br>It is the policy of the facility to ensure that licensed nursing staff are notified of residents falling and completing as assessed for injury prior to resident being transferred.<br>**What corrective action(s) will be accomplished for those residents found to have been** | 02/05/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155556 | A. BUILDING 00<br>B. WING | 01/09/2024 |

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

| (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 |
|---|---|---|---|---|
| | The record for Resident 2 was reviewed on 1/8/24 at 2:55 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (paralysis and weakness) affecting the right side of the body, cerebral infraction (stroke), and osteoporosis without a pathological fracture (low bone mass which increases the risk of bone fractures/breaks).<br><br>A quarterly Minimum Data Set (MDS) assessment, dated 10/19/23, indicated the following:<br>a. The resident had a BIMS (Brief Interview for Mental Status) score of 15 which indicated she was cognitively intact.<br>b. The resident had an impairment on one (1) side to both her upper and lower extremities.<br>c. The resident was dependent (helper did all the effort) to move from a lying position to sitting on the side of the bed.<br><br>A care plan, initiated on 08/05/2023 and discontinued on 01/08/24, indicated the resident was a fall risk.<br><br>There were no nursing notes found in the resident's record to indicate the events which led to the resident having fell or being lowered to the ground on 12/22/23.<br><br>There was no nursing assessment found in the resident's record to indicate the nurse had assessed the resident after she fell or was lowered to the ground on 12/22/23.<br><br>The resident's progress notes did not indicate a change in the resident's mental condition from 12/19/23 to 12/22/23. | | **affected by the deficient practice?**<br>Resident 2 was sent to the hospital on December 30, 2023, and has not returned to facility.<br><br>CNA 3 and QMA 2 were terminated on January 5, 2024<br><br>Residents who reside in the facility have the potential to be affected by this finding. Therefore, this plan of correction applies to all residents in the facility.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**<br><br>At an in-service held by the Administrator/Designee on 1/29/2024 for all clinical staff the following was reviewed:<br>1 Incident and Accidents Policy<br>2 Notifications in relation to Falls, Pain, and Changes in Condition<br>3 Hoyer/Mechanical Lift Policy<br>4 QMA – Scope of Practice<br>5 Pain Documentation in relation to including location of pain.<br>All unlicensed staff were educated to notify a licensed nurse prior to transferring a resident after a fall. Additionally, any staff who fail to | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155556 | A. BUILDING 00<br>B. WING | 01/09/2024 |

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

| (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 |
|---|---|---|---|---|
| | A physician's note, dated 12/22/23, indicated the physician did see the resident for complaints of bilateral knee pain (both knees) and shoulder pain. The resident reported to the physician she had slid off the bed and landed on her knee. The physician's finding was mild tenderness of both knees without significant effusion (fluid gathered in the space). The time of the physician's report was 10:28, without specification of a.m./p.m. There was no documentation of when the physician had assessed the resident only the time of his report, on 12/22/23 at 10:28:13 and another time/date stamp on 12/22/23 at 11:20:24.<br><br>The Medication Administration Record (MAR) indicated the following:<br>a. The resident had complaints of 4/10 pain, on 12/24/23, and was given acetaminophen 325 milligrams x 2 tablets at 3:09 p.m.<br>b. The resident had complaints of 5/10 pain, on 12/28/23, and was given acetaminophen 325 mg x 2 tablets at 9:56 a.m.<br>c. The resident had complaints of 10/10 pain, on 12/29/23 at 7:40 a.m., and was given acetaminophen 325 mg x 2.<br>There was no entry as to where the resident was experiencing pain noted in the Medication Administration Record or notes.<br><br>A facility document, titled "Basic Investigation Form," undated, indicated Resident 2 had a witnessed fall, on 12/22/23, in her room. CNA 3 was assisting the resident from bed. The CNA sat the resident on the side of the bed, turned her back to get the sit to stand mechanical lift and the resident slid to the floor from the edge of the bed. CNA 3 and QMA 2 assisted the resident from the floor to a wheelchair. The QMA did get the resident's vital signs and they were normal. The resident denied any pain. The physician was | | comply with the points of the in-service will be further educated/disciplined as indicated.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?**<br>The DON/Designee will audit falls for completion of assessments, resident was not transferred by unlicensed staff after the fall, documentation, notification and incident report completion 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months.<br>The DON/Designee will audit 10 random residents pain medications for documentation of location of pain x 4 weeks, then 5 random residents a week x 4 weeks, then 5 random residents a month x 4 months.<br>If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped.<br>At the monthly QAPI meeting, the 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. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155556 | A. BUILDING 00<br>B. WING | 01/09/2024 |

