

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/21/2013
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NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932
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F000000	<p>This visit was for the Investigation of Complaint IN00129189.</p> <p>Complaint IN00129189 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F312, and F465.</p> <p>Survey Date: 5/21/2013.</p> <p>Facility Number: 000128 Provider Number: 155223 AIM Number: 100289650</p> <p>Survey Team: Heather Lay, RN - TC</p> <p>Census Bed Type: SNF: 0 SNF/NF: 103 Total: 103</p> <p>Census Payor Type: Medicare: 26 Medicaid: 60 Other: 17 Total: 103</p> <p>Sample: 6</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p>	F000000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. We respectfully request a desk review regarding this survey.	

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.

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	Quality Review completed on 05/22/2013 by Brenda Nunan, RN.			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a fall intervention of having a call light within reach of a resident with a history of unassisted transfers for 1 of 3 residents reviewed for falls and failed to provide scheduled showers to a resident who required extensive assistance with cleanliness and grooming for 1 of 6 residents reviewed for activities of daily living [Resident E].</p> <p>Findings include:</p> <p>1. On 5/21/13 at 9:50 A.M. through 11:50 A.M., Resident E was observed in bed with her call light laying on the floor at that head of the bed. At that time, in an interview, Resident E indicated she was unaware where her call light was located.</p> <p>On 5/21/13 at 11:15 A.M., Resident E's record was reviewed. Diagnoses included, but were not limited to, diabetes, hypertension, and psychosis.</p>	F000282	<p>F-282 It is the intent of this facility to minimize the opportunity for resident falls. A. Action Taken: A 100% audit of all call light fastening clips was completed 5/22/13. Nursing personnel will be inserviced to ensure that call lights are properly placed within resident reach at all times. B. Others Identified: No other residents were identified during a 100% audit on 5/22/13 of call light placement. C. Measures Taken: Quality Assurance Team will monitor call light placement during daily QA rounds to ensure they are properly fastened and within resident reach. D. How Monitored: The DON/designee will make perform random call light checks daily on working days for 2 weeks, then weekly for 1 month then continue monthly. Results of the audits will be reviewed by the CEO/designee at the quarterly Quality Assurance Meeting. E. Completion Date: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is June 20, 2013.</p>	06/20/2013

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	<p>A quarterly Minimum Data Set screening, dated 3/11/13 indicated the resident had cognitive impairment and required extensive assistance of 2 or more staff for transfers and bathing.</p> <p>A "Fall Care Plan," dated 12/20/12, indicated, "...Resident [E] at risk for fall related to hypertension, diabetes, poor safety awareness at times, antipsychotic medication use, weakness, and limited mobility... Resident [E] will have no falls... Assist with Activities of Daily Living [ADLs]/transfers as needed, Keep call light in reach, Non-skid socks, Low bed with mats, bed alarm and chair alarms added..."</p> <p>A "Nurses Notes," dated 2/21/13 at 8:45 A.M., indicated, "...Resident [E] fell in room... Found laying on left side... Denies any complaints of pain...."</p> <p>A "Nurses Notes," dated 3/1/13 at 9:45 P.M., indicated, "...Resident [E] found by Certified Nursing Aide [CNA] laying on right side... Denies hitting head, states bumped right knee and it's sore, no injuries noted...."</p> <p>A "Nurses Notes," dated 3/2/13 at 11:00 A.M., indicated, "...Resident [E]</p>			

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	<p>fell attempting to get out of bed... CNA found laying on floor... Small abrasion to elbow and knee...."</p> <p>A "Nurses Notes," dated 3/13/13 at 6:05 A.M., indicated, "...Resident [E] found on floor... Was laying beside her mat... Denies pain...."</p> <p>A "Nurses Notes," dated 3/13/13 at 10:20 A.M., indicated, "...Called to resident's [Resident E's] room by housekeeper who witnessed resident fall... Resident [E] got up unassisted out of bed and stumbled and fell back... Observed to be sitting on mat next to bed... Resident [E] states she didn't hit her head... No injury noted...."</p> <p>A "Nurses Notes," dated 5/12/13 at 10:45 A.M., indicated, "...Resident [E] attempting to get self out of bed and stated I rolled onto my knees... Found laying on right side on floor... Denies pain...."</p> <p>2. On 5/21/13 at 10:37 A.M., in an interview, Resident E's granddaughter indicated the facility failed to give Resident E a shower on all scheduled shower days.</p> <p>On 5/21/13 at 1:15 P.M., the Director of Nursing [DoN] provided the</p>			

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	<p>"Nursing Assistant Pocket Worksheet," dated 5/21/13. The worksheet indicated Resident E received showers on Monday and Thursday and was an assist with Activities of Daily Living [ADLs].</p> <p>On 5/21/13 at 1:30 P.M., the Director of Nursing [DoN] provided Resident E's shower documentation for the last 3 months [March, April, and May, 2013]. At that time, in an interview, the DoN indicated staff were expected to complete a "CNA [Certified Nursing Aide] Bath Checklist" for each scheduled shower even if the resident refused care as a skin assessment should have been completed.</p> <p>The record indicated 2 showers per week were not given to Resident E for the following weeks: March, 2013: Week 1: Out to hospital, Week 2: No showers, Week 3: Only received 1 of 2 showers, and Week 4: Only received 1 of 2 showers. April, 2013: Week 1: Only received 1 of 2 showers, Week 2: No showers, and Week 3: No showers.</p> <p>On 5/21/13 at 2:25 P.M., the DoN indicated the facility did not have any additional documentation to provide.</p>			
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	<p>This federal tag relates to Complaint IN00129189.</p> <p>3.1-35(g)(2)</p>			

