STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BU	JILDING	00	COMPL	ETED
		155573	B. WING 04/26/2024				
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
	05 141001 57014	N 01411 I ED NILIDOINIO EA 011 ITX T	–		ECHWOOD AVE		
WATERS	OF MIDDLE FOW	N SKILLED NURSING FACILITY, T	HE	MIDDL	ETOWN, IN 47356		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	16	DATE
F 0000							
Bldg. 00							
J	This visit was for the	ne Investigation of Complaints	F 00	000			
		431711, IN00431980 and		,,,,			
	IN00432008.	, , , , , , , , , , , , , , , , , , , ,					
	Complaint IN00430	0719 Federal/state deficiency					
	_	ations is cited at F732.					
	Complaint IN0043	1711 No deficiencies related to					
	the allegations are						
	and anti-gautiens are						
	Complaint IN0043	1980 Federal/state deficiency					
	_	ations is cited at F741.					
	related to the anego	tions is cited at 1 /41.					
	Complaint IN0043	2008 Federal/state deficiency					
	_	ations is cited at F732.					
	related to the anego	ations is cited at 1 732.					
	Unrelated deficienc	ries are cited					
	Omerated deficient	ries are effect.					
	Survey dates: Anri	1 24, 25 and 26, 2024					
	Burvey dates. Apri	121, 23 and 20, 2021					
	Facility number: (000342					
	Provider number:						
	AIM number: 1002						
	7 mvi number. 1002	207140					
	Census Bed Type:						
	SNF/NF: 24						
	Total: 24						
	10tai. 24						
	Census Payor Type						
	Medicare: 1	•					
	Medicaid: 10						
	Other: 13						
	Total: 24						
	10tai. 2 1						
	These deficiencies	reflect State Findings cited in					
	accordance with 41						
	accordance with 41	V 11 10 10.2-J.1.					