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

| (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 |
|---|---|---|---|---|
| | notified while he was in the facility making rounds and did see the resident on 12/22/23. The CNA and QMA were suspended pending an investigation. The resident had continued complaints of pain. Orders for x-rays were obtained and the results of the x-ray were bilateral femur fractures. The resident was sent to the hospital for evaluation and treatment. The QMA was terminated for practicing outside of her scope of practice and the CNA was terminated for not following facility policy and procedure.<br><br>A facility document, titled " ...Facility Separation Form," dated 1/5/24 and received from the Executive Director on 1/9/24 at 10:26 a.m., indicated QMA 2 was terminated from the facility for performance, gross violation of safety rules, working outside of her scope of practice, not following facility policy and procedure.<br><br>A facility document, titled " ...Facility Separation Form," dated 1/5/24 and received from the Executive Director on 1/9/24 at 10:26 a.m., indicated CNA 3 was terminated for performance, violation of safety rules, violation of company policy and /or procedure. CNA did not follow facility mechanical lift policy or reporting incidents/accidents policy.<br><br>In a facility document, titled "Confidential Witness Statement," dated 12/29/23 and received from the Director of Nursing on 1/9/24 at 10:26 a.m., CNA 3 indicated, on 12/22/23, Resident 2 was sitting on the side of the bed. CNA 3 turned her back to grab the stand-up lift; when she turned back around Resident 2 was starting to fall. CNA 3 had to move the lift, so the resident did not fall on it. The CNA hollered for the QMA. When QMA 2 entered the room, she asked Resident 2 she asked if she was okay. The resident told the QMA she | | **By what date the systemic change for the deficiency will be completed?**<br>Date of Compliance: February 5, 2024 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155556 | A. BUILDING 00<br>B. WING | 01/09/2024 |

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

| (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 |
|---|---|---|---|---|
| | was okay, and then they moved the resident and took her to breakfast. When the CNA was asked why she did not notify the nurse she stated " ...I don't know, I know I should of I thought [name of QMA 2] did it ...." The Assistant Director of Nursing asked CNA 3 why she was using the stand lift without another staff, CNA 3 indicated " ...I don't know, I know I am supposed to ...."<br><br>In a facility document, titled "Confidential Witness Statement," dated 12/29/23 and received from the Director of Nursing on 1/9/24 at 10:26 a.m., QMA 2 indicated, on 12/22/23, the CNA came and got her while she was passing medications. She indicated Resident 2 was on the floor. QMA 2 went into the resident's room, assessed her, and Resident 2 seemed okay. She assisted CNA 3 to put the resident into her wheelchair so she could go to breakfast. The Assistant Director of Nursing asked QMA 2 if she had notified the nurse on duty of the fall. QMA 2 stated to the Assistant Director of Nursing and the Administrator, " ...No I got busy again with my med pass and forget to tell her ...." The Assistant Director of Nursing asked QMA 2 why she assessed the resident when it was outside of her scope of practice. QMA 2 indicated " ...I don't know I had a lapse in judgement ...."<br><br>A facility document, titled "Confidential Witness Statement" dated 12/31/23 and received from the Director of Nursing on 1/9/24 at 10:26 a.m., indicated when the Assistant Director of Nursing asked CNA 3 what time the incident happened, she indicated she thought it was around 7:00 a.m. CNA 3 told her she went into the resident's room to get her up. She checked the resident and set her up on the side of the bed. The resident was fine. She pulled the lift to the side of the bed and noticed Resident 2 was starting to slide. She | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155556 | A. BUILDING 00<br>B. WING | 01/09/2024 |