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on interview and record review, the facility failed to provide the care and assistance needed to meet the cleanliness and grooming needs of a resident who required extensive assistance. This deficient practice affected 1 of 6 residents reviewed for activities of daily living [Resident E].</p> <p>Findings include:</p> <p>On 5/21/13 at 10:37 A.M., in an interview, Resident E's granddaughter indicated the facility failed to give Resident E a shower on all scheduled shower days.</p> <p>On 5/21/13 at 1:15 P.M., the Director of Nursing [DoN] provided the "Nursing Assistant Pocket Worksheet," dated 5/21/13. The worksheet indicated Resident E received showers on Monday and Thursday and was an assist with Activities of Daily Living [ADLs].</p> <p>On 5/21/13 at 1:30 P.M., the Director of Nursing [DoN] provided Resident</p>	F000312	<p>F-312 It is the intent of this facility to ensure that all residents receive care and assistance needed to meet the proper cleanliness and grooming needs.</p> <p>A. Action Taken: Nursing personnel will be retrained regarding the proper completion of the Bath Check List; to include completing the Bath Check List when the resident refuses a bath by June 10, 2013. B. Others Identified: No other residents were identified based on a 100% audit of Bath Check Lists completed 5/22/13. C. Measures Taken: A Bath Check List binder was created and placed at each nursing station. The Charge Nurse must sign the Bath Check List upon completion of the bath by the CNA and place the document in the binder. D. How Monitored: The DON/designee will monitor the Bath Check List binder daily on working days for 2 weeks, then weekly for 1 month, then monthly and ongoing. The CEO/designee will review all audits in the quarterly Quality Assurance meeting. E. Completion Date: This plan of correction constitutes our credible</p>	06/20/2013	

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	<p>E's shower documentation for the last 3 months [March, April, and May, 2013]. At that time, in an interview, the DoN indicated staff were expected to complete a "CNA [Certified Nursing Aide] Bath Checklist" for each scheduled shower even if the resident refused care as a skin assessment should have been completed.</p> <p>The record indicated 2 showers per week were not given to Resident E for the following weeks: March, 2013: Week 1: Out to hospital, Week 2: No showers, Week 3: Only received 1 of 2 showers, and Week 4: Only received 1 of 2 showers. April, 2013: Week 1: Only received 1 of 2 showers, Week 2: No showers, and Week 3: No showers.</p> <p>On 5/21/13 at 2:25 P.M., the DoN indicated the facility did not have any additional documentation to provide.</p> <p>This federal tag relates to Complaint IN00129189.</p> <p>3.1-38(a)(3)(A)</p>		allegation of compliance with all regulatory requirements. Our date of completion is June 20, 2013.				

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F000465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a resident's wheelchair remained clean and sanitary. This deficient practice affected 2 of 6 residents reviewed for a clean and sanitary environment [Residents E and G].</p> <p>Findings include:</p> <p>1. On 5/21/13 at 9:20 A.M., tour of the facility was initiated with the Assistant Director of Nursing. At that time, Resident E's wheelchair was observed outside her room in the hallway. The wheelchair had a cushion with food debris as well as smeared, light brown debris observed under the cushion.</p> <p>On 5/21/13 at 1:25 P.M., the Director of Nursing [DoN] provided a "Third Shift Nightly Duties" sheet, dated 5/2/13 that indicated Resident E's wheelchair had been cleaned on 5/2/13. She did not provide any other documentation of wheelchair cleaning for Resident E. There was no documentation of Resident E's</p>	F000465	<p>F-465 It is the intent of this facility to maintain a safe, functional, sanitary and comfortable environment for all residents, staff and the public. A. Action Taken: The two identified wheelchairs were immediately cleaned once noted. A 100% audit of all wheelchairs was completed 5/22/13 and appropriate action taken. B. Others Identified: Based on the 100% audit on 5/22/13, no other resident wheelchairs were identified as requiring cleaning. C. Measures Taken: A Wheelchair Cleaning List binder was created and placed at each nursing station. The Charge Nurse must sign the Wheelchair Cleaning List upon confirming the wheelchair has been cleaned by the CNA and place the document in the binder. Nursing personnel will be inserviced regarding the wheelchair cleaning procedure by 6/10/13. D. How Monitored: DON/designee will audit the Wheelchair Cleaning List and observe wheelchairs daily for 2 weeks, then weekly for a month and then monthly and ongoing. The CEO/designee will review all audits in the quarterly Quality Assurance Committee meeting. E.</p>	06/20/2013			

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	<p>wheelchair being cleaned for weeks 2 and 3 of May, 2013.</p> <p>2. On 5/2/13 at 9:30 A.M., Resident G's wheelchair was observed outside her room in the hallway. At that time, the wheelchair was observed with cushion with food debris as well as smeared, light brown debris under the cushion.</p> <p>On 5/21/13 at 1:25 P.M., the DoN provided "Third Shift Nightly Duties" sheets for the dates of 5/8/13 and 5/15/13. At that time, in an interview, the DoN indicated that although wheelchairs were cleaned once per week on the night shift, some residents are more messy during the day like Resident G and staff were expected to keep the resident's equipment clean.</p> <p>This federal tag relates to Complaint IN00129189.</p> <p>3.1-19(f)</p>		<p>Completion Date: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is June 20, 2013.</p>		