STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155304	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF NEW CASTLE THE	1000 N 16TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for the a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00139948. Complaint IN00139948 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: January 5, 8, 9, and 10, 2014 Facility number: 000201 Provider number: 155304 AIM number: 100267910 Survey team: Barbara Gray, RN, TC Penny Marlatt, RN Leslie Parrett, RN Angel Tomlinson, RN Census bed type: SNF: 3 SNF/NF: 50 Total: 53 Census payor type: Medicare: 24 Medicaid: 20 Other: 9 Total: 53	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.This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is February 9, 2014.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on January 13, 2014, by Janelyn Kulik, RN.			
F000315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on interview and record review, the facility failed to have a medical diagnosis or physician's order for an urinary Foley catheter, for 1 of 2 residents reviewed for a urinary catheter of the 2 who met the criteria for urinary catheter. (Resident #115)	F000315	F315It is the intent of this facility to ensure a physician order and medical diagnosis is present for urinary foley catheter use.1. Corrective action for affected resident(s):Resident #115 was no longer in the facility.2. Other residents with potential to be affected:Audit completed for all residents identified with an urinary foley catheter - Physician order and diagnosis present. 3.	02/09/2014

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	Findings include: On 1/5/14 at 3:22 P.M., RN #1 indicated Resident #115 had an indwelling Foley catheter for a diagnosis of chronic kidney disease. On 1/8/14 at 9:25 A.M., the MDS Coordinator indicated Resident #115 had been transferred to a local hospital that morning. On 1/9/14 at 1:05 P.M., Resident #115's spouse indicated he remained in the local hospital. Resident #115's record was reviewed on 1/10/14 at 10:00 A.M. Resident #115 was admitted to the facility on 12/27/13, from a local hospital. Diagnoses included hypotension, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, thrombocytopenia, myelodysplastic syndrome, other abnormal blood chemistry, pain in his shoulder joints, pain in his lower leg, generalized muscle weakness, debility, chronic ischemic heart disease, diabetes, osteoarthrosis, and malnutrition of moderate degree. A local hospital note for Resident		Measures to prevent reoccurrence:Inservice held for licensed nurses and IDT team members re: MD order and diagnosis for use of urinary foley catheter. 4. Monitoring of corrective action to ensure the practice will not recur:The DON/designee will complete an audit of residents with urinary foley catheter use weekly for one month, bi-weekly for one month, and then monthly. This plan of correction will be monitored weekly during the CQI/PAR meeting and again at the quarterly QA meeting with the Administrator. 5. Date systematic changes will be completed: 2/9/2014	

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	#115 indicated he was admitted to the local hospital on 12/23/13, with diagnoses of hypotension, anemia, and acute renal failure. A local hospital physician's order for Resident #115 dated 12/23/13, indicated to anchor a Foley catheter. A local hospital physician's order for Resident #115 dated 12/27/13, indicated he would be discharged to the Extended Care Facility. His anchored Foley catheter was to be removed upon his arrival to the Extended Care Facility. A December 2013 Treatment Record for Resident #115 indicated he would receive catheter care every shift. A January 2014 Treatment Record for Resident #115 indicated he would receive catheter care every shift. The catheter care was documented as completed from 1/1/14 through 1/7/14. Resident #115 had catheter output documented daily from 12/30/13 until 1/8/14. Resident #115's admission Minimum Data Set (MDS) assessment dated			

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	1/3/14, indicated he had an indwelling urinary catheter. No documentation was available in Resident #115's record of a physician's order or a diagnosis for an indwelling urinary catheter. The facility was unable to provide a physician's order or diagnosis for his indwelling urinary catheter. On 1/10/14 at 11:40 A.M., the MDS Coordinator indicated Resident #115 was admitted to the facility from a local hospital on 12/27/13, with an indwelling Foley catheter. She indicated Resident #115 had the indwelling Foley catheter since he was admitted to the facility. She indicated catheter care was initiated on his treatment record and his intake and catheter output were monitored. She indicated when she was working on his MDS assessment she realized he did not have a physician's order for the catheter. She indicated she reviewed Resident #115's record and believed the urinary catheter was anchored for urinary retention. She indicated she was going to clarify the need for the catheter and get an order from the physician. She indicated Resident #115 was transferred to a local hospital on			

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	1/8/14, before she had spoke with the physician to obtain an order and diagnosis. On 1/10/14 at 1:15 P.M., the Medical Director reviewed Resident #115's local hospital medical records. He indicated he was unable to find any hospital documentation on Resident #115 as to what his medical diagnosis was for the urinary catheter. On 1/10/14 at 1:58 P.M., CNA #2 indicated she had assisted Resident #115 on 1/6/14 and 1/7/14, with turning and repositioning. She indicated he had a indwelling urinary catheter and she completed catheter care on him. On 1/10/14 at 2:00 P.M., RN #3 indicated Resident #115 had an indwelling Foley catheter when she cared for him on 1/3/14. On 1/10/14 at 3:55 P.M., the MDS Coordinator indicated when she had completed Resident #115's admission MDS she had added the diagnosis of retention of urine but the diagnosis was incorrect. The "PAR (Persons at Risk)" policy and procedure provided by the MDS			

