

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/04/2024
NAME OF PROVIDER OR SUPPLIER  Waters of Scottsburg, The		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N Todd Dr Scottsburg, IN 47170	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>34231</p> <p>Based on observation, interview and record review, the facility failed to ensure dressing changes on residents' (Resident B and Resident D) peripherally inserted central catheter line were completed as ordered for 2 of 2 residents reviewed for quality of care.</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 11/2/24 at 5:56 p.m. The resident's diagnosis included, but was not limited to, acute osteomyelitis of the right foot and ankle.</p> <p>The physician's order, dated 10/5/24, indicated to change the peripherally inserted central catheter (PICC) line dressing weekly and as needed.</p> <p>The care plan, dated 10/24/24, indicated the resident had a PICC line to the right upper extremity and to change the dressing per order.</p> <p>During an observation on 11/1/24 at 1:12 p.m., Resident B's PICC line dressing to the right upper extremity was dated 10/24/24.</p> <p>During an observation on 11/2/24 at 4:53 p.m., Resident B's PICC line dressing to the right upper extremity was dated 10/24/24.</p> <p>The November 2024 medication administration record indicated the treatment was completed on 11/1/24.</p> <p>On 11/2/24 at 5:00 p.m., LPN (Licensed Practical Nurse) 6 indicated PICC line dressings should be changed every 7 days.</p> <p>2. The clinical record for Resident D was reviewed on 11/2/24 at 6:25 p.m. The resident's diagnosis included, but was not limited to, bacteremia.</p> <p>The physician's order, dated 9/26/24, indicated to change the transparent dressing to the PICC line on admission then weekly.</p> <p>The care plan, dated 9/27/24, indicated the resident was receiving IV (intravenous) medication and to change the PICC line dressing as ordered.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/1/24 at 2:35 p.m., Resident D's PICC line dressing was dated 10/24/24.</p> <p>On 11/2/24 at 4:51 p.m., Resident D's PICC line dressing was dated 10/24/24.</p> <p>Review of the October 2024 medication administration record indicated the dressing change was completed on 10/31/24.</p> <p>On 11/2/24 at 6:50 p.m., the Director of Nursing provided a current copy of the document titled Dressing Change, Peripherally Inserted Central Catheter (PICC) and dated 1/2012. It included, but was not limited to, Process .Dressing changes using transparent dressings are performed .Every seven (7) days thereafter</p> <p>3.1-37</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>34231</p> <p>Based on interview and record review, the facility failed to ensure a resident's (Resident E) routine Lorazepam (narcotic antianxiety medication) was administered, as ordered by the physician, for 1 of 3 residents reviewed for pharmaceutical services.</p> <p>Findings include:</p> <p>The clinical record for Resident E was reviewed on 11/4/24 at 9:45 a.m. The resident's diagnoses included, but was not limited to, anxiety and chronic obstructive pulmonary disease.</p> <p>During an interview on 11/2/24 at 6:24 p.m., Resident E indicated her anxiety medications were frequently late and sometimes she did not get it at all.</p> <p>The care plan, dated 5/17/24, indicated the resident was at increased risk for anxiousness due to anxiety and to administer the anxiety medication as ordered.</p> <p>The physicians's order, dated 7/26/24, indicated the resident was to receive Lorazepam 1 mg (milligram) routinely at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m.</p> <p>The October 2024 medication administration record indicated the resident received the Lorazepam 1 mg on the following dates and times:</p> <ul style="list-style-type: none"> <li>-10/04/24 at 8:00 p.m.</li> <li>-10/05/24 at 8:00 p.m.</li> <li>-10/11/24 at 8:00 p.m.</li> <li>-10/12/24 at 8:00 p.m.</li> <li>-10/16/24 at 8:00 p.m.</li> <li>-10/18/24 at 8:00 p.m.</li> <li>-10/19/24 at 8:00 p.m.</li> <li>-10/24/24 at 4:00 p.m.</li> <li>-10/25/24 at 4:00 p.m. and 8:00 p.m.</li> <li>-10/26/24 at 8:00 p.m.</li> </ul> <p>The October 2024 controlled drug record lacked documentation that the Lorazepam was administered on the above dates and times.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The November 2024 medication administration record indicated the resident received the Lorazepam on 11/1/24 at 8:00 p.m. and 11/2/24 at 8:00 p.m.</p> <p>The November 2024 controlled drug record lacked documentation that the Lorazepam was administered on the above dates and time.</p> <p>During an interview on 11/4/24 at 12:12 p.m., RN (Registered Nurse) 7 indicated when routine narcotics are administered, the medication should be signed off on the controlled durg record when removed. After the medication was administered, it should be signed out on the medication administration record.</p> <p>On 11/4/24 at 2:35 p.m., the Director of Nursing provided a current copu ot the document titled Medication Administration dated 2/2017. It included, but was not limited to, Purpose .To administer all medications safely and appropriately to aid residents to .relieve and prevent symptoms .and help in diagnosis .Procedure .Give the resident the medication .document medication administration with initials in appropriate spaces</p> <p>3.1-25(b)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34231</p> <p>Based on observation, interview and record review, the facility failed to ensure food was served at appropriate temperatures for 1 of 1 observations of food temperatures. ([NAME] Hall)</p> <p>Findings include:</p> <p>On 11/1/24 at 12:00 p.m., upon entrance to the dining room, a meal time sign was observed to be posted which included the following meal times for [NAME] Hall:</p> <p>Lunch - 12:15 p.m.