STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155573	A. BUILDING 00 B. WING	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF MIDDLETOWN SKILLED NURSING FACILITY, THE	981 BEECHWOOD AVE MIDDLETOWN, IN 47356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00430719, IN00431711, IN00431980 and IN00432008. Complaint IN00430719 -- Federal/state deficiency related to the allegations is cited at F732. Complaint IN00431711 -- No deficiencies related to the allegations are cited. Complaint IN00431980 -- Federal/state deficiency related to the allegations is cited at F741. Complaint IN00432008 -- Federal/state deficiency related to the allegations is cited at F732. Unrelated deficiencies are cited. Survey dates: April 24, 25 and 26, 2024 Facility number: 000342 Provider number: 155573 AIM number: 100289140 Census Bed Type: SNF/NF: 24 Total: 24 Census Payor Type: Medicare: 1 Medicaid: 10 Other: 13 Total: 24 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

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	Quality review completed on April 30, 2024			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to protect the resident's right to be free from verbal and physical abuse of a staff member towards a resident for 1 of 3 residents reviewed for abuse. (Resident D, CNA 6) Findings include: The clinical record of Resident D was reviewed on 4-26-24 at 9:43 a.m. Her diagnoses included, but were not limited to cerebral infarction due to occlusion or stenosis of MCA (middle cerebral artery) affecting the non-dominant left side with hemiplegia and hemiparesis. A review of Resident D's most recent Minimum Data Set assessment, dated 2-6-24, indicated her cognitive status was moderately impaired, she was non-ambulatory, used a wheelchair with assistance of 1 person for wheelchair mobility, required substantial assistance with bed mobility and was dependent	F 0600	It is the intent of this facility for the resident s to be free from abuse, neglect, misappropriation of residents property and exploitation. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident D had psycho-social follow up completed by Social Service Director on with no negative psycho social affects noted from allegation. CNA 6 was terminated related to no tolerance policy on 04/23/2024 How other residents having the potential to be affected by the same deficient practice will be	05/20/2024

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WATERS OF MIDDLETOWN SKILLED NURSING FACILITY, THE	981 BEECHWOOD AVE MIDDLETOWN, IN 47356

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	for toileting needs and bathing assistance. In an interview with the Executive Director (ED) on 4-24-24 at 10:35 a.m., she indicated the facility recently had a new employee, CNA 6. She further explained the facility had received a report of rough treatment during care of a resident by a staff member, CNA 6. The ED summarized CNA 6 was was terminated due to inappropriate language and intimidation and with her being on orientation, or just off of orientation, she was terminated due to the facility's "zero tolerance policy" towards abuse. The ED indicated she had submitted a report of the incident to the Indiana Department of Health's Long-Term Care Division on the same date the facility received the allegation of abuse. In an interview on 4-24-24 at 2:20 p.m., with Resident D, she indicated she is generally speaking, treated very well and very professionally, with one exception. She explained, "recently, a new aide got upset with me when she was trying to roll me over [for incontinence care] and I told her it was hurting me. Sometimes, my joints just hurt and she just kept going on. She just didn't listen to me. Just kind of hurrying things along. So, I spoke with the administrator about it. I told her that I didn't want the girl punished, just talk to her about not rushing so much and listen to what people tell her. Well, later that day, she came back to me and told me, kind of hateful like, that she thought it awful that I told on her and now she was in trouble. She just stood in the doorway and kind of hollered at me, she definitely raised her voice to me. Later, when I was talking to somebody, I found out they let her go. I hate that, but you can't treat people that way." She added, due to the Administrator taking care of issues so quickly, she has no further		identified and what corrective action will be taken. All residents that currently reside in the facility have the potential to be affected by the alleged deficient practice. DON/Designee will complete a facility wide skin sweep on residents with a Bim's of 12 or less by 5-20-2024. SSD/Designee will complete abuse questionnaires by 5-20-2024 for all residents with a Bim's score of 13 or higher. Any concerns for addressed or reported as needed. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The Administrator/designee will complete education with facility staff on the Abuse Prevention Program including ensuring residents were free from abuse on Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place. The DON\designee will complete 10 random skin assessments weekly on residents with a Bim's of 12 or less x 4 weeks, then 5 residents a week x 4 weeks, then	

