

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 02/21/2025
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>51675</p> <p>Based on record review and interview, the facility failed to adequately secure residents in the facility van when transporting 1 of 3 residents reviewed for accidents (Resident 66)</p> <p>Findings include:</p> <p>The clinical record for Resident 66 was reviewed on 2/19/25 at 1:30 p.m. The resident's diagnoses included, but were not limited to, chronic osteomyelitis with draining sinus to the left radius and ulna, muscle weakness, difficulty in walking, unsteadiness on feet, radiculopathy, lumbosacral region intervertebral disc disorders with radiculopathy, and lack of coordination.</p> <p>The baseline care plan completed on admission to the facility, dated 1/15/25, indicated the resident had no previous history of falls.</p> <p>The Minimum Data Set (MDS) assessment, dated 1/21/25, indicated the resident was cognitively intact. The resident required extensive assistance with two staff members to complete her Activities of Daily Living (ADL's).</p> <p>The ADL care plan, dated 2/7/25, indicated Resident 66 had a risk for falls due to weakness, impaired mobility, lumbosacral radiculopathy, and sacroiliitis. The interventions included, but were not limited to, attempt to keep resident areas free of clutter; keep the call light in resident's reach; notify and update the physician; and resident will have a therapy screen as indicated, quarterly and as needed.</p> <p>The Bus driver/Certified Nurse Aide (CNA) 10 had an in-service on 2/10/25 on the proper technique for securing residents in their wheelchair while on the wheelchair van. This documented training was three days after the incident.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nurse's note, dated 2/7/25, indicated Resident 66 was in the wheelchair on the wheelchair van. The wheelchair van driver rounded a corner, and the resident and wheelchair fell to the right side. The wheelchair van immediately stopped, and the driver assisted Resident 66 and the wheelchair to an upright position. Resident 66 was assessed for injuries and no injuries were noted. The resident was denying pain or discomfort. Resident 66 was transported back to the facility, then brought into the facility to be assessed by a nurse. Her range of motion was normal for the resident. Neurologic assessments were initiated, and her vital signs were obtained. Resident 66 was wheeling about facility in a wheelchair.</p> <p>On the Medication Administration Record (MAR) on 2/7/25, the resident received acetaminophen 1000 milligrams by mouth at 12:49 p.m. due to complaints of pain.</p> <p>A radiology result, dated 2/7/25, for testing on the resident's right hip and right knee, indicated the reason for the testing was pain. An ultrasound report, dated 2/10/25, indicated the abdominal ultrasound was completed due to the abdominal pain the resident had been experiencing since the fall.</p> <p>An Interdisciplinary Team's (IDT) note, dated 2/10/25, indicated the team reviewed the fall on 2/7/25. The IDT determined the root cause for the resident fall was that the Bus driver did not have the resident securely fastened into the wheelchair during transport and this caused the wheelchair to turn over with the resident.</p> <p>A nurse's note, dated 2/17/25, indicated a new order was received for a Computed tomography (CT) of the head (this test used special x-ray equipment to help assess the resident's brain). This test was ordered because of the resident's recent fall and use of blood thinning medication.</p> <p>During an interview, on 2/19/25 at 9:45 a.m., the resident indicated that the wheelchair van driver had strapped her in the wheelchair but when they went around a curve, she was ejected from the wheelchair onto the right side which was her bad side. She had noticed one strap was loose and flew up when she was ejected. The resident indicated that she had a bump on the right side of her head, pain in her right hip and right knee and she had declined in her progress in therapy. The wheelchair van driver did not call 911 and the resident indicated that the wheelchair bus driver had assisted with getting the wheelchair upright.