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

(X6) DATE

TITLE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155573	B. W	ING		04/26/	/2024
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	t .			ECHWOOD AVE		
WATERS	OF MIDDLETOWN	N SKILLED NURSING FACILITY,	ГНЕ	MIDDLI	ETOWN, IN 47356		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	Quality review com	pleted on April 30, 2024					
F 0600	483.12(a)(1)						
SS=D	Free from Abuse a	and Neglect					
Bldg. 00		from Abuse, Neglect, and					
3	Exploitation						
	·	the right to be free from					
		isappropriation of resident					
	property, and expl	loitation as defined in this					
	subpart. This incl	udes but is not limited to					
	freedom from corp	•					
	involuntary seclusion and any physical or						
		not required to treat the					
	resident's medical	symptoms.					
	§483.12(a) The fa	cility must-					
	§483.12(a)(1) Not use verbal, mental, sexual,						
	- , , , ,	, corporal punishment, or					
	involuntary seclus						
	1	and record review, the facility	F 0	600	It is the intent of this facility for	r the	05/20/2024
	failed to protect the	resident's right to be free from			resident s to be free from abus	se,	
		abuse of a staff member			neglect, misappropriation of		
		for 1 of 3 residents reviewed			residents property and		
	for abuse. (Resider	nt D, CNA 6)			exploitation.		
	Findings in ded.				What corrective action will be	4-	
	Findings include:				accomplished for those reside		
	The clinical record	of Resident D was reviewed on			found to have been affected b deficient practice.	y u i c	
		. Her diagnoses included, but			Resident D had psycho-social		
		cerebral infarction due to			follow up completed by Social		
	occlusion or stenosi	is of MCA (middle cerebral			Service Director on with no		
		non-dominant left side with			negative psycho social affects	i	
	hemiplegia and hem	niparesis. A review of Resident			noted from allegation. CNA 6		
	D's most recent Mir	nimum Data Set assessment,			terminated related to no tolera	nce	
	dated 2-6-24, indicated her cognitive status was				policy on 04/23/2024		
		d, she was non-ambulatory,					
		vith assistance of 1 person for			How other residents having th		
	-	v, required substantial			potential to be affected by the		
	assistance with bed	mobility and was dependent	1		same deficient practice will be	,	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 04/26/2024 155573 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 981 BEECHWOOD AVE WATERS OF MIDDLETOWN SKILLED NURSING FACILITY, THE MIDDLETOWN, IN 47356 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE for toileting needs and bathing assistance. identified and what corrective action will be taken. In an interview with the Executive Director (ED) All residents that currently reside on 4-24-24 at 10:35 a.m., she indicated the facility in the facility have the potential to recently had a new employee, CNA 6. She further be affected by the alleged deficient explained the facility had received a report of practice. DON/Designee will rough treatment during care of a resident by a complete a facility wide skin staff member, CNA 6. The ED summarized CNA 6 sweep on residents with a Bim's was was terminated due to inappropriate language of 12 or less by 5-20-2024. and intimidation and with her being on SSD/Designee will complete orientation, or just off of orientation, she was abuse questionnaires by terminated due to the facility's "zero tolerance 5-20-2024 for all residents with a policy" towards abuse. The ED indicated she had Bim's score of 13 or higher. Any submitted a report of the incident to the Indiana concerns for addressed or Department of Health's Long-Term Care Division reported as needed. on the same date the facility received the allegation of abuse. What measures will be put in place and what systemic changes In an interview on 4-24-24 at 2:20 p.m., with will be made to ensure that the Resident D, she indicated she is generally deficient practice does not recur. speaking, treated very well and very The Administrator/designee will professionally, with one exception. She explained, complete education with facility "recently, a new aide got upset with me when she staff on the Abuse Prevention was trying to roll me over [for incontinence care] Program including ensuring and I told her it was hurting me. Sometimes, my residents were free from abuse on joints just hurt and she just kept going on. She Additionally, any employee who just didn't listen to me. Just kind of hurrying fails to comply with the points of things along. So, I spoke with the administrator the in-service may be further about it. I told her that I didn't want the girl educated and/or progressively punished, just talk to her about not rushing so disciplined as indicated. much and listen to what people tell her. Well, later How the corrective action will be that day, she came back to me and told me, kind of monitored to ensure the deficient hateful like, that she thought it awful that I told on practice will not recur, i.e what her and now she was in trouble. She just stood in quality assurance program will be the doorway and kind of hollered at me, she put into place. definitely raised her voice to me. Later, when I The DON\designee will complete was talking to somebody, I found out they let her 10 random skin assessments go. I hate that, but you can't treat people that weekly on residents with a Bim's way." She added, due to the Administrator taking of 12 or less x 4 weeks, then 5 care of issues so quickly, she has no further residents a week x 4 weeks, then