</p> <p>Dinner - 5:20 p.m.</p> <p>Review of the September 2024 resident council minutes, dated 9/19/24 at 2:00 p.m., indicated the residents had concerns of breakfast food being served cold and dinner being served late.</p> <p>Review of the October 2024 resident council minutes, dated 10/24/24 at 2:00 p.m., indicated the residents had concerns of the breakfast food being served cold and dinner was late.</p> <p>On 11/1/24 at 12:58 p.m., the lunch trays were brought to the [NAME] Hall at 12:58 p.m.</p> <p>On 11/1/24 at 1:08 p.m., with the Dietary Manager, the following food temperatures were observed:</p> <ul style="list-style-type: none"> <li>-Cheesy grits with shrimp - 145 degrees</li> <li>-Collard greens - 126 degrees</li> <li>-Garlic toast - 108.6 degrees</li> </ul> <p>On 11/2/24 at 5:46 p.m., the dinner trays were brought to [NAME] Hall.</p> <p>On 11/1/24 at 1:12 p.m., Resident B indicated when he ate in the dining room the food was hot, but whenever he ate on the hall the food was cold and late. He tried to go to the dining room for all his meals.</p> <p>On 11/1/24 at 2:35 p.m., Resident D indicated she liked to go to the dining room. If she ate in her room, the food was late and cold by the time she got it, but it was hot if she ate in the dining room.</p> <p>On 11/4/24 at 10:44 a.m., Resident K indicated the food would be an insult to give to his dogs and was always late by close to an hour and cold by the time it was served.</p> <p>On 11/4/24 at 11:57 a.m., Resident L indicated the food was cold by the time it reached the hall and usually always late.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This Citation relates to Complaint IN00446242</p> <p>3.1-21(a)(2)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>34231</p> <p>Based on interview and record review, the facility failed to ensure as resident's (Resident E) medication administration record accurately reflected the administration of as needed narcotic pain medication for 1 of 3 residents reviewed for medical records.</p> <p>Findings include:</p> <p>The clinical record for Resident E was reviewed on 11/4/24 at 9:45 a.m. The resident's diagnoses included, but were not limited to, end stage heart failure, anxiety and chronic obstructive pulmonary disease.</p> <p>The physician's order, dated 8/2/24, indicated the resident was to receive Morphine Sulfate (narcotic pain medication), 0.75 mg (milligrams) every 2 hours as needed for pain.</p> <p>The October 2024 controlled drug record indicated the resident received the medication on the following dates and times:</p> <ul style="list-style-type: none"> <li>-10/3/24 at 12:02 a.m., 5:30 a.m., 7:30 a.m., 9:30 a.m., 11:30 a.m., 1:30 p.m., 3:30 p.m., 5:30 p.m. and 7:30 p.m.</li> <li>-10/4/24 at 5:00 a.m., 7:45 p.m., and 9:45 a.m.</li> <li>-10/5/24 at 4:00 a.m., 6:00 a.m., 8:00 p.m. and 10:00 p.m.</li> <li>-10/6/24 at 12:00 a.m., 2:00 a.m., 4:00 a.m., 6:00 a.m. and 8:15 p.m.</li> <li>-10/8/24 at 8:30 a.m., 10:35 a.m. and 2:00 p.m.</li> <li>-10/9/24 at 5:00 a.m.</li> <li>-10/11/24 at 7:25 p.m., 9:15 p.m. and 11:15 p.m.</li> <li>-10/12/24 at 1:45 a.m., 3:45 a.m. 3:00 p.m. 7:45 p.m. and 9:15 p.m.</li> <li>-10/13/24 at 9:45 a.m. and 6:00 p.m.</li> <li>-10/14/24 at 12:00 a.m. 9:30 a.m. and 12:07 p.m.</li> <li>-10/16/24 at 5:30 a.m. 10:15 p.m.</li> <li>-10/17/24 at 12:15 a.m., 2:15 a.m., 4:15 a.m., 6:00 a.m., 6:30 p.m., 8:30 p.m. and 10:00 p.m.</li> <li>-10/18/24 at 1:15 p.m., 6:00 p.m., 9:00 p.m. and 11:00 p.m.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-10/19/24 at 1:20 a.m., 4:00 a.m., 6:00 p.m. and 10:00 p.m.</p> <p>-10/22/24 at 4:30 p.m.</p> <p>-10/23/24 at 8:00 p.m.</p> <p>-10/24/24 at 10:40 p.m.</p> <p>-10/26/24 at 8:00 a.m. at 3:45 p.m.</p> <p>-10/28/24 at 4:30 a.m.</p> <p>-10/31/24 at 2:30 p.m. and 4:30 p.m.</p> <p>The October 2024 medication administration lacked documentation of the administered above dates and times.</p> <p>The November 2024 controlled drug record indicated the Morphine was administered on the following dates and times:</p> <p>-11/2/24 at 12:30 a.m.</p> <p>-11/3/24 at 3:00 a.m.</p> <p>The November 2024 medication administration record lacked documentation on the above dates and times.</p> <p>During an interview on 11/4/24 at 12:12 p.m., RN (Registered Nurse) 7 indicated when a PRN (as needed) narcotic is administered, the medication should be signed out on the controlled drug record and, once administered, the medication administration record would be initialed by the nurse. The resident should followed up on after 30 minutes to make sure the pain medication was effective.</p> <p>On 11/4/24 at 2:35 p.m., the Director of Nursing provided a current copu of the document titled Medication Administration dated 2/2017. It included, but was not limited to, Purpose .To administer all medications safely and appropriately to aid residents to .relieve and prevent symptoms .and help in diagnosis .Procedure .Give the resident the medication .document medication administration with initials in appropriate spaces</p> <p>3.1-50(a)(2)</p>		