STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155217	A. BUILDING 00 B. WING	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGBURG, THE	1712 LELAND DR HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00448316. Complaint IN00448316 - Federal/state deficiencies related to the allegations are cited at F842. Survey dates: December 17, 18, 2024 Facility number: 000122 Provider number: 155217 AIM number: 100290560 Census Bed Type: SNF/NF: 42 Total: 42 Census Payor Type: Medicare: 2 Medicaid: 31 Other: 9 Total: 42 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 20, 2024.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, 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: January 13, 2025. Facility is respectfully requesting paper compliance for all deficiencies in this POC.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on interview and record review, the facility failed to ensure accurate documentation of resident records for 3 of 3 records reviewed. Staff members that initialed they were completing assessments were not on the schedule as worked at the time of the assessments. (Resident B, Resident C, Resident D)	F 0842	It is the policy of this facility to maintain records on each resident that are complete, accurate, assessable, and organized. what corrective action(s) will be accomplished for those	01/13/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rebecca Brown	Administrator	01/08/2025

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
	155217	A. BUILDING 00 B. WING	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGBURG, THE	1712 LELAND DR HUNTINGBURG, IN 47542

(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
	Findings include: 1. On 12/17/24 at 9:30 A.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, anxiety, depression, and psychotic disorder. The most recent Annual MDS (Minimum Data Set) Assessment, dated 11/18/24, indicated a severe cognitive impairment, partial or moderate assist required with toileting, and supervision or touching assist with all other ADLs (activities of daily living). A progress note, dated 11/30/24 at 6:43 A.M. indicated Resident B had experienced an unwitnessed fall in the dining room. A neurological (neuro) evaluation flow sheet, dated 11/30/24, indicated neuro checks were completed from 11/30/24 at 5:00 A.M. through 12/3/24 during the 7:00 A.M. to 3:00 P.M. day shift. The form lacked initials to indicate what staff member completed each check. All entries on the form were completed with the same handwriting. 2. On 12/17/24 at 10:14 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and depression. The most recent Admission MDS Assessment, dated 11/19/24, indicated a severe cognitive impairment, and supervision or touching assistance with all ADLs. A progress note, dated 11/16/24 at 2:44 A.M. indicated Resident C had experienced an unwitnessed fall in his room at 2:00 A.M. that		residents found to have been affected by the deficient practice; The DNS/Designee assessed residents B, C and D and no negative outcome related to the alleged cited deficient practice on 1/7/2024. 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; All residents that reside in the facility have to potential to be affected by the alleged deficient practice, therefore, this plan of correction applies to all residents that reside in the facility. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The DON/Designee in-serviced nursing staff on completion of neuro checks timely after a fall on 1/7/2024. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. how the corrective action(s) will be monitored to ensure the deficient practice will not recur,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155217	A. BUILDING 00 B. WING	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGBURG, THE	1712 LELAND DR HUNTINGBURG, IN 47542

(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
	morning. A neurological evaluation flow sheet, dated 11/16/24, indicated neuro checks were completed from 11/16/24 at 2:00 A.M. through 11/19/24 at 5:45 A.M. The Assistant Director of Nursing (ADON) had initialed she had completed the following neuro checks: 11/16/24 at 2:00 A.M. 11/16/24 at 2:15 A.M. 11/16/24 at 2:30 A.M. 11/16/24 at 2:45 A.M. 11/16/24 at 3:15 A.M. 11/16/24 at 3:45 A.M. 11/16/24 at 4:45 A.M. The MDS Coordinator had initialed she had completed the following neuro checks: 11/16/24 at 9:45 P.M. 11/17/24 at 9:45 P.M. 11/18/24 at 9:45 P.M. On 12/17/24 at 2:30 P.M., the Administrator provided the schedules as worked for nursing staff from November 2024 through December 2024. The schedules indicated the ADON had not worked on 11/16/24. The schedule lacked information for the MDS Coordinator. The Administrator indicated at that time that the MDS Coordinator had just started, and was not on the schedule and had been using employee timesheet correction forms to record her time. Employee timesheet correction forms indicated the MDS Coordinator had left at 4:00 P.M. on 11/16/24, 11/17/24, and 11/18/24. 3. On 12/17/24 at 10:32 A.M., Resident D's clinical		i.e., what quality assurance program will be put into place; The DON/Designee will audit neuro checks after resident fall for timely completion 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. by what date the systemic changes for each deficiency will be completed. 1/13/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155217	A. BUILDING 00 B. WING	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGBURG, THE	1712 LELAND DR HUNTINGBURG, IN 47542

(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
	record was reviewed. Diagnoses included, but were not limited to, dementia, anxiety, and psychotic disorder. The most recent Quarterly MDS Assessment, dated 12/4/24, indicated a severe cognitive impairment, and substantial or maximum assistance with all ADLs. A progress note, dated 11/22/24 at 6:01 P.M., indicated Resident D had experienced an unwitnessed fall. A neurological evaluation flow sheet, dated 11/22/24, indicated neuro checks were completed from 11/22/24 at 4:00 P.M. through 11/25/24 at 9:45 P.M. The Assistant Director of Nursing (ADON) had initialed she had completed the following neuro checks: 11/22/24 at 8:45 P.M. 11/22/24 at 9:45 P.M. 11/23/24 at 9:45 P.M. 11/24/24 at 5:45 A.M. The MDS Coordinator had initialed she had completed the following neuro checks: 11/25/24 at 5:45 A.M. 11/25/24 at 9:45 P.M. On 12/17/24 at 2:30 P.M., the Administrator provided the schedules as worked for nursing staff from November 2024 through December 2024. The schedules indicated the ADON had not worked on 11/22/24, had left at 2:00 P.M. on 11/23/24, and had started a shift at 3:00 P.M. on 11/24/24. A timesheet for the MDS Coordinator indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155217	A. BUILDING 00 B. WING	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGBURG, THE	1712 LELAND DR HUNTINGBURG, IN 47542

(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
	she clocked in on 11/25/24 at 8:18 A.M. and clocked out at 4:24 P.M. During an interview with the ADON and MDS Coordinator on 12/18/24 at 11:46 A.M., the MDS Coordinator indicated since they lived close to the facility, they would "pop in" before and after their scheduled shifts to check on residents and staff. She indicated that could be the reason for initialing for neuro checks outside of scheduled shifts. The ADON indicated at times, the Qualified Medication Aide (QMA) would get vitals on the scheduled neuro check times, and because they did not fill in the forms, would save that information and give to her to fill in the forms when she was there. They both indicated at that time they were unable to provide documentation that they were in the building at the time of the neuro checks for Resident C and Resident D. On 12/18/24 at 11:25 A.M., the Administrator indicated they did not have a current policy for accurate documentation, but provided a Nurse Job Description at that time that indicated "Performs administrative duties such as completing medical forms, reports, evaluations, studies, charting ... Signs and dates all entries made in the resident's medical record. This citation relates to Complaint IN00448316. 3.1-50(a)			