</p> <p>During an interview, on 2/20/25 at 9:00 a.m., the Executive Director (ED) indicated that she was on vacation on 2/7/25 at the time of the incident The corporate ED did not fill out an incident report and the facility ED was unaware she needed to fill out an incident report since she was told the resident was not injured. The ED completed the report today. She knew that the resident had an accident in the wheelchair van and had to then return to the facility. She indicated that she thought the Bus driver had to do an in-service on proper transportation techniques.</p> <p>An initial incident report was completed, on 2/20/25 by the ED, the report indicated Resident 66 had fallen during transport in the facility van.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 2/21/25 at 9:00 a.m., the Director of Nursing (DON) indicated that the resident was on the facility wheelchair van when they went around a curve and the wheelchair turned over. It was determined that the bus driver had not strapped the resident in correctly. The wheelchair van driver had to complete a new in-service on 2/10/25. The DON indicated that she did not think the resident was injured but she had complaints of increased pain later on with her right leg and shoulder. Testing was ordered and completed. Then two days after the fall, the resident had complaints of a headache and a bump on her head, so a CT of the head was ordered.</p> <p>During an interview, on 2/21/25 at 9:15 a.m., the Bus driver indicated that she strapped the resident correctly in the wheelchair van. She thought the resident dropped her phone, unlocked the wheelchair to reach it and the wheelchair turned over to the right side when the driver was making a turn. The resident was not ejected from the wheelchair and was still in the wheelchair when the driver assisted her upright. The resident did not have any pain and did not want the driver to tell the facility this had happened. She returned the resident to the facility. She provided the transport calendar, but did not have a transfer log. The tentative facility wheelchair bus schedule for the week of February 3, 2025, showed on 2/7/25 the resident had an 8:30 a.m. appointment with a physician.</p> <p>The most current facility policy titled, Transportation Policy and Procedure manual, last revised 4/1/20 and was provided on 2/19/25 by the Director of Nursing. The policy on Transport Emergency Procedures included, but was not limited to, .The purpose of this policy is to provide a mechanism for assuring that emergency services are available to residents during transport . If a resident fall occurs at any time during transport, call 911 . Do not move the resident or transport resident yourself .</p> <p>The most current facility policy titled, Transportation Policy and Procedure manual, last revised 4/1/20 and was provided on 2/19/25 by the Director of Nursing. The policy on Safety During Transport-Securing Chair included, but was not limited to, . It is the policy of this facility to secure resident wheelchair in transport vehicle to ensure resident safety during transport . 1. Check that you have all the equipment you need for the transport .7. Apply lap/seatbelt around resident .Ensure belt is across lap under wheelchair armrest to fit snugly .10. All wheelchairs must be secured in the vehicle .</p> <p>3.1-45(2)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>35732</p> <p>Based on record review and interview, the facility failed to ensure dialysis site monitoring and assessments were completed for 1 of 3 residents reviewed for dialysis. (Resident 24)</p> <p>Findings include:</p> <p>The record for Resident 24 was reviewed on 2/19/25 at 10:15 p.m. The resident's diagnoses included, but were not limited to, dependence on renal dialysis, end stage renal disease, and diabetes mellitus</p> <p>The physician's order, dated 5/13/24, indicated staff were to monitor the resident's AV (arterial vascular) fistula for signs and symptoms of infection, bleeding, bruit/thrill every shift. The order was discontinued on 12/29/24 related to the resident being sent to the hospital.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 9/26/24, indicated the resident's cognition was moderately impaired. The resident required substantial or maximal staff assistance with his Activities of Daily Living (ADL's).</p> <p>The care plan, dated 6/20/23, indicated Resident 24 had end stage renal disease with the need for dialysis. The interventions included, but were not limited to, dialysis per dialysis schedule, monitor shunt for bruit and thrill, no blood pressure or needle sticks in the arm with the shunt, notify the physician and family of noted problems such as: bleeding after removal of dressing, absence of bruit thrill or any decrease in physical or mental function, and observe the shunt site after return from dialysis.