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

| (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 |
|---|---|---|---|---|
| | pulled the call light and yelled for QMA 2 to help. By the time QMA 2 got into the room, CNA 3 had pushed the lift out of the way; if it had remained in place, it would have 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 put Resident 2 into the wheelchair and the resident said she was fine. The Assistant Director of Nursing asked the CNA what the resident's position was after she had been lowered to the floor. CNA 3 indicated the resident was kind of sitting up straight. Her back was straight, and her legs were out in front of her. Her legs were not folded/bent in any way. When asked if the CNA had notified the nurse; CNA 3 indicated " ...No I didn't I'm sorry ...."<br><br>A facility document, titled "Confidential Witness Statement," dated 12/31/23 and received from the Director of Nursing on 1/9/24 at 10:26 a.m., indicated when the Assistant Director of Nursing asked QMA 2 what happened, she indicated she was out on the medication cart passing medication when CNA 3 came and got her. CNA 3 had informed her; she had slowly put Resident 2 on the floor. QMA 3 entered the room and asked the resident if she was hurt. The resident denied pain at any location on her body. She did not appear to have any red marks or anything. The QMA and the CNA then transferred her into the wheelchair. She asked the resident if she was okay, and the resident said yes. She then took the resident's vital signs. She could not recall the vital signs but indicated her blood pressure was good and she went to breakfast. The resident did not say anything else to her about it the rest of the day. When asked about the position of the resident when the QMA entered the room, she | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155556 | A. BUILDING 00<br>B. WING | 01/09/2024 |

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

| (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 |
|---|---|---|---|---|
| | indicated the resident's knees were bent, she had boots on her feet, and she was leaning against the bed on her bottom. The QMA did not administer pain medication to the resident that day.<br><br>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 lowered to the ground. She did not witness the incident. She was informed by CNA 3. The incident happened between 7:00 and 8:00 a.m. The CNA told her, she had sat the resident up on the side of the bed, went to get the stand-up lift, and the resident slid to the floor. QMA 2 retrieved the vital sign machine and then went to the room. The resident was found on the floor with her legs extended out in front of her, in a sitting position, with the CNA supporting her. The resident told QMA 2 she was fine. A few minutes later, the CNA took the resident to the dining room. The resident seemed fine. QMA 2 indicated she did tell the nurse of the fall when the nurse came to the unit to administer insulin. She did not know if the nurse assessed the resident. The nurse administered insulin, returned the insulin pens to the medication cart, and then left the unit. Resident 2 used the sit to stand lift for transfers.<br><br>During a telephone interview, on 1/8/24 at 2:46 p.m., CNA 3 indicated the day of the fall was a normal morning. Resident 2 used a sit to stand mechanical lift, for transfers, and she had not ever had trouble with the resident using the lift before. She sat the resident on the side of the bed and noticed the resident was starting to slip. She turned on the call light and yelled for the QMA in the hall. She lowered the resident very gently to the floor as soft as she could. The QMA came, looked at the resident, and all was okay. The CNA and QMA transferred Resident 2 into her | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155556 | A. BUILDING 00<br>B. WING | 01/09/2024 |

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

| (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 |
|---|---|---|---|---|
| | wheelchair and the resident was fine. She indicated the QMA reported the fall to the nurse. The nurse did not assess the resident from the time of the fall to when Resident 2 was transported to the dining room. She understood the resident was to be a one person assist using the sit to stand lift but was informed after the incident the resident required two (2) staff to use the lift.<br><br>During an interview, on 1/8/24 at 2:57 p.m., the Executive Director indicated QMA 2, nor CNA 3 had notified the nurse of the fall. The QMA cannot assess. The facility policy had not been followed and both the CNA and QMA had been terminated from employment.<br><br>During an interview, on 01/8/24 at 3:01 p.m., the Executive Director indicated the reason there was not an assessment in the resident's record was due to neither the CNA nor the QMA had reported the fall to the nurse.<br>During a telephone interview, on 1/9/24 at 9:45 a.m., LPN 1 indicated she had not been informed of the fall involving Resident 2 until she returned to work on 12/27/23. She did go to the unit, look at the resident's sliding scale, administer her insulin, return the items back to the medication cart, and then returned to the unit she was working on that day. During the time she spent with Resident 2 on the day of the incident, the resident did not mention she had fallen.<br><br>During an interview, on 1/9/24 at 10:04 a.m., the Executive Director indicated insulin was administered to Resident 2, by LPN 1, on 12/22/23 at 9:01 a.m.<br><br>During an interview, on 1/9/24 at 1:02 p.m., the Executive Director indicated the facility found out | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155556 | A. BUILDING 00<br>B. WING | 01/09/2024 |