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155573	B. W	ING		04/26/	2024
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
\A/A TED	OF MIDDLETOMA	LOWILED MUDDING FACILITY T			ECHWOOD AVE		
WATERS	OF MIDDLE TOWN	N SKILLED NURSING FACILITY, T	HE	MIDDLE	ETOWN, IN 47356		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	concerns related abo	use or neglect. "By the			5 residents a month x 4 month	IS.	
	administrator taking	g care of things so quick, it			Additionally, The Social Serv	ice	
	shows me they mea	n business and take care of			Director/designee will complet		
	things like they sho				random abuse questionnaires		
					residents with a bim's score of		
	A review of CNA 6	's employee file indicated she			or higher weekly x 4 weeks, th	en	
		24. Her employee file indicated			5 random residents a week x 4		
		education regarding resident			weeks, then 5 random residen		
	•	ition and six hours of			weekly x 4 months.		
		ng on or before her hire date.			If the facility is within 95%		
		ge Form," dated 4-19-24 and			compliance at the end of the 6	;	
		CNA 6 was terminated, effective			months; then monitoring can b		
		lity for "Violation of company			stopped. Results of the monitor		
	policy."				will be reviewed at the monthly	-	
					QAPI meeting. Any concerns v		
	The investigative fil	le of the allegation of abuse			have been addressed. Howev		
	-	eportable was faxed to the,			any patterns will be identified.		
		of Health's Long-Term Care			needed Action Plan will be wri	-	
	_	1, follow-up interviews with			by the QAPI committee. Any		
	other residents regar	rding abuse were conducted,			written Action Plan will be		
		conducted with facility staff			monitored by the Administrato	r	
	on 4-22-24, pre-emp	ployment screening for			weekly until resolved.		
	certification validity	y, criminal background check			By what date the systemic		
	and reference check	s, and Resident D was			changes for each deficient will	be	
		imum of 72 hours for any			completed.		
	negative effects afte	er this incident.			05/20/2024		
	On 4-25-24 at 1:20	p.m., the ED provided an					
		olicy entitled, "Abuse					
	Prevention Program	n." This policy indicated, "to					
	prevent resident abu	ise, neglectEach resident					
	-	ervices in a person-centered					
		ch all individuals are treated as					
	human beingsStaf	f members who are suspected					
		luct shall immediately					
	(regardless of time	left on shift) be barred from					
		with residents of the facility					
	-	om duty, pending the					
	_	estigation, prosecution or					
		against the employee."					
							l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155573		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 00 COMPLETED B. WING 04/26/2024			ETED	
	ROVIDER OR SUPPLIER	N SKILLED NURSING FACILITY,	THE	981 BE	ADDRESS, CITY, STATE, ZIP COD ECHWOOD AVE ETOWN, IN 47356		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL U.S.C. IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION
F 0607 SS=D Bldg. 00	3.1-27(a) 3.1-27(b) 483.12(b)(1)-(5)(ii) Develop/Implement §483.12(b) The faimplement written that: §483.12(b)(1) Proneglect, and explomisappropriation of superior	ant Abuse/Neglect Policies cility must develop and policies and procedures hibit and prevent abuse, bitation of residents and of resident property, ablish policies and estigate any such ude training as required at 5, ablish coordination with the quired under §483.75. sure reporting of crimes ally-funded long-term care ance with section 1150B of cies and procedures must t limited to the following Posting a conspicuous e rights, as defined at		TAG	DEFICIENCY		DATE
	retaliation, as defi and (2) of the Act. Based on interview	ned at section 1150B(d)(1)	F 06	507	It is the intent of this facility for resident s to be free from abu		05/20/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	· ′	JILDING	00	COMPL	
		155573	B. WI	NG		04/26	/2024
		<u> </u>		CTDEET 4	ADDRESS CITY STATE ZIR COD		
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
\\\\\\\	CE MIDDLETOW	N SKILLED NURSING FACILITY, T	ue.		ECHWOOD AVE ETOWN, IN 47356		
WATERS	OF MIDDLE IOW	N SKILLED NURSING FACILITY, I		MIDDE	= 1 OVVIN, IIN 47 330		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		lent's right to be free from			neglect, misappropriation of		
		l abuse of a staff member			residents property and		
		for 1 of 3 residents reviewed			exploitation.		
	for abuse. (Reside	ent D, CNA 6)			What corrective action will be		
					accomplished for those reside		
	Findings include:				found to have been affected b	y the	
		6D 11 1D			deficient practice.		
		of Resident D was reviewed on			Resident D had psycho-socia		
		n. Her diagnoses included, but			follow up completed by Social	l	
		cerebral infarction due to			Service Director on with no		
		is of MCA (middle cerebral			negative psycho social affects		
		e non-dominant left side with			noted from allegation. CNA 6		
		miparesis. A review of Resident			terminated related to no tolera	ance	
