STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	**07/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WATERS OF SCOTTSBURG, THE	**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)
F 0557 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident was treated with dignity upon return from the hospital for 1 of 3 residents reviewed for dignity. (Resident B) Finding included: The clinical record for Resident B was reviewed on 7/15/20 at 12: 30 p.m. The resident's [DIAGNOSES REDACTED]. A Nursing Note, dated 4/25/20 at 3:09 p.m., indicated the resident was experiencing respiratory issues with new orders by the physician to send the resident to the emergency room for evaluation. The Director of Nursing was notified of the need to transfer the resident to the hospital. The emergency room notes, dated 4/25/20, indicated the resident was seen for heart failure and elevated brain natruietic peptide (BNP) level. After treatment, the resident did not meet admission criteria and was transfer back to the nursing home. The facility was called and a report was given to the facility nurse. The ambulance arrived at the facility at 6:18 p.m. The review of the EMS (Emergency Medical Services) run report, dated 4/25/20, indicated the following, . ER staff stated they gave report to staff/ (name of nurse) .Pt (patient) was transported to (name of facility)/ Pt was moved from the Ambulance to the back door of (name of facility). EMS staff knocked on the door several times, staff looked up from the Nurses station without response. Nurse finally came to the door and refused to let EMS staff to bring the pt back into the building. Nurse stated she was told by the Administrative staff to not allow the Pt back in the building due to the fact that the resident had been to the ER and had the possibility of being exposed to COVID-19. EMS staff asked if they could bring the pt in out of the rain until we can work out the problem. Staff said no that they could not let us in .Pt was then moved back into the Ambulance to be protected from the weather . After (name of EMS worker) talked with (name of facility) staff they stated that the D.O.N. (Director of Nursing) stated they could except (sic) the Pt . The patient was finally placed in his bed by 6:35 p.m. During an interview on 7/15/20 at 1:35 p.m., RN 1 indicated she had received a call from the ER letting her know the resident was ready to return from the hospital and she accepted the re-admission orders [REDACTED]. She indicated she told the DON and the DON agreed the resident could come back, but the former Administrator turned around and said the resident could not return until he spoke with someone else to see if it was okay to re-admit the resident. By this time, the ambulance had arrived outside the facility and she informed the EMS personnel that the facility could not accept the resident back at this time. She was caught in the middle between the EMS staff and the Administrator. After 15 minutes, the DON finally gave consent that the resident could be readmitted . The resident had been placed back in the ambulance during this process. During an interview on 7/15/20 at 1:45 p.m., the DON indicated the former Administrator did not want anyone sent out to the hospital unless he approved, but the nurse used her nursing instincts and went ahead and sent the resident to the hospital anyway. When she was told by the nurse that the resident was ready to come back from the ER, she told the nurse that the Administrator had to approve his coming back and that he originally said no. The DON had gone back and forth with the Administrator about accepting the resident back and that after the Administrator had gotten approval from Corporate, she gave the nurse consent to go ahead and let EMS bring the resident back into the building. The whole event took about 15 minutes to be resolved. The resident was going to be placed back into isolation and monitored for 14 days. The incident should not have happened. This Federal tag relates to Complaint IN 979 3.1-3(t)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.