

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA 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, The		STREET ADDRESS, CITY, STATE, ZIP CODE  981 Beechwood Ave Middletown, IN 47356	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>28309</p> <p>Based on interview and record review, the facility failed to protect the resident's right to be free from verbal and physical abuse of a staff member towards a resident for 1 of 3 residents reviewed for abuse. (Resident D, CNA 6)</p> <p>Findings include:</p> <p>The clinical record of Resident D was reviewed on 4-26-24 at 9:43 a.m. Her diagnoses included, but were not limited to cerebral infarction due to occlusion or stenosis of MCA (middle cerebral artery) affecting the non-dominant left side with hemiplegia and hemiparesis. A review of Resident D's most recent Minimum Data Set assessment, dated 2-6-24, indicated her cognitive status was moderately impaired, she was non-ambulatory, used a wheelchair with assistance of 1 person for wheelchair mobility, required substantial assistance with bed mobility and was dependent for toileting needs and bathing assistance.</p> <p>In an interview with the Executive Director (ED) on 4-24-24 at 10:35 a.m., she indicated the facility recently had a new employee, CNA 6. She further explained the facility had received a report of rough treatment during care of a resident by a staff member, CNA 6. The ED summarized CNA 6 was terminated due to inappropriate language and intimidation and with her being on orientation, or just off of orientation, she was terminated due to the facility's zero tolerance policy towards abuse. The ED indicated she had submitted a report of the incident to the Indiana Department of Health's Long-Term Care Division on the same date the facility received the allegation of abuse.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 4-24-24 at 2:20 p.m., with Resident D, she indicated she is generally speaking, treated very well and very professionally, with one exception. She explained, recently, a new aide got upset with me when she was trying to roll me over [for incontinence care] and I told her it was hurting me. Sometimes, my joints just hurt and she just kept going on. She just didn't listen to me. Just kind of hurrying things along. So, I spoke with the administrator about it. I told her that I didn't want the girl punished, just talk to her about not rushing so much and listen to what people tell her. Well, later that day, she came back to me and told me, kind of hateful like, that she thought it awful that I told on her and now she was in trouble. She just stood in the doorway and kind of hollered at me, she definitely raised her voice to me. Later, when I was talking to somebody, I found out they let her go. I hate that, but you can't treat people that way. She added, due to the Administrator taking care of issues so quickly, she has no further concerns related abuse or neglect. By the administrator taking care of things so quick, it shows me they mean business and take care of things like they should.</p> <p>A review of CNA 6's employee file indicated she was hired on 4-10-24. Her employee file indicated she had completed education regarding resident rights, abuse prohibition and six hours of dementia care training on or before her hire date. A Personnel Change Form, dated 4-19-24 and 4-20-24, indicated CNA 6 was terminated, effective 4-19-24, by the facility for Violation of company policy.</p> <p>The investigative file of the allegation of abuse indicated the state reportable was faxed to the, Indiana Department of Health's Long-Term Care Division on 4-19-24, follow-up interviews with other residents regarding abuse were conducted, staff education was conducted with facility staff on 4-22-24, pre-employment screening for certification validity, criminal background check and reference checks, and Resident D was monitored for a minimum of 72 hours for any negative effects after this incident.</p> <p>On 4-25-24 at 1:20 p.m., the ED provided an undated copy of a policy entitled, Abuse Prevention Program. This policy indicated, to prevent resident abuse, neglect .Each resident receives care and services in a person-centered environment in which all individuals are treated as human beings .Staff members who are suspected of abuse or misconduct shall immediately (regardless of time left on shift) be barred from any further contact with residents of the facility and be suspended from duty, pending the outcome of the investigation, prosecution or disciplinary action against the employee.</p> <p>3.1-27(a)</p> <p>3.1-27(b)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>28309</p> <p>Based on interview and record review, the facility failed to implement policies and procedures protecting the resident's right to be free from verbal and physical abuse of a staff member towards a resident for 1 of 3 residents reviewed for abuse. (Resident D, CNA 6)</p> <p>Findings include:</p> <p>The clinical record of Resident D was reviewed on 4-26-24 at 9:43 a.m. Her diagnoses included, but were not limited to cerebral infarction due to occlusion or stenosis of MCA (middle cerebral artery) affecting the non-dominant left side with hemiplegia and hemiparesis. A review of Resident D's most recent Minimum Data Set assessment, dated 2-6-24, indicated her cognitive status was moderately impaired, she was non-ambulatory, used a wheelchair with assistance of 1 person for wheelchair mobility, required substantial assistance with bed mobility and was dependent for toileting needs and bathing assistance.</p> <p>In an interview with the Executive Director (ED) on 4-24-24 at 10:35 a.m., she indicated the facility recently had a new employee, CNA 6. She further explained the facility had received a report of rough treatment during care of a resident by a staff member. The ED summarized CNA 6 was terminated due to inappropriate language and intimidation and with her being on orientation, or just off of orientation, she was terminated due to the facility's zero tolerance policy towards abuse. The ED indicated she had submitted a report of the incident to the Indiana Department of Health's Long-Term Care Division on the same date as discovery of the allegation of abuse.</p> <p>In an interview on 4-24-24 at 2:20 p.m., with Resident D, she indicated she is generally speaking, treated very well and very professionally, with one exception. She explained, recently, a new aide got upset with me when she was trying to roll me over [for incontinence care] and I told her it was hurting me. Sometimes, my joints just hurt and she just kept going on. She just didn't listen to me. Just kind of hurrying things along. So, I spoke with the administrator about it. I told her that I didn't want the girl punished, just talk to her about not rushing so much and listen to what people tell her. Well, later that day, she came back to me and told me, kind of hateful like, that she thought it awful that I told on her and now she was in trouble. She just stood in the doorway and kind of hollered at me, she definitely raised her voice to me. Later, when I was talking to somebody, I found out they let her go. I hate that, but you can't treat people that way. She added, due to the Administrator taking care of issues so quickly, she has no further concerns related abuse or neglect. By the administrator taking care of things so quick, it shows me they mean business and take care of things like they should.