		nimum Data Set assessment,			policy on 04/23/2024		
		ated her cognitive status was			How other registerate having a th		
		ed, she was non-ambulatory, with assistance of 1 person for			How other residents having the		
		y, required substantial			potential to be affected by the same deficient practice will be		
		l mobility and was dependent			identified and what corrective		
		and bathing assistance.			action will be taken.		
	101 toffering fields	and canning assistance.			All residents that currently res	ide	
	In an interview with	h the Executive Director (ED)			in the facility have the potentia		
		5 a.m., she indicated the facility			be affected by the alleged def		
		employee, CNA 6. She further			practice. DON/Designee will	Joint	
	•	ty had received a report of			complete a facility wide skin		
	_	ring care of a resident by a			sweep on residents with a Bi	m's	
	_	ED summarized CNA 6 was			of 12 or less by 5-20-2024.	-	
		e to inappropriate language and			SSD/Designee will complete		
		ith her being on orientation, or			abuse questionnaires by		
		on, she was terminated due to			5-20-2024 for all residents wit	h a	
	the facility's "zero t	tolerance policy" towards			Bim's score of 13 or higher. A	ny	
	abuse. The ED ind	licated she had submitted a			concerns for addressed or	•	
	report of the incide	nt to the Indiana Department of			reported as needed.		
	_	n Care Division on the same					
	date as discovery o	f the allegation of abuse.			What measures will be put in		
					place and what systemic char	nges	
		4-24-24 at 2:20 p.m., with			will be made to ensure that th	е	
		licated she is generally			deficient practice does not red	cur.	
	speaking, treated vo				The Administrator/designee w	/ill	
	professionally, with	n one exception. She explained,			complete education with facili	ty	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 04/26/2024 155573 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 981 BEECHWOOD AVE WATERS OF MIDDLETOWN SKILLED NURSING FACILITY, THE MIDDLETOWN, IN 47356 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE "recently, a new aide got upset with me when she staff on the Abuse Prevention was trying to roll me over [for incontinence care] Program including ensuring and I told her it was hurting me. Sometimes, my residents were free from abuse joints just hurt and she just kept going on. She on Additionally, any employee just didn't listen to me. Just kind of hurrying who fails to comply with the points things along. So, I spoke with the administrator of the in-service may be further about it. I told her that I didn't want the girl educated and/or progressively punished, just talk to her about not rushing so disciplined as indicated. much and listen to what people tell her. Well, later How the corrective action will be that day, she came back to me and told me, kind of monitored to ensure the deficient hateful like, that she thought it awful that I told on practice will not recur. i.e what her and now she was in trouble. She just stood in quality assurance program will be the doorway and kind of hollered at me, she put into place. definitely raised her voice to me. Later, when I The DON\designee will complete was talking to somebody, I found out they let her 10 random skin assessments go. I hate that, but you can't treat people that weekly on residents with a Bim's way." She added, due to the Administrator taking of 12 or less x 4 weeks, then 5 care of issues so quickly, she has no further residents a week x 4 weeks, then concerns related abuse or neglect. "By the 5 residents a month x 4 months. administrator taking care of things so quick, it Additionally, The Social Service shows me they mean business and take care of Director/designee will complete 10 things like they should." random abuse questionnaires on residents with a bim's score of 13 The investigative file of the allegation of abuse or higher weekly x 4 weeks, then indicated the state reportable was faxed to the, 5 random residents a week x 4 Indiana Department of Health's Long-Term Care weeks, then 5 random residents Division on 4-19-24, follow-up interviews with weekly x 4 months. other residents regarding abuse were conducted, If the facility is within 95% staff education was conducted with facility staff compliance at the end of the 6 on 4-22-24, pre-employment screening for months; then monitoring can be certification validity, criminal background check stopped. Results of the monitoring and reference checks, and Resident D was will be reviewed at the monthly monitored for a minimum of 72 hours for any QAPI meeting. Any concerns will negative effects after this incident. have been addressed. However, any patterns will be identified. Any A review of CNA 6's employee file indicated she needed Action Plan will be written was hired on 4-10-24. Her employee file indicated by the QAPI committee. Any she had completed education regarding resident written Action Plan will be