</p> <p>The clinical record lacked documentation indicating the dialysis order was continued after the resident returned from the hospital. The resident continued to receive dialysis three times a week.</p> <p>During an interview, on 2/19/25 at 11:00 a.m., Licensed Practical Nurse (LPN) 5 reviewed the resident's physician orders and indicated when the resident returned from the hospital, the physician's order was not put back in the computer and it should have been. The resident received dialysis three times a week and there wasn't any documentation of the fistula was being monitored.</p> <p>During an interview, on 2/19/25 at 11:30 a.m., the Director of Nursing (DON) indicated the order to monitor the fistula post dialysis was in the physician's orders until 12/29/24, when the resident went to the hospital. When the resident returned, the order was not put back in, so the fistula had not been monitored for two months. The staff should have confirmed the resident's dialysis orders.</p> <p>During an interview, on 2/20/25 at 10:00 a.m., LPN 4 indicated staff would obtain the resident's vital signs before and after dialysis. The resident's medication should be sent with the resident to dialysis. Her main concern after a resident returned from dialysis was to make sure the resident received food and fluids.</p> <p>(continued on next page)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Care of Resident Receiving Dialysis Treatments policy, dated 9/2009, and revised 3/24/20, included, but was not limited to, . 3. Monitor for infection or clotting of the access area. a. Do not take the blood pressure in the arm with the dialysis access site. B. Monitor for swelling, pain, redness, or drainage of the shunt. C. Monitor bruit as ordered. D. Daily screening to include body temperature, new or worsened cough, shortness of breath, sore throat, vomiting, diarrhea, or loss of sense of taste or smell .</p> <p>3.1-37(a)</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35732</p> <p>Based on record review and interview, the facility failed to schedule 8-hour consecutive RN coverage for 6 of 6 months reviewed. (July, August, September, October, November, and December 2024). This had the potential to affect all 60 residents currently residing in the facility.</p> <p>Findings include:</p> <p>The review of the July through December 2024 Licensed Nursing schedule indicated the following days were short of 8 consecutive hours of RN coverage:</p> <ul style="list-style-type: none"> - On July 6, 2024, there were only 6 hours of consecutive RN coverage. - On July 7, 2024, there were only 6 hours of consecutive RN coverage. - On July 20, 2024, there were only 6 hours of consecutive RN coverage. - On July 21, 2024, there were only 6 hours of consecutive RN coverage. - On August 3, 2024, there were only 6 hours of consecutive RN coverage. - On August 4, 2024, there were only 6 hours of consecutive RN coverage. - On August 17, 2024, there were only 6 hours of consecutive RN coverage. - On August 18, 2024, there were only 6 hours of consecutive RN coverage. - On August 31, 2024, there were only 6 hours of consecutive RN coverage. - On September 1, 2024, there were only 6 hours of consecutive RN coverage. - On September 14, 2024, there were only 6 hours of consecutive RN coverage. - On September 15, 2024, there were only 6 hours of consecutive RN coverage. - On September 28, 2024, there were only 6 hours of consecutive RN coverage. - On September 29, 2024, there were only 6 hours of consecutive RN coverage. - On October 12, 2024, there were only 6 hours of consecutive RN coverage. - On October 13, 2024, there were only 6 hours of consecutive RN coverage. - On October 26, 2024, there were only 6 hours of consecutive RN coverage. <p>(continued on next page)</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - On October 27, 2024, there were only 6 hours of consecutive RN coverage. - On November 9, 2024, there were only 6 hours of consecutive RN coverage. - On November 10, 2024, there were only 6 hours of consecutive RN coverage. - On November 23, 2024, there were only 6 hours of consecutive RN coverage. - On November 24, 2024, there were only 6 hours of consecutive RN coverage. - On December 7, 2024, there were only 6 hours of consecutive RN coverage. - On December 8, 2024, there were only 6 hours of consecutive RN coverage. - On December 21, 2024, there were only 6 hours of consecutive RN coverage. - On December 22, 2024, there were only 6 hours of consecutive RN coverage. <p>During an interview, on 2/19/25 at 11:00 a.m., the Executive Director (ED) indicated she was not aware that the RN hours had to be 8 consecutive hours. She indicated according to the schedules; they did not have the required RN coverage hours.