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	concerns related abuse or neglect. "By the administrator taking care of things so quick, it shows me they mean business and take care of things like they should." A review of CNA 6's employee file indicated she was hired on 4-10-24. Her employee file indicated she had completed education regarding resident rights, abuse prohibition and six hours of dementia care training on or before her hire date. A "Personnel Change Form," dated 4-19-24 and 4-20-24, indicated CNA 6 was terminated, effective 4-19-24, by the facility for "Violation of company policy." The investigative file of the allegation of abuse indicated the state reportable was faxed to the, Indiana Department of Health's Long-Term Care Division on 4-19-24, follow-up interviews with other residents regarding abuse were conducted, staff education was conducted with facility staff on 4-22-24, pre-employment screening for certification validity, criminal background check and reference checks, and Resident D was monitored for a minimum of 72 hours for any negative effects after this incident. On 4-25-24 at 1:20 p.m., the ED provided an undated copy of a policy entitled, "Abuse Prevention Program." This policy indicated, "to prevent resident abuse, neglect...Each resident receives care and services in a person-centered environment in which all individuals are treated as human beings...Staff members who are suspected of abuse or misconduct shall immediately (regardless of time left on shift) be barred from any further contact with residents of the facility and be suspended from duty, pending the outcome of the investigation, prosecution or disciplinary action against the employee."		5 residents a month x 4 months. Additionally, The Social Service Director/designee will complete 10 random abuse questionnaires on residents with a bim's score of 13 or higher weekly x 4 weeks, then 5 random residents a week x 4 weeks, then 5 random residents weekly 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 deficient will be completed. 05/20/2024	

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	3.1-27(a) 3.1-27(b)			
F 0607 SS=D Bldg. 00	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. Based on interview and record review, the facility failed to implement policies and procedures	F 0607	It is the intent of this facility for the resident s to be free from abuse,	05/20/2024

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	protecting the resident's right to be free from verbal and physical abuse of a staff member towards a resident for 1 of 3 residents reviewed for abuse. (Resident D, CNA 6) Findings include: The clinical record of Resident D was reviewed on 4-26-24 at 9:43 a.m. Her diagnoses included, but were not limited to cerebral infarction due to occlusion or stenosis of MCA (middle cerebral artery) affecting the non-dominant left side with hemiplegia and hemiparesis. A review of Resident D's most recent Minimum Data Set assessment, dated 2-6-24, indicated her cognitive status was moderately impaired, she was non-ambulatory, used a wheelchair with assistance of 1 person for wheelchair mobility, required substantial assistance with bed mobility and was dependent for toileting needs and bathing assistance. In an interview with the Executive Director (ED) on 4-24-24 at 10:35 a.m., she indicated the facility recently had a new employee, CNA 6. She further explained the facility had received a report of rough treatment during care of a resident by a staff member. The ED summarized CNA 6 was was terminated due to inappropriate language and intimidation and with her being on orientation, or just off of orientation, she was terminated due to the facility's "zero tolerance policy" towards abuse. The ED indicated she had submitted a report of the incident to the Indiana Department of Health's Long-Term Care Division on the same date as discovery of the allegation of abuse. In an interview on 4-24-24 at 2:20 p.m., with Resident D, she indicated she is generally speaking, treated very well and very professionally, with one exception. She explained,		neglect, misappropriation of residents property and exploitation. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident D had psycho-social follow up completed by Social Service Director on with no negative psycho social affects noted from allegation. CNA 6 was terminated related to no tolerance policy on 04/23/2024 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents that currently reside in the facility have the potential to be affected by the alleged deficient practice. DON/Designee will complete a facility wide skin sweep on residents with a Bim's of 12 or less by 5-20-2024. SSD/Designee will complete abuse questionnaires by 5-20-2024 for all residents with a Bim's score of 13 or higher. Any concerns for addressed or reported as needed. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The Administrator/designee will complete education with facility	