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rights, abuse prohibition and six hours of

dementia care training on or before her hire date.

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monitored by the Administrator

weekly until resolved.

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

PRINTED: 05/28/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155573		l í	UILDING	ONSTRUCTION 00	(X3) DATE COMPL 04/26 /	ETED	
	PROVIDER OR SUPPLIER	N SKILLED NURSING FACILITY,	THE	STREET ADDRESS, CITY, STATE, ZIP COD 981 BEECHWOOD AVE THE MIDDLETOWN, IN 47356			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	4-20-24, indicated (ge Form," dated 4-19-24 and CNA 6 was terminated, effective ility for "Violation of company			By what date the systemic changes for each deficient wil completed. 05/20/2024	lbe	
	undated copy of a p Prevention Program prevent resident above receives care and see environment in which human beingsState of abuse or miscond (regardless of time any further contact and be suspended froutcome of the investigation.)	p.m., the ED provided an solicy entitled, "Abuse n." This policy indicated, "to use, neglectEach resident ervices in a person-centered ch all individuals are treated as ff members who are suspected duct shall immediately left on shift) be barred from with residents of the facility rom duty, pending the estigation, prosecution or against the employee."					
F 0732 SS=E Bldg. 00	§483.35(g)(1) Dat must post the follo basis: (i) Facility name. (ii) The current da (iii) The total numl worked by the follo licensed and unlice responsible for rese (A) Registered nu (B) Licensed prace	Staffing Information. a requirements. The facility owing information on a daily te. ber and the actual hours owing categories of tensed nursing staff directly sident care per shift: rses. tical nurses or licensed (as defined under State					

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Event ID:

HE0011

Facility ID: 000342

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ í		NSTRUCTION	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED			
		155573	B. WING 04/26/2024						
	PROVIDER OR SUPPLIER	N SKILLED NURSING FACILITY, T	HE	981 BEI	ADDRESS, CITY, STATE, ZIP COD ECHWOOD AVE ETOWN, IN 47356				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
	(i) The facility must data specified in p section on a daily each shift. (ii) Data must be p (A) Clear and read (B) In a prominent residents and visit §483.35(g)(3) Pubstaffing data. The written request, m available to the puto exceed the come syamily staffing data. The written request, m available to the puto exceed the come syamily staffing for This deficient practical adversely affect all Findings include: On 4-24-24 at 9:55 staffing was observed unusing station. The for 4-18-24 and 4-1 unchanged at an observation of the syamily syamily syamily syamily staffing was upon the symilar transportant of the symil	dable format. It place readily accessible to cors. Dic access to posted nurse of facility must, upon oral or ake nurse staffing data ablic for review at a cost not annunity standard. Did to the facility must maintain the extra staffing data for a conths, or as required by ever is greater. Don, interview and record failed to post the facility's five (5) consecutive dates. The potential to residents. Date of the facility's posted end to be located by the exposted staffing dates were 9-24. This posting was servation conducted on	F 07	732	Preparation and/or execution of this plan of correction in generor this corrective action does reconstitute an admission of agreement by this facility of the facts alleged or conclusions so forth in this statement of deficiencies. The plan of corrective actions prepared and/or executed in compliance with State and Fee Laws. Facility's date of alleged compliance is May 20,2024 Facility is respectfully requesting paper compliance all deficiencies in this POC.	ral, not e et ection s are deral d	05/20/2024		

FORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID: 000342

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

PRINTED: 05/28/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155573	A. B	MULTIPLE CO UILDING /ING	ONSTRUCTION 00	COMP	E SURVEY LETED 5/2024
	PROVIDER OR SUPPLIER	N SKILLED NURSING FACILITY,	THE	981 BE	ADDRESS, CITY, STATE, ZIP COD ECHWOOD AVE ETOWN, IN 47356		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ION D BE OPRIATE	(X5) COMPLETION DATE
IAG	In an interview with 4-25-24 at 4:30 p.m conducting the nurs time at the facility. In an interview with 4-25-24 at 4:45 p.m the daily posted nur current.	h the Executive Director on h., she indicated she has been sing work schedules for some has the Executive Director on h., she indicated had not noticed raing staffing sheets were not hat ates to Complaints IN00430719		IAG	post nursing staffing information. What corrective action will accomplished for those refound to have been affected deficient practice. There were no residents aby this alleged deficient protential to be affected by same deficient practice wite identified and what correct action will be taken. All residents that currently in the facility have the pote be affected by the alleged practice. Posted nurse stawas updated by facility on 04/25/2024. What measures will be purplace and what systemic of will be made to ensure the deficient practice does not the Administrator/designe completed education with scheduler on posting nurses staffing information daily conformation daily conformation of the in-service further educated and/or progressively disciplined a indicated. How the corrective action monitored to ensure the depractice will not recur, i.e. of quality assurance program put into place.	mation I be sidents ed by the ed by the effected factice. If the ential to deficient effing et the ential to deficient effing et the ential to deficient effing et the ential to deficient efficient efficie	DATE

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

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155573	r í	UILDING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/26/2024	
	PROVIDER OR SUPPLIER	N SKILLED NURSING FACILITY, T	HE	981 BE	ADDRESS, CITY, STATE, ZIP COD ECHWOOD AVE ETOWN, IN 47356		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
F 0741 SS=D Bldg. 00	Needs §483.40(a) The farstaff who provide of with the appropriates to provide nutron assure resident maintain the higher mental and psychoresident, as determanted assessments and considering the nutron diagnoses of the fain accordance with competencies and	individual plans of care and imber, acuity and acility's resident population in §483.70(e). These I skills sets include, but are wledge of and appropriate			The Administrator/designee was complete daily staffing posting audits 5x's weekly to verify condate is posted x 6 months. If facility is within 95% complian at the end of the 6 months; the monitoring can be stopped. Results of the monitoring will reviewed at the monthly QAPI meeting. Any concerns will habeen addressed. However, an patterns will be identified. Any needed Action Plan will be wroby 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 completed. Date: May 20,2024	d rrect the ce en be l vve ny r	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì í		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155573	B. WI	NG		04/26/	2024
	PROVIDER OR SUPPLIER	S SKILLED NURSING FACILITY, T	HF.	STREET ADDRESS, CITY, STATE, ZIP COD 981 BEECHWOOD AVE HE MIDDLETOWN, IN 47356			
	<u> </u>				1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	DEI ICEA CT		DATE
	and psychosocial residents with a hi post-traumatic stree been identified in a conducted pursua [as linked to histor post-traumatic stree implemented beging (Phase 3)]. §483.40(a)(2) Impronon-pharmacologic Based on interview failed to ensure aderfor the long-term can well as for the secur facility for 1 of 1 ni residents of the long-building and for 7 resecuted dementia can be in the property of the secured dementia can be in the property of	_	F 07	741	Preparation and/or execution of this plan of correction in gener or this corrective action does reconstitute an admission of agreement by this facility of the facts alleged or conclusions of forth in this statement of deficiencies. The plan of corrective actions prepared and/or executed in compliance with State and Fee Laws. Facility's date of alleged compliance is May 20,2024. Facility is respectful requesting paper compliance all deficiencies in this POC. It is the intent of this facility to provide sufficient staff. What corrective action will be accomplished for those reside found to have been affected by deficient practice. There were no residents affected by this alleged deficient practice.	ral, not e et ction are deral d lly for	05/20/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155573	B. W	ING		04/26/	2024
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	R			ECHWOOD AVE		
WATERS	OF MIDDLETOWN	N SKILLED NURSING FACILITY, 1	THE		ETOWN, IN 47356		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOWIDEDIC DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
	were both on the lo	ng term care unit at that time.			How other residents having th	е	
	They explained that	since they were the only two			potential to be affected by the		
	staff here, that was	the best way to handle the			same deficient practice will be	!	
	situation. I immedi	ately sent the nurse to the			identified and what corrective		
	memory care unit a	and the memory care unit door			action will be taken.		
	was closed and lock	xed. I had no idea any of this			All residents that currently res	ide	
		that moment. I have no idea			in the facility have the potentia	al to	
		een going on. Our census on			be affected by the alleged def	icient	
		She indicated she remained in	1		practice. This plan of correction	ons	
	1	rest of that shift and she			applies to all residents in the		
		ory care unit residents were			facility.		
	up or wandering ab	out.					
					What measures will be put in		
		erview, they indicated, "It's			place and what systemic chan	•	
		, but there have been a few			will be made to ensure that the		
		ked unit has not had a staff			deficient practice does not rec	ur.	
		ftI couldn't give you a date,			The Regional Director of		
		time or two when the locked			Operations in-serviced the		
		ed when I have checked it			Administrator on 5-13-2024. t		
		am." They indicated they did			ensure the facility is staffed to		
	_	ory care unit being unlocked to			provide adequate supervision.		
		y thought management would			Additionally, any staff that fails	s to	
		ce management puts together			comply with the points of this		
	the schedules.				in-service will be further		
	0.40004 110.4	1 ED 111			educated/disciplined as		
		2 a.m., the ED provided an			indicated.		
		Census Report," for 3-20-24,	1				
	_	ty's census included 7, memory			How the corrective action will		
		and 17, long-term care unit			monitored to ensure the defici		
	residents, for a total	census of 24 residents.	1		practice will not recur, i.e what		
	In an interview:41	the ED on 4.25.24 at 4.20			quality assurance program wil	ı pe	
		the ED on 4-25-24 at 4:30 p.m.,			put into place.		
	_	tht shift was the date of 3-20-24 D indicated shortly thereafter			The Administrator will audit	ility	
		education with the licensed			staffing levels to verify the faci	-	
	1				is providing adequate supervision to the state of the sta		
		ed regarding notification to			days a week x 4 weeks, then 3		
		changes in the schedule and			days a week x 4 weeks, then times a month x 4 months.	5	
		ait is to staffed at all times and cured/locked at all times.					
	ine door is to be sec	ured focked at all tillies.			If the facility is within 95% compliance at the end of the 6	•	
	ī		1		T COMORANCE AT THE END OF THE P)	