</p> <p>During an interview, on 2/19/25 at 11:15 a.m., the Corporate Nurse Consultant indicated in her [AGE] years of nursing, she was not aware the RN hours had to be consecutive. Every other weekend there was RN coverage, but not every weekend.</p> <p>During an interview, on 2/20/25 at 9:30 a.m., the Director of Nursing (DON) indicated she was aware the RN coverage had to be consecutive and that every other weekend the facility lacked those RN hours.</p> <p>The review of the Facility Assessment, dated 6/28/24 , indicated the facility required 6 licensed nurses providing direct care and 4 Certified Nursing Aides per 12-hour shifts.</p> <p>3.1-17(b)(3)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34309</p> <p>Based on observation, record review, and interview, the facility failed to ensure narcotic medication counts were properly documented at the time of administration and expired insulins were removed for 3 of 5 medication carts reviewed. ([NAME] Drive medication cart 1, [NAME] Avenue medication cart 1 and Memory Care medication cart 1).</p> <p>Findings include:</p> <p>1. During an observation on [DATE] at 10:08 a.m., of the [NAME] Drive Medication Cart 1, the following concerns were identified in the narcotic drawer:</p> <p>a. The Controlled Drug Receipt Record/Disposition sheet indicated that Resident 53 had 3 tablets of the Tramadol left on the sheet. The Tramadol medication card had 2 tablets left.</p> <p>The record for Resident 53 was reviewed on [DATE] at 8:21 a.m. The diagnoses included, but were not limited to, nondisplaced fracture of the right radius of the neck, hereditary and idiopathic neuropathy, gout, diverticulosis, abdominal pain, and irritable bowel syndrome.</p> <p>The physician's order, dated [DATE], indicated to administer 50 mg (milligrams) of Tramadol hydrochloride two times daily for moderate pain.</p> <p>The February Medication Administration Record (MAR) indicated the resident last received her Tramadol on [DATE] at 8:00 a.m., by Licensed Practical Nurse (LPN) 6.</p> <p>During the observation, on [DATE] at 8:41 a.m., of LPN 6's administration of Resident 6's Tramadol, the LPN failed to sign out the resident's Tramadol on the Controlled Drug Receipt Record/Disposition sheet. At 10:08 a.m., Resident 6's Tramadol administered by LPN 6 still lacked documentation on the Controlled Drug Receipt Record as being administered during the 8:41 a.m. observation.</p> <p>b. The Controlled Drug Receipt Record/Disposition sheet indicated that Resident 6 had 16 tablets of the clonazepam left on the sheet. The clonazepam medication card had 15 tablets left.</p> <p>The record for Resident 6 was reviewed on [DATE] at 1:45 p.m. The resident's diagnoses included, but were not limited to, anxiety disorders, obsessive compulsive disorder, and dementia with psychotic disturbance.</p> <p>The physician's order, dated [DATE], indicated staff were to administer 0.5 mg of clonazepam two times daily for anxiety.</p> <p>The February MAR indicated the resident had last received the clonazepam on [DATE] at 8:00 a.m., by LPN 6.</p> <p>c. The Controlled Drug Receipt Record/Disposition sheet indicated that Resident 8 had 21 tablets of the Tramadol left on the sheet. The Tramadol medication card had 20 tablets left.</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 - Some</p>	<p>The record for Resident 8 was reviewed on [DATE] at 1:15 p.m. The resident's diagnosis, included, but were not limited to, metabolic encephalopathy, cerebral infarction, rhabdomyolysis, subarachnoid hemorrhage affecting the left non-dominant side, and severe vascular dementia with mood disturbance.</p> <p>The physician's order, dated [DATE], indicated to administer 50 mg of Tramadol three times daily for pain.</p> <p>The February MAR indicated the resident received Tramadol on [DATE] at 8:00 a.m., by LPN 6.