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	"recently, a new aide got upset with me when she was trying to roll me over [for incontinence care] and I told her it was hurting me. Sometimes, my joints just hurt and she just kept going on. She just didn't listen to me. Just kind of hurrying things along. So, I spoke with the administrator about it. I told her that I didn't want the girl punished, just talk to her about not rushing so much and listen to what people tell her. Well, later that day, she came back to me and told me, kind of hateful like, that she thought it awful that I told on her and now she was in trouble. She just stood in the doorway and kind of hollered at me, she definitely raised her voice to me. Later, when I was talking to somebody, I found out they let her go. I hate that, but you can't treat people that way." She added, due to the Administrator taking care of issues so quickly, she has no further concerns related abuse or neglect. "By the administrator taking care of things so quick, it shows me they mean business and take care of things like they should." The investigative file of the allegation of abuse indicated the state reportable was faxed to the, Indiana Department of Health's Long-Term Care Division on 4-19-24, follow-up interviews with other residents regarding abuse were conducted, staff education was conducted with facility staff on 4-22-24, pre-employment screening for certification validity, criminal background check and reference checks, and Resident D was monitored for a minimum of 72 hours for any negative effects after this incident. A review of CNA 6's employee file indicated she was hired on 4-10-24. Her employee file indicated she had completed education regarding resident rights, abuse prohibition and six hours of dementia care training on or before her hire date.		staff on the Abuse Prevention Program including ensuring residents were free from abuse on Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place. The DON\designee will complete 10 random skin assessments weekly on residents with a Bim's of 12 or less x 4 weeks, then 5 residents a week x 4 weeks, then 5 residents a month x 4 months. Additionally, The Social Service Director/designee will complete 10 random abuse questionnaires on residents with a bim's score of 13 or higher weekly x 4 weeks, then 5 random residents a week x 4 weeks, then 5 random residents weekly 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.	

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	A "Personnel Change Form," dated 4-19-24 and 4-20-24, indicated CNA 6 was terminated, effective 4-19-24, by the facility for "Violation of company policy." On 4-25-24 at 1:20 p.m., the ED provided an undated copy of a policy entitled, "Abuse Prevention Program." This policy indicated, "to prevent resident abuse, neglect...Each resident receives care and services in a person-centered environment in which all individuals are treated as human beings...Staff members who are suspected of abuse or misconduct shall immediately (regardless of time left on shift) be barred from any further contact with residents of the facility and be suspended from duty, pending the outcome of the investigation, prosecution or disciplinary action against the employee." 3.1-27(a)(1) 3.1-27(b)		By what date the systemic changes for each deficient will be completed. 05/20/2024	
F 0732 SS=E Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.			

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	§483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview and record review, the facility failed to post the facility's nursing staffing for five (5) consecutive dates. This deficient practice has the potential to adversely affect all residents. Findings include: On 4-24-24 at 9:55 a.m., the facility's posted staffing was observed to be located by the nursing station. The posted staffing dates were for 4-18-24 and 4-19-24. This posting was unchanged at an observation conducted on 4-24-24 at 1:35 p.m. This posting was updated as of an observation on 4-25-24 at 1:56 p.m., to the current date of 4-25-24.	F 0732	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 **May 20,2024** Facility is respectfully requesting paper compliance for all deficiencies in this POC. It is the intent of this facility to	05/20/2024

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	In an interview with the Executive Director on 4-25-24 at 4:30 p.m., she indicated she has been conducting the nursing work schedules for some time at the facility. In an interview with the Executive Director on 4-25-24 at 4:45 p.m., she indicated had not noticed the daily posted nursing staffing sheets were not current. This Federal tag relates to Complaints IN00430719 and IN00432008. 3.1-17(a)		post nursing staffing information daily. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. There were no residents affected by this alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents that currently reside in the facility have the potential to be affected by the alleged deficient practice. Posted nurse staffing was updated by facility on **04/25/2024.** What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The Administrator/designee completed education with facility scheduler on posting nursing staffing information daily on 05-13-2024. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place.	