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155573			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/26/2024	
NAME OF PROVIDER OR SUPPLIER WATERS OF MIDDLETOWN SKILLED NURSING FACILITY, TI			STREET ADDRESS, CITY, STATE, ZIP COD 981 BEECHWOOD AVE THE MIDDLETOWN, IN 47356					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	expectations for the locked/secured at a aide present at all ti On 4-25-24 at 5:06 a document entitled with a revision date indicated the facilit your resident popul and support, descril staffing to ensure the meet the needs of the time," includes, but staffing to, "1 Nursinghts," with staffing and 1.25 certified in residents. "[Name always have a mini days/evenings [and related to census."	ememory care unit is that it be all times and there be a nurse or times." p.m., the ED provided a copy of I, "Facility Assessment Tool," of 10-17-23. This document y's staffing plan as, "based on ation and their needs for care be your general approach to nat you have sufficient staff to me residents at any given to does not limit the nursing se Nightsand 1 [nurse aide] and ratios of 1.25 licensed nurse ursing assistant for every 25 of the memory care unit] will mum of: Nurse or QMA on [] Night staff aide on-site			months; then monitoring can be stopped. Results of the monitor will be reviewed at the monthly QAPI meeting. Any concerns thave been addressed. However any patterns will be identified. Needed Action Plan will be writed by the QAPI committee. Any written Action Plan will be monitored by the Administrato weekly until resolved. By what date the systemic changes for each deficient will completed. Date: May 20,2024	oring y will er, Any tten		

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