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

| (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 |
|---|---|---|---|---|
| | about the fall, on 12/29/23, when Resident 2 reported pain to QMA 2. Both QMA 2 and CNA 3 were then interviewed about the fall. There was a physician's note related to the fall on that day, but the physician did not notify the facility of the fall. During a telephone interview, on 1/9/24 at 2:00 p.m., Physician 8 indicated he was making rounds in the facility and a nurse informed him Resident 2 wanted to see him because the resident was having knee pain after a fall which occurred that day. He did assess the resident and had low suspicions of any fractures and thought it was a mild injury. He indicated Resident 2 did not fall, she was lowered to the ground.<br><br>During an interview, on 1/9/24 at 2:08 p.m., the Executive Director indicated the physician did refer to the QMA as a nurse.<br><br>A facility document, titled "Job Description," undated and received from the Executive Director on 1/9/24 at 10:26 a.m., indicated the QMA responsibility was to administer medications under the supervision of a licensed nurse. It did not include assessing residents.<br><br>A facility policy, titled "Policy and Procedure Sit to Stand Lift," undated and received from the Executive Director on 1/9/24 at 3:39 p.m., indicated " ...The operation of the lift requires a minimum on one trained operator ...." The resident's care plan indicated she was 2-person mechanical lift for transfers.<br><br>A facility policy, titled "Accident Incident Reporting Policy," undated and received from the Executive Director on 1/9/24 at 10:26 a.m., indicated "...Any accident/incident will be reported immediately to the nurse or appropriate person designated to be in charge...If a resident is | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155556 | A. BUILDING 00<br>B. WING | 01/09/2024 |

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

| (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 |
|---|---|---|---|---|
| | involved in an accident/incident an immediate assessment of the resident will be completed...."<br><br>The Indiana Department of Health (IDOH) Qualified Medication Aide (QMA) Training Curriculum Student Manual, dated 1/2/24, indicated " ...Lesson 1: Role and Responsibilities of the Qualified Medication Aide ...Tasks the QMA is PROHIBITED from Performing 1. Assess a resident's condition ..."<br><br>This Federal tag relates to Complaints IN00425077 and IN00425307.<br><br>3.1-37(a) | | | |
| F 0689 SS=G Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on interview and record review, the facility failed to ensure adequate supervision and staff assistance to prevent falls was provided to a resident who required the use of a mechanical lift and the assistance of two staff during transfers. This deficient practice resulted in Resident 2 experiencing an unwitnessed fall and bilateral femur fractures. (Resident 2)<br><br>Finding includes:<br><br>A document, titled "Indiana State Department of | F 0689 | 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 | 02/05/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155556 | A. BUILDING 00<br>B. WING | 01/09/2024 |

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

| (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 |
|---|---|---|---|---|
| | Health Survey Report System," dated 12/30/23 at 5:01 a.m., indicated Resident 2 had a witnessed fall on 12/22/23. At the time of the fall, the resident's skin and pain was assessed with no concerns. The physician and family were notified of the fall. The resident was noted to have increased pain on 12/29/23 and the physician was notified. X-rays were ordered on 12/29/23. The family and physician were aware of the femur fracture and resident was sent to the emergency department for evaluation.<br><br>The record for Resident 2 was reviewed on 1/8/24 at 2:55 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (paralysis and weakness) affecting the right side of the body, cerebral infraction (stroke), and osteoporosis without a pathological fracture (low bone mass which increases the risk of bone fractures/breaks).<br><br>A quarterly Minimum Data Set (MDS) assessment, dated 10/19/23, indicated the following:<br>a. The resident had a BIMS (Brief Interview for Mental Status) score of 15 which indicated she was cognitively intact.<br>b. The resident had an impairment on one (1) side to both her upper and lower extremities.<br>c. The resident was dependent (helper did all the effort) to move from a lying position to sitting on the side of the bed.<br><br>A care plan, initiated on 9/7/17 and discontinued on 1/8/24, indicated the resident had late loss Activity of Daily Living (ADL) and needed total assist with transfers due to hemiplegia. Interventions included, but were not limited to, mechanical lift and to see the CNA assignment sheet for details on the staff assist needed. The | | compliance is: 2/5/2024.¿**Facility is respectfully requesting paper compliance for all deficiencies in this POC.¿¿**<br><br>It is the policy of the facility to ensure that all residents receive adequate supervision and staff to prevent falls and two staff members for mechanical lift transfers.<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>Resident 2 was sent to the hospital on December 30, 2023 and has not returned to facility.<br><br>CNA 3 and QMA 2 were terminated on January 5, 2024<br><br>All residents have the potential to be affected. Therefore, this plan of correction applies to all residents of the facility.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?**<br><br>At an in-service held by the Administrator/Designee on 1/29/2024 for all clinical staff the following was reviewed:<br>1 Incident and Accidents | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155556 | A. BUILDING 00<br>B. WING | 01/09/2024 |