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	Coordinator on 1/10/14 at 3:35 P.M., indicated the following: "Guideline: It is the intent of this facility to aggressively address the status of residents who are considered to be at risk. Responsibility: It is the responsibility of the PAR Committee to screen residents to be added to the PAR program. Definitions of PAR Residents - ...11.) Residents who have catheters... The following are to be reviewed each week by the PAR Committee. A Committee member is assigned to document (and sign) resident conditions and changes on the PAR sheet. All residents records are to be at the PAR meeting along with other documents as needed, e.g., incident reports, intake records. Manually update Care Plans at the time of the PAR meeting as needed. Designate staff member to complete additional documentation/changes as outlined below... Foley Catheter - 1.) Review to ensure appropriate medical diagnosis to support catheter use. 2.) Review nurse's notes. 3.) Review intake and output records (as appropriate). 4.) Ensure the use of a privacy bag over catheter bag. 5.) Review medications - any infection processes? 6.) Review appropriateness of removing catheter. 7.) Update care plan (as			

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	appropriate). 8.) Complete nursing note (as appropriate). 9.) Document changes on 24 hr. report sheet. 10.) Update C.N.A. assignment sheet (as appropriate)...." 3.1-41(a)(1)			
F000323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure hot water was maintained at a safe temperature for random testing in the bathrooms of 16 residents, of 53 residents who resided in the facility. (Room #308, #300, #342, #332, #350, #356,	F000323	It is the intent of this facility to ensure hot water is maintained at a safe temperature.1. Corrective action for affected residents:HCH Maintenance Director was contacted and hot water temperatures were adjusted.2. Other residents with potential to be affected:Facility determined that all residents have the	02/09/2014

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	#372, #378, #382, and #328) Findings include: Random water temperatures were tested in the resident's bathrooms and indicated the following temperatures: On 1/5/14 at 1:38 P.M., room #308's water temperature reached 120.9 degrees. Resident #43 resided in the room and at that time denied ever being harmed by the water temperature. On 1/5/14 at 2:20 P.M., room #300's water temperature reached 120.9 degrees. Resident #70 resided in the room and at that time denied ever being harmed by the water temperature. On 1/5/14 at 4:42 P.M., room #342's water temperature reached 124.2 degrees. Resident #19 and #39 resided in the room and at that time denied ever being harmed by the water temperature. On 1/5/14 at 5:23 P.M., room #332's water temperature reached 126.5 degrees. Resident #114 and #115 resided in the room and at that time denied ever being harmed by the water temperature. On 1/5/14 at 5:37 P.M., room #350's water temperature reached 125.8 degrees. Resident #78 and #103 resided in the room. On 1/5/14 at 5:40 P.M.,		potential to be affected.3. Measures to prevent reoccurrence:Environmental Services Supervisor/designee will perform and log 3 random water temperatures daily with notification to HCH Maintenance for temperatures outside of the 105-120 degree range. 4. Monitoring of corrective action to ensure the practice will not recur:Water temperature logs will be reviewed with the Administrator in the monthly safety meeting and again the the quarterly QA meeting. 5. The date systematic changes will be completed: February 9, 2014	

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	room #356's water temperature reached 130.5 degrees. Resident #66 and #16 resided in the room. At that time Resident #16 denied ever being harmed by the water temperature. On 1/5/14 at 5:47 P.M., room #372's water temperature reached 127.4 degrees. Resident #6 resided in the room and at that time denied ever being harmed by the water temperature. On 1/5/14 at 5:48 P.M., room #378's water temperature reached 125.4 degrees. Resident #48 and #27 resided in the room. At that time Resident #48 denied ever being harmed by the water temperature. On 1/5/14 at 5:50 P.M., room #382's water temperature reached 125.3 degrees. Resident #71 resided in the room and at that time denied ever being harmed by the water temperature. On 1/5/14 at 6:36 P.M., room #328's water temperature reached 124.0 degrees. Resident #33 and #88 resided in the room and at that time denied ever being harmed by the water temperature. On 1/5/14 at 5:44 P.M., the Administrator indicated water temperature maintenance included random daily water temperatures tested and documented by the			

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	Environmental Services Supervisor. She indicated if the water temperatures were out of an acceptable range the Environmental Services Supervisor would contact the hospital's Maintenance Director to have the water temperature adjusted. On 1/5/14 at 6:37 P.M., the Environmental Services Supervisor provided for review, the "Domestic Water Temperature Logs" from 1/1/13 until 1/4/14. All water temperatures documented indicated no water temperature exceeded 120.0 degrees. He indicated his water temperature maintenance included taking 2 random water temperatures everyday, Monday through Friday. He indicated if he had any temperatures that exceeded 120.0 degrees he would notify the hospital's Maintenance Director of the need to adjust the water temperature. He indicated he would continue to test the water temperatures until they were in an acceptable range below 120.0 degrees. On 1/8/14 at 10:33 A.M., the Administrator indicated no resident had ever complained of harm related to the water temperatures. She			

