STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Tipton Skilled Nursing Facility, The	300 Fairgrounds Rd Tipton, IN 46072

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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 38872 Based on interview and record review, the facility failed to ensure unlicensed staff notified a licensed staff member when a resident was found to have discolored areas located on both shoulders for 1 of 1 resident reviewed for an injury of unknown origin. (Resident 2) Finding includes: The clinical record for Resident 2 was reviewed on 12/30/24 at 11:30 a.m. The diagnoses included, but were not limited to, cognitive communication deficient, atrial fibrillation, and dementia. A facility shower sheet, dated 6/26/24 and signed by a QMA on the nurse signature line, indicated .red bruising was found on both shoulders. On the same document, dated 6/28/24, the resident was given a bed bath. There was no note of bruising on the sheet. The next entry on the same document, dated 7/5/24, indicated the resident had a shower. Faded bruising was noted at the area of both shoulders and the upper chest area. A facility document, titled SHOWER SHEET:SKIN CHECKS, dated 6/29/24 and provided by the Director of Nursing on 12/31/24 at 9:06 a.m., indicated the resident had .bruising near collarbone A Hospice visit note, dated 6/29/24, indicated the facility nurse had notified the Director of Nursing and the Administrator of bruising of unknown origin found around the resident's neck. It was described as red and purple bruising on the lower right side of her neck and circling around the front area of the body above the collarbone, between the neck and the muscle that ran from the back of the neck to the shoulder. The skin was found unbroken and did not appear to be from fingers, fingernails, or another object. The Medication Administration Record and Treatment Administration Record, for June 2024 and July 2024, did not have an order to monitor for bruising to the shoulders. There was no nurse's note found in the progress notes about the bruising. The facility was unable to provide an initial assessment, by a licensed staff member, when the bruising was found on 6/26/24. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 12/30/24 at 1:13 p.m., QMA 3 indicated if a new skin area was observed during a shower, it was noted on the shower sheet and the nurse was to be informed. The nurse would need to assess the area, measure it and document it. During an interview, on 12/30/24 at 12:58 p.m., LPN 5 indicated if a skin issue was identified the nurse would assesses the resident. If the skin issue did not dissipate, a skin alteration was put into risk management. She indicated the CNA, and the nurse were supposed to sign the shower sheet/skin sheet. The QMA could sign the form, but the QMA needed to take any issues or concerns to the nurse or unit manager. During an interview, on 12/31/24 at 8:45 a.m., the Director of Nursing indicated the facility did not have an initial assessment to show a licensed nurse had assessed the areas found on the resident's shoulders. During an interview, on 12/31/24 at 8:55 a.m., LPN 6 indicated if a new skin issue was found during the resident shower, the CNA was to inform the nurse and document it on the shower sheet. The licensed nurse was to assess and treat the resident, measure the area, and document the finding in risk management. Documentation would include the measurements of the area and a description of the skin concern. The skin concern would then be noted on the 24-hour sheet and reported to the next shift. An order would be put into the system to monitor the area every shift. Bruises were to be monitored for seven days or until healed. A current facility policy, titled GUIDELINES FOR SKIN OBSERVATION/ASSESSMENT, dated 5/28/23 and received from the Director of Nursing on 12/31/24 at 9:06 a.m., indicated .Only licensed nurses can assess the skin .If the care giver is not a nurse and they observe a change in the resident's skin, the care giver will notify the nurse immediately so the nurse can perform a skin assessment .Appropriate documentation .will be completed as per policy 3.1-37(a)