</p> <p>d. The Controlled Drug Receipt Record/Disposition sheet indicated that Resident 63 had 8 tablets of the Pregabalin (Lyrica) on the sheet. The Pregabalin medication card had 7 tablets left.</p> <p>The record for Resident 63 was reviewed on [DATE] at 1:10 a.m. The resident's diagnosis included, but was not limited to, type 2 diabetes mellitus with diabetic neuropathy.</p> <p>The February MAR indicated the resident received 100 mg capsule of Lyrica last on [DATE] at 4:00 p.m., by LPN 11.</p> <p>The physician's order, dated [DATE], indicated to administer 100 mg of Pregabalin three times daily for neuropathy. The order was discontinued on [DATE].</p> <p>During an interview, on [DATE] at 10:33 a.m., LPN 6 indicated he had administered the medication during the morning, but had not signed them out yet on the narcotic sheet. He had found patches the day before that had been administered, but not signed out and the count was off. He should have signed the narcotics out when he had administered them.</p> <p>e. Resident 5's Admelog (Humalog) vial had an open date of [DATE]. No expiration date was documented on the vial. The Admelog expired on [DATE] at 28 days.</p> <p>The record for Resident 5 was reviewed on [DATE] at 2:10 p.m. The resident's diagnosis included, but was not limited to, type 2 diabetes mellitus with hyperglycemia.</p> <p>The physician's order, dated [DATE], indicated to administer Humalog (Admelog) kwikpen subcutaneously per sliding scale: if 200 to 250 mg/dL (milligrams per deciliter) give 4 units; 251 to 300 mg/dL give 8 units; 301 to 350 mg/dL give 12 units; 351 to 400 mg/dL give 16 units; 401 to 450 mg/dL give 20 units If greater than 450 mg/dL give 20 units and notify the physician, subcutaneously four times a day related to type 2 diabetes mellitus. Notify the physician if the resident's blood sugar was less than 60 or greater than 450 mg/dL.</p> <p>The February MAR indicated the resident last received the Humalog (Admelog) on [DATE] at 12:00 p.m. by LPN 6. The resident's blood sugar was 442 and the resident received 20 units.</p> <p>f. Resident 63's Lispro (Humalog) kwikpen had an open date of [DATE] with no written expiration date. The Lispro expired on [DATE] at 28 days. The resident's Humalog vial had an open date of [DATE] with no expiration date. The Humalog expired on [DATE] at 28 days.</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 - Some</p>	<p>The record for Resident 63 was reviewed on [DATE] at 1:10 a.m. The resident's diagnosis included, but was not limited to, type 2 diabetes mellitus with diabetic neuropathy.</p> <p>The care plan, dated [DATE], indicated the resident had a diagnosis of diabetic neuropathy. The interventions, dated [DATE], included, but were not limited to, administer medication as ordered for the diagnosis, and notify the physician as needed.</p> <p>The physician's order, dated [DATE], indicated to administer the Humalog (Lispro) per sliding scale, if 200 to 250 mg/dL administer 4 units, if 251 to 300 mg/dL administer 8 units, if 301 to 350 mg/dL administer 12 units, if 351 to 400 mg/dL administer 16 units, if 401 to 450 mg/dL administer 20 units, subcutaneously three times daily related to type 2 diabetes mellitus.</p> <p>The February MAR indicated the resident had last received 12 units of Humalog (Lispro) on [DATE] at 5:00 p. m., for a blood sugar of 305 mg/dL by RN 7.</p> <p>2. During an observation on [DATE] at 10:25 a.m., of the Memory Care Unit medication cart, the following concerns were identified in the narcotic drawer:</p> <p>a. The Controlled Drug Receipt Record/Disposition sheet indicated that Resident 21 had 11 tablets of the alprazolam left on the sheet. The alprazolam medication card had 10 tablets left.</p> <p>The record for Resident 21 was reviewed on [DATE] at 11:47 a.m. The resident's diagnoses, included, but were not limited to, severe dementia with anxiety and psychotic disturbance, and anxiety disorder.</p> <p>The physician's order, dated [DATE], indicated to administer 0.5 mg of alprazolam two times daily for anxiety and agitation.</p> <p>The February MAR indicated the resident last received her alprazolam on [DATE] at 8:00 a.m., by Qualified Medication Aide (QMA) 9.</p> <p>b. The Controlled Drug Receipt Record/Disposition sheet indicated that Resident 38 had 5 tablets of the Cetirizine/PSE (Pseudoephedrine) left on the sheet. The Cetirizine/PSE medication card had 4 tablets left.</p> <p>The record for Resident 38 was reviewed on [DATE] at 10:20 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, allergic rhinitis, and sleep apnea.</p> <p>The physician's orders, dated [DATE], indicated to administer ,d+[DATE] mg of cetirizine-pseudoephedrine extended release 12-hour medication daily for allergies.</p> <p>The February MAR indicated the resident last received cetirizine PSE on [DATE] at 8:00 a.m., by QMA 9.</p> <p>c. The Controlled Drug Receipt Record/Disposition sheet indicated Resident 13 had 29 tablets of the lorazepam left on the sheet. The lorazepam medication card had 28 tablets left.</p> <p>(continued on next page)</p>		