</p> <p>The investigative file of the allegation of abuse indicated the state reportable was faxed to the, Indiana Department of Health's Long-Term Care Division on 4-19-24, follow-up interviews with other residents regarding abuse were conducted, staff education was conducted with facility staff on 4-22-24, pre-employment screening for certification validity, criminal background check and reference checks, and Resident D was monitored for a minimum of 72 hours for any negative effects after this incident.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of CNA 6's employee file indicated she was hired on 4-10-24. Her employee file indicated she had completed education regarding resident rights, abuse prohibition and six hours of dementia care training on or before her hire date. A Personnel Change Form, dated 4-19-24 and 4-20-24, indicated CNA 6 was terminated, effective 4-19-24, by the facility for Violation of company policy.</p> <p>On 4-25-24 at 1:20 p.m., the ED provided an undated copy of a policy entitled, Abuse Prevention Program. This policy indicated, to prevent resident abuse, neglect .Each resident receives care and services in a person-centered environment in which all individuals are treated as human beings .Staff members who are suspected of abuse or misconduct shall immediately (regardless of time left on shift) be barred from any further contact with residents of the facility and be suspended from duty, pending the outcome of the investigation, prosecution or disciplinary action against the employee.</p> <p>3.1-27(a)(1)</p> <p>3.1-27(b)</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>28309</p> <p>Based on observation, interview and record review, the facility failed to post the facility's nursing staffing for five (5) consecutive dates. This deficient practice has the potential to adversely affect all residents.</p> <p>Findings include:</p> <p>On 4-24-24 at 9:55 a.m., the facility's posted staffing was observed to be located by the nursing station. The posted staffing dates were for 4-18-24 and 4-19-24. This posting was unchanged at an observation conducted on 4-24-24 at 1:35 p.m.</p> <p>This posting was updated as of an observation on 4-25-24 at 1:56 p.m., to the current date of 4-25-24.</p> <p>In an interview with the Executive Director on 4-25-24 at 4:30 p.m., she indicated she has been conducting the nursing work schedules for some time at the facility.</p> <p>In an interview with the Executive Director on 4-25-24 at 4:45 p.m., she indicated had not noticed the daily posted nursing staffing sheets were not current.</p> <p>This Federal tag relates to Complaints IN00430719 and IN00432008.</p> <p>3.1-17(a)</p>

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.</p> <p>28309</p> <p>Based on interview and record review, the facility failed to ensure adequate nursing staff coverage for the long-term care portion of the facility, as well as for the secured dementia care unit of the facility for 1 of 1 night shift and for the 17 residents of the long-term care portion of the building and for 7 residents of the facility's secured dementia care unit of the facility.</p> <p>Findings include:</p> <p>In an interview with the Executive Director (ED) on 4-25-24 at 2:50 p.m., she indicated around the end of March and beginning of April of 2024, only one RN 4 and one CNA 3 were on duty for the night shift. She shared that on that particular night, CNA 3 called her around 11:00 p.m., to discuss some concerns she had regarding the facility. During the conversation, she mentioned that the memory care unit wasn't staffed and there was only a nurse and aide in the building and the door of the memory care unit was open and unlocked. I immediately came into the building. When I got here, I found the memory care unit door open to the long term care unit and obviously unlocked. [Names of RN 4 and CNA 3] were both on the long term care unit at that time. They explained that since they were the only two staff here, that was the best way to handle the situation. I immediately sent the nurse to the memory care unit and the memory care unit door was closed and locked. I had no idea any of this was going on until that moment. I have no idea how long this had been going on. Our census on that date was 22. She indicated she remained in the building for the rest of that shift and she noted none of memory care unit residents were up or wandering about.</p> <p>In a confidential interview, they indicated, It's not happened often, but there have been a few times where the locked unit has not had a staff person for night shift .I couldn't give you a date, but I am aware of a time or two when the locked unit was left unlocked when I have checked it when I come in at 6 am. They indicated they did not report the memory care unit being unlocked to management as they thought management would be aware of this since management puts together the schedules.</p> <p>On 4-26-24 at 10:42 a.m., the ED provided an updated Midnight Census Report, for 3-20-24, indicating the facility's census included 7, memory care unit residents and 17, long-term care unit residents, for a total census of 24 residents.</p> <p>In an interview with the ED on 4-25-24 at 4:30 p.m., she clarified the night shift was the date of 3-20-24 into 3-21-24. The ED indicated shortly thereafter [date unspecified], education with the licensed nurses was conducted regarding notification to management of any changes in the schedule and the memory care unit is to be staffed at all times and the door is to be secured/locked at all times.</p> <p>4-30-24 at 4:30 p.m., the ED indicated, My expectations for the memory care unit is that it be locked/secured at all times and there be a nurse or aide present at all times.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4-25-24 at 5:06 p.m., the ED provided a copy of a document entitled, Facility Assessment Tool, with a revision date of 10-17-23. This document indicated the facility's staffing plan as, based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff to meet the needs of the residents at any given time, includes, but does not limit the nursing staffing to, 1 Nurse Nights .and 1 [nurse aide] nights, with staffing ratios of 1.25 licensed nurse and 1.25 certified nursing assistant for every 25 residents. [Name of the memory care unit] will always have a minimum of: Nurse or QMA on days/evenings [and] Night staff aide on-site related to census.</p> <p>This Federal tag relates to Complaint IN00431980.</p> <p>3.1-17(b)(1)</p> <p>3.1-17(c)(2)</p>		