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			The Administrator/designee will complete daily staffing posting audits 5x's weekly to verify correct date is posted x 6 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 deficient will be completed. Date: May 20,2024	
F 0741 SS=D Bldg. 00	483.40(a)(1)(2) Sufficient/Competent Staff-Behav Health Needs §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:			

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WATERS OF MIDDLETOWN SKILLED NURSING FACILITY, THE	981 BEECHWOOD AVE MIDDLETOWN, IN 47356

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	§483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. Based on interview and record review, the facility failed to ensure adequate nursing staff coverage for the long-term care portion of the facility, as well as for the secured dementia care unit of the facility for 1 of 1 night shift and for the 17 residents of the long-term care portion of the building and for 7 residents of the facility's secured dementia care unit of the facility. Findings include: In an interview with the Executive Director (ED) on 4-25-24 at 2:50 p.m., she indicated around the end of March and beginning of April of 2024, only one RN 4 and one CNA 3 were on duty for the night shift. She shared that on that particular night, CNA 3 called her around 11:00 p.m., to discuss some concerns she had regarding the facility. "During the conversation, she mentioned that the memory care unit wasn't staffed and there was only a nurse and aide in the building and the door of the memory care unit was open and unlocked. I immediately came into the building. When I got here, I found the memory care unit door open to the long term care unit and obviously unlocked. [Names of RN 4 and CNA 3]	F 0741	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 **May 20,2024.** Facility is respectfully requesting paper compliance for all deficiencies in this POC. It is the intent of this facility to provide sufficient staff. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. There were no residents affected by this alleged deficient practice.	05/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155573	A. BUILDING 00 B. WING	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	were both on the long term care unit at that time. They explained that since they were the only two staff here, that was the best way to handle the situation. I immediately sent the nurse to the memory care unit and the memory care unit door was closed and locked. I had no idea any of this was going on until that moment. I have no idea how long this had been going on. Our census on that date was 22." She indicated she remained in the building for the rest of that shift and she noted none of memory care unit residents were up or wandering about. In a confidential interview, they indicated, "It's not happened often, but there have been a few times where the locked unit has not had a staff person for night shift...I couldn't give you a date, but I am aware of a time or two when the locked unit was left unlocked when I have checked it when I come in at 6 am." They indicated they did not report the memory care unit being unlocked to management as they thought management would be aware of this since management puts together the schedules. On 4-26-24 at 10:42 a.m., the ED provided an updated "Midnight Census Report," for 3-20-24, indicating the facility's census included 7, memory care unit residents and 17, long-term care unit residents, for a total census of 24 residents. In an interview with the ED on 4-25-24 at 4:30 p.m., she clarified the night shift was the date of 3-20-24 into 3-21-24. The ED indicated shortly thereafter [date unspecified], education with the licensed nurses was conducted regarding notification to management of any changes in the schedule and the memory care unit is to staffed at all times and the door is to be secured/locked at all times.		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents that currently reside in the facility have the potential to be affected by the alleged deficient practice. This plan of corrections applies to all residents in the facility. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The Regional Director of Operations in-serviced the Administrator on 5-13-2024. to ensure the facility is staffed to provide adequate supervision. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place. The Administrator will audit staffing levels to verify the facility is providing adequate supervise, 5 days a week x 4 weeks, then 3 days a week x 4 weeks, then 3 times a month x 4 months. If the facility is within 95% compliance at the end of the 6	

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	4-30-24 at 4:30 p.m., the ED indicated, "My expectations for the memory care unit is that it be locked/secured at all times and there be a nurse or aide present at all times." On 4-25-24 at 5:06 p.m., the ED provided a copy of a document entitled, "Facility Assessment Tool," with a revision date of 10-17-23. This document indicated the facility's staffing plan as, "based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff to meet the needs of the residents at any given time," includes, but does not limit the nursing staffing to, "1 Nurse Nights...and 1 [nurse aide] nights," with staffing ratios of 1.25 licensed nurse and 1.25 certified nursing assistant for every 25 residents. "[Name of the memory care unit] will always have a minimum of: Nurse or QMA on days/evenings [and] Night staff aide on-site related to census." This Federal tag relates to Complaint IN00431980. 3.1-17(b)(1) 3.1-17(c)(2)		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 deficient will be completed. Date: May 20,2024	