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

| (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 |
|---|---|---|---|---|
| | care plan did not specify how many staff were needed for total assistance with transfers or the use of the mechanical lift.<br><br>A care plan, initiated on 8/5/23 and discontinued on 1/8/24, indicated the resident was a fall risk and to use the assist of 2 people with the mechanical sit to stand lift, and do not leave the resident while sitting on the side of the bed.<br><br>A physician's order, dated 11/24/19, indicated "...Assistive device...May use mechanical lift for transfers...."<br><br>There were no nursing notes found in the resident's record to indicate the events which led to the resident having fell or being lowered to the ground on 12/22/23.<br><br>The resident's progress notes did not indicate a change in the resident's mental condition from 12/19/23 to 12/22/23.<br><br>A physician's note, dated 12/22/23, indicated the physician did see the resident for complaints of bilateral knee pain (both knees) and shoulder pain. The resident reported to the physician she had slid off the bed and landed on her knee. The physician's finding was mild tenderness of both knees without significant effusion (fluid gathered in the space). The time of the physician's report was 10:28, without specification of a.m./p.m. There was no documentation of when the physician had assessed the resident only the time of his report, on 12/22/23 at 10:28:13 and another time/date stamp on 12/22/23 at 11:20:24.<br><br>The Medication Administration Record (MAR) indicated the following:<br>a. The resident had complaints of 4/10 pain, on | | Policy<br>2 Notifications in relation to Falls, Pain, and Changes in Condition<br>3 Hoyer/Mechanical Lift Policy<br>4 QMA – Scope of Practice<br>5 Pain Documentation in relation to including location.<br>All unlicensed staff were educated to notify a licensed nurse prior to transferring a resident after a fall.<br>Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?**<br>The DON/Designee will audit falls for completion of assessments, resident was not transferred by unlicensed staff after the fall, documentation, notification and incident report completion 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months.<br>The DON/Designee will audit 6 random staff members a week for 2-person mechanical lift transfers x 4 weeks, then 4 random staff members x 4 weeks, then 2 random staff a month x 4 months.<br>The DON/Designee will audit 10 random residents pain | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155556 | A. BUILDING 00<br>B. WING | 01/09/2024 |

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

| (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 |
|---|---|---|---|---|
| | 12/24/23, and was given acetaminophen 325 milligrams x 2 tablets at 3:09 p.m.<br>b. The resident had complaints of 5/10 pain, on 12/28/23, and was given acetaminophen 325 mg x 2 tablets at 9:56 a.m.<br>c. The resident had complaints of 10/10 pain, on 12/29/23 at 7:40 a.m., and was given acetaminophen 325 mg x 2.<br><br>There was no entry as to where the resident was experiencing pain noted in the Medication Administration Record or notes.<br><br>A facility document, titled "Basic Investigation Form," undated, indicated Resident 2 had a witnessed fall, on 12/22/23, in her room. CNA 3 was assisting the resident from bed. The CNA sat the resident on the side of the bed, turned her back to get the sit to stand mechanical lift and the resident slid to the floor from the edge of the bed. CNA 3 and QMA 2 assisted the resident from the floor to a wheelchair. The QMA did get the resident's vital signs and they were normal. The resident denied any pain. The physician was notified while he was in the facility making rounds and did see the resident on 12/22/23. The CNA and QMA were suspended pending an investigation. The resident had continued complaints of pain. Orders for x-rays were obtained and the results of the x-ray were bilateral femur fractures. The resident was sent to the hospital for evaluation and treatment. The QMA was terminated for practicing outside of her scope of practice and the CNA was terminated for not following facility policy and procedure.<br><br>A facility document, titled " ...Facility Separation Form," dated 1/5/24 and received from the Executive Director on 1/9/24 at 10:26 a.m., indicated QMA 2 was terminated from the facility | | medications for documentation of location of pain x 4 weeks, then 5 random residents a week x 4 weeks, then 5 random residents a month x 4 months.<br>If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped<br>Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated.<br>At the monthly QAPI meeting, the 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.<br>**By what date the systemic change for the deficiency will be completed?**<br>Date of Compliance: February 5, 2024 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155556 | A. BUILDING 00<br>B. WING | 01/09/2024 |