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 02/21/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The record for Resident 13 was reviewed on [DATE] at 10:37 a.m. The resident's diagnoses included, but were not limited to, generalized anxiety disorder, major depressive disorder, reactions to severe stress, and post-traumatic stress disorder.</p> <p>The physician's order, dated [DATE], indicated to administer 0.5 mg of lorazepam two times daily for anxiety.</p> <p>The February MAR, indicated the resident last received the lorazepam on [DATE] at 8:00 a.m., by QMA 9.</p> <p>d. The Controlled Drug Receipt/Record/Disposition sheet indicated that Resident 19 had 13 tablets of the clonazepam left on the sheet. The clonazepam medication card had 12 tablets left.</p> <p>The record for Resident 19 was reviewed on [DATE] at 11:05 a.m. The resident's diagnoses included, but were not limited to, acute and chronic respiratory failure with hypercapnia and hypoxia, obstructive sleep apnea, anxiety disorder, panic disorder, and post traumatic stress disorder.</p> <p>The physician's order, dated [DATE], indicated to administer 0.5 mg of clonazepam two times daily for anxiety.</p> <p>The February MAR indicated the resident last received the clonazepam on [DATE] at 8:00 a.m., by QMA 9.</p> <p>During an interview, on [DATE] at 10:30 a.m., QMA 9 indicated that she had to run out of the building to run an errand and had not signed out her narcotics. Her not signing out the narcotics when she administered them was a bad habit that she had gotten into.</p> <p>3. During an observation on [DATE] at 10:00 a.m., of the [NAME] Avenue medication cart, Resident 28's Humalog kwikpen had an open date of [DATE]. The Humalog expired on [DATE] at 28 days.</p> <p>The record for Resident 28 was reviewed on [DATE] at 2:18 p.m. The resident's diagnosis included, but was not limited to, type 2 diabetes mellitus with diabetic neuropathy.</p> <p>The physician's order, dated [DATE], indicated to administer 26 units of Humalog kwikpen subcutaneously four times a day for diabetes mellitus. The order was discontinued on [DATE].</p> <p>The physician's order, dated [DATE], indicated to inject 26 units of Humalog kwikpen subcutaneously four times a day for diabetes mellitus. The order was discontinued on [DATE].</p> <p>The December MAR indicated the resident last received the Humalog on [DATE] at 11:00 a.m., by LPN 6.</p> <p>During an interview, on [DATE] at 10:21 a.m., LPN 6 indicated he would check the expiration date of the insulin before he administered it.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Waters of Scottsburg, The		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N Todd Dr Scottsburg, IN 47170	
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview, on [DATE] at 10:06 a.m., LPN 8 indicated Resident 28 had been in the hospital and came back last week. She would have disposed of the insulin and replaced it, if she knew it was there. She hadn't thought of checking for it in the cart. She would have checked the date before administration of the insulin.</p> <p>The Guidelines for Controlled Substance Medication-an Overview policy, dated [DATE], included, but was not limited to, . Controlled Medication Delivery Manifest: A Controlled Medication Delivery Manifest will accompany all schedule II, III, IV and V medication deliveries. The following information will be present . Quantity dispensed . Individual Charting Record: An Individual Charting Record (Controlled Drug Receipt/Record/Disposition Form) will accompany the controlled substances which are dispensed to the facility from the pharmacy. This record will be maintained by the nursing staff at the time of each administration of the medication as follows . 2) Record each dose at the time of administration . 