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

| (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 |
|---|---|---|---|---|
| | for performance, gross violation of safety rules, working outside of her scope of practice, not following facility policy and procedure.<br><br>A facility document, titled " ...Facility Separation Form," dated 1/5/24 and received from the Executive Director on 1/9/24 at 10:26 a.m., indicated CNA 3 was terminated for performance, violation of safety rules, violation of company policy and /or procedure. CNA did not follow facility mechanical lift policy or reporting incidents/accidents policy.<br><br>In a facility document, titled "Confidential Witness Statement," dated 12/29/23 and received from the Director of Nursing on 1/9/24 at 10:26 a.m., CNA 3 indicated, on 12/22/23, Resident 2 was sitting on the side of the bed. CNA 3 turned her back to grab the stand-up lift; when she turned back around Resident 2 was starting to fall. CNA 3 had to move the lift, so the resident did not fall on it. The CNA hollered for the QMA. When QMA 2 entered the room, she asked Resident 2 she asked if she was okay. The resident told the QMA she was okay, and then they moved the resident and took her to breakfast. When the CNA was asked why she did not notify the nurse she stated " ...I don't know, I know I should of I thought [name of QMA 2] did it ...." The Assistant Director of Nursing asked CNA 3 why she was using the stand lift without another staff, CNA 3 indicated " ...I don't know, I know I am supposed to ...."<br><br>In a facility document, titled "Confidential Witness Statement," dated 12/29/23 and received from the Director of Nursing on 1/9/24 at 10:26 a.m., QMA 2 indicated, on 12/22/23, the CNA came and got her while she was passing medications. She indicated Resident 2 was on the floor. QMA 2 went into the resident's room, | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155556 | A. BUILDING 00<br>B. WING | 01/09/2024 |

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

| (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 |
|---|---|---|---|---|
| | assessed her, and Resident 2 seemed okay. She assisted CNA 3 to put the resident into her wheelchair so she could go to breakfast. The Assistant Director of Nursing asked QMA 2 if she had notified the nurse on duty of the fall. QMA 2 stated to the Assistant Director of Nursing and the Administrator, " ...No I got busy again with my med pass and forget to tell her ...." The Assistant Director of Nursing asked QMA 2 why she assessed the resident when it was outside of her scope of practice. QMA 2 indicated " ...I don't know I had a lapse in judgement ...."<br><br>A facility document, titled "Confidential Witness Statement" dated 12/31/23 and received from the Director of Nursing on 1/9/24 at 10:26 a.m., indicated when the Assistant Director of Nursing asked CNA 3 what time the incident happened, she indicated she thought it was around 7:00 a.m. CNA 3 told her she went into the resident's room to get her up. She checked the resident and set her up on the side of the bed. The resident was fine. She pulled the lift to the side of the bed and noticed Resident 2 was starting to slide. She pulled the call light and yelled for QMA 2 to help. By the time QMA 2 got into the room, CNA 3 had pushed the lift out of the way; if it had remained in place, it would have 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 put Resident 2 into the wheelchair and the resident said she was fine. The Assistant Director of Nursing asked the CNA what the resident's position was after she had been lowered to the floor. CNA 3 indicated the resident was kind of sitting up straight. Her back was straight, and her legs were out in front of her. Her legs were not folded/bent in any way. When asked if the CNA | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155556 | A. BUILDING 00<br>B. WING | 01/09/2024 |

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

| (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 |
|---|---|---|---|---|
| | had notified the nurse; CNA 3 indicated " ...No I didn't I'm sorry ...."<br><br>A facility document, titled "Confidential Witness Statement," dated 12/31/23 and received from the Director of Nursing on 1/9/24 at 10:26 a.m., indicated when the Assistant Director of Nursing asked QMA 2 what happened, she indicated she was out on the medication cart passing medication when CNA 3 came and got her. CNA 3 had informed her; she had slowly put Resident 2 on the floor. QMA 3 entered the room and asked the resident if she was hurt. The resident denied pain at any location on her body. She did not appear to have any red marks or anything. The QMA and the CNA then transferred her into the wheelchair. She asked the resident if she was okay, and the resident said yes. When asked about the position of the resident when the QMA entered the room, she indicated the resident's knees were bent, she had boots on her feet, and she was leaning against the bed on her bottom. The QMA did not administer pain medication to the resident that day.<br><br>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 lowered to the ground. She did not witness the incident. She was informed by CNA 3. The incident happened between 7:00 and 8:00 a.m. The CNA told her, she had sat the resident up on the side of the bed, went to get the stand-up lift, and the resident slid to the floor. The resident was found on the floor with her legs extended out in front of her, in a sitting position, with the CNA supporting her. The resident told QMA 2 she was fine. A few minutes later, the CNA took the resident to the dining room. The resident seemed fine. QMA 2 indicated she did tell the nurse of the | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155556 | A. BUILDING 00<br>B. WING | 01/09/2024 |

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

| (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 |
|---|---|---|---|---|
| | fall when the nurse came to the unit to administer insulin. She did not know if the nurse assessed the resident. The nurse administered insulin, returned the insulin pens to the medication cart, and then left the unit. Resident 2 used the sit to stand lift for transfers.<br><br>During a telephone interview, on 1/8/24 at 2:46 p.m., CNA 3 indicated the day of the fall was a normal morning. Resident 2 used a sit to stand mechanical lift, for transfers, and she had not ever had trouble with the resident using the lift before. She sat the resident on the side of the bed and noticed the resident was starting to slip. She turned on the call light and yelled for the QMA in the hall. She lowered the resident very gently to the floor as soft as she could. The QMA came, looked at the resident, and all was okay. The CNA and QMA transferred Resident 2 into her wheelchair and the resident was fine. She indicated the QMA reported the fall to the nurse. She understood the resident was to be a one person assist using the sit to stand lift but was informed after the incident the resident required two (2) staff to use the lift.<br><br>During an interview, on 1/8/24 at 2:57 p.m., the Executive Director indicated QMA 2, nor CNA 3 had notified the nurse of the fall. The facility policy had not been followed and both the CNA and QMA had been terminated from employment.<br><br>During a telephone interview, on 1/9/24 at 9:45 a.m., LPN 1 indicated she had not been informed of the fall involving Resident 2 until she returned to work on 12/27/23. She did go to the unit, look at the resident's sliding scale, administer her insulin, return the items back to the medication cart, and then returned to the unit she was working on that day. During the time she spent with Resident 2 on | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155556 | A. BUILDING 00<br>B. WING | 01/09/2024 |

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

| (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 |
|---|---|---|---|---|
| | the day of the incident, the resident did not mention she had fallen.<br><br>During an interview, on 1/9/24 at 1:02 p.m., the Executive Director indicated the facility found out about the fall, on 12/29/23, when Resident 2 reported pain to QMA 2. Both QMA 2 and CNA 3 were then interviewed about the fall. There was a physician's note related to the fall on that day, but the physician did not notify the facility of the fall.<br><br>During a telephone interview, on 1/9/24 at 2:00 p.m., Physician 8 indicated he was making rounds in the facility and a nurse informed him Resident 2 wanted to see him because the resident was having knee pain after a fall which occurred that day. He did assess the resident and had low suspicions of any fractures and thought it was a mild injury. He indicated Resident 2 did not fall, she was lowered to the ground.<br><br>During an interview, on 1/9/24 at 2:08 p.m., the Executive Director indicated the physician did refer to the QMA as a nurse.<br><br>A facility policy, titled "Policy and Procedure Sit to Stand Lift," undated and received from the Executive Director on 1/9/24 at 3:39 p.m., indicated " ...The operation of the lift requires a minimum on one trained operator ...." The resident's care plan indicated she was 2-person mechanical lift for transfers.<br><br>A facility policy, titled "Accident Incident Reporting Policy," undated and received from the Executive Director on 1/9/24 at 10:26 a.m., indicated "...Any accident/incident will be reported immediately to the nurse or appropriate person designated to be in charge...If a resident is involved in an accident/incident an immediate | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155556 | A. BUILDING 00<br>B. WING | 01/09/2024 |

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

| (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 |
|---|---|---|---|---|
| | assessment of the resident will be completed...."<br><br>This Federal tag relates to Complaints IN00425077 and IN00425307.<br><br>3.1-45(a)(2) | | | |