3. Confirm that the amount of the controlled drug supply is correct prior to, as well as after, assembling the required dose that is being given-Verify the following . Number of doses/quantity remaining .</p> <p>The Guidelines For Insulin Pens policy, dated [DATE], included, but were not limited to, . 3) Upon opening for the first time, the insulin pen will have a date sticker applied. This will be done by the nurse. The date will reflect the date the seal was broken for use . 6) Insulin pens will be considered expired after 28 days and up to 45 days depending on the manufacturer's instructions--after they are opened, no matter of the amount of insulin still remaining in the pen. 7) Insulin pens will never be shared with other residents--even if the other resident has the exact same order related to their insulin requirements per their physician's order.</p> <p>3XXX,d+[DATE](n)</p>		

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NAME OF PROVIDER OR SUPPLIER Waters of Scottsburg, The		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N Todd Dr Scottsburg, IN 47170	
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>34309</p> <p>Based on observation, record review, and interview, the facility failed to store and dispose of discontinued insulin pens appropriately for 1 of 5 medication carts reviewed for medication storage. (Eagle Court Hall Medication Cart)</p> <p>Findings include:</p> <p>1.a. During an observation on 2/18/25 at 10:35 a.m. of the Eagle Court Hall Medication Cart, Resident 18's Humalog kwikpen was lying freely in the drawer without a pharmacy label, but had a sticker on the kwikpen with the resident's name. The Humalog had an open date of 2/17/25.</p> <p>The record for Resident 18 was reviewed on 2/18/25 at 10:40 a.m. The resident's diagnosis included, but was not limited to, type 2 diabetic mellitus with diabetic neuropathy.</p> <p>The physician's order, dated 1/8/25, indicated staff were to administer Lispro (Humalog) subcutaneously, four times daily for diabetes, per sliding scale: if 150 to 199 mg/dL (milligrams per deciliter) give 4 units ; 200 to 249 mg/dL give 8 units; 250 to 299 mg/dL give 12 units; 300 to 349 mg/dL give 16 units for blood sugar greater than 350 mg/dL give 20 units and notify the physician. The order was discontinued on 1/16/25.</p> <p>The record lacked documentation of a current physician's order for Humalog (Lispro).</p> <p>The January MAR indicated the resident last received 8 units of Humalog (Lispro) on 1/16/25 at 11:00 a.m., by RN 7. The resident's blood sugar was 226.</p> <p>The record lacked documentation in the February MAR for administration of the Humalog to the resident.</p> <p>During an interview, on 2/21/25 at 10:11 a.m., RN 7 indicated Resident 18 was currently on 10 units of Lantus at bedtime. She didn't receive any insulin during the day. She had an order to discontinue the Humalog on 1/8/25. It wouldn't make sense for her to have an open date of 2/17/25 on the Humalog. She did not share resident's medications with other residents and she didn't know of any staff who did that, because medications were available in the emergency medication dispensing machine.</p> <p>b. An illegible name was on a Aspart kwikpen. The kwikpen was dated with an open dated of 1/3/25 and an expiration date of 2/3/25. The kwikpen was lying freely in the Eagle Court Hall Medication Cart.</p> <p>c. An Insulin Aspart kwikpen, with no name on the sticker, no physician's order, or pharmacy label, had an open date of 11/18/24 with an expiration date of 12/18/24 on the pen. The kwikpen was lying freely in the Eagle Court Hall Medication Cart.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Guidelines For Insulin Pens policy, dated 8/10/23, included, but was not limited to, . 7) Insulin pens will never be shared with other residents - even if the other resident has the exact same order related to their insulin requirements per their physician's order.</p> <p>The Medication Storage In The Facility policy, dated March 2023, included, but was not limited to, . 14. Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled or without secure closures will immediately withdrawn from stock by the facility. They will be disposed of according to drug disposal procedures, and reordered from the pharmacy if a current order exists.</p> <p>3.1-25(k)(1)</p> <p>3.1-25(k)(2)</p> <p>3.1-25(k)(5)</p> <p>3.1-25(k)(7)</p> <p>3.1-25(0)</p>		