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	indicated there had been no incidents of burns related to the water temperatures. On 1/8/14 at 11:23 A.M., the Administrator indicated the facility did not have any policy and procedure related to water temperatures. She indicated the "Domestic Water Temperature Log" stated the water temperature should remain in the range of 105.0 to 120.0 degrees and that was the range the facility followed. A copy of the "Domestic Water Temperature Log" provided by the Administrator on 1/8/14 at 11:51 A.M., indicated the following: "The water temperatures must be maintained between 105 degrees Fahrenheit and 120 degrees Fahrenheit, any reading above or below these ranges the Administrator and Property Manager must be notified immediately." 3.1-45(a)(1)			

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F000441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility	F000441	It is the intent of this facility to ensure sanitary practices are	02/09/2014

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	failed to use sanitary practices while serving 1 resident his meal, for 1 of 2 dining observations observed. This practice had the potential to affect all 53 residents who resided in the facility. (Resident #125) Findings include: On 1/5/14 at 1:03 P.M., Social Services was observed assisting Resident #125 with his meal in his bedroom. Social Service moved Resident #125's plastic catheter bag from one side of his bed and hung it on the other side of the bed on the bed rail. She had not donned gloves prior to moving the catheter bag. She then, opened a pepper packet and sprinkled the pepper on his food and opened 2 sugar packets and sprinkled in his coffee. On 1/5/14 at 1:07 P.M., Social Services indicated she would normally wear gloves to move the catheter bag and wash her hands after that and prior to opening the pepper and sugar packets. She indicated she had not donned gloves prior to moving the catheter bag and had not washed her hands after that and prior to opening the pepper and sugar packets.		used while serving resident meals. 1. Corrective action for affected resident:Staff person stated procedure that should have been followed. 2. Other residents with potential to be affected: All residents have the potential to be affected. 3. Measures to prevent re-occurrence:In-Service education with all staff covering Standard Precautions in regards to glove use and Hand Hygiene. DON/designee to monitor dining service 1 time a week times 4 weeks, bi-weekly times 4 weeks, then monthly to ensure hand hygiene is occurring. 4. Monitoring of corrective action to ensure the practice will not recur: DON/designee will review the outcome of the dining service audit with the administrator during the quarterly QA meeting. 5. The date systematic changes will be completed: February 9, 2014	

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	The "Standard Precautions" policy and procedure provided by the Administrator on 1/10/14 at 10:02 A.M., indicated the following: "B. Gloves - Wear gloves (clean, non-sterile gloves are adequate) when touching blood, body fluids, secretions, excretions, and contaminated items. Put on clean gloves just before touching mucous membranes and nonintact skin. Change gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching noncontaminated items and environmental surfaces, and before going to another patient, and wash hands immediately to avoid transfer of microorganisms to other patients or environments...." The "Hand Hygiene" policy and procedure provided by the Administrator on 1/10/14 at 11:54 A.M., indicated the following: "Purpose: Hand hygiene is the single most efficient means of preventing the spread of infection. Indications for Hand Washing and Hand Antisepsis Hand Washing: Wash hands with either a non-antimicrobial soap and water or			

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	an antimicrobial soap and water when hands are visibly dirty or are visibly soiled with blood or other body fluids such as urine or feces. Wash hands with either a non-antimicrobial soap and water or an anti-microbial soap and water if exposure to a spore forming organism is suspected or proven. Wash hands before eating, after eating and after using the restroom with a non-anti-microbial soap and water or an anti-microbial soap and water. Hand Antisepsis and Alcohol Based Hand Rubs: If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations. Some of these situations include before and after contact with residents, before putting on and taking off gloves, and before handling an indwelling catheter or other invasive devices that do not require a sterile procedure. Alcohol-based waterless antiseptic agents are the most effective way to remove germs and are considered the gold standard. Decontaminate hands before and after contact with a resident's intact skin such as lifting a resident or taking a blood pressure. Decontaminate hands after contact with bodily fluids or excretions, mucous membranes,			

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	non-intact skin and wound dressings if hands are not visibly soiled. Decontaminate hands if moving from a contaminated body site to a clean body site during resident care. Decontaminate hands after contact with an inanimate object in the immediate vicinity of the resident. Decontaminate hands after removing gloves...." 3.1-18(l)			
F009999	3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording, unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting	F009999	It is the intent of this facility to ensure employees have a timely tuberculosis screening prior to employment. 1. Corrective action for affected resident(s): 2 step PPD for Laundry Staff #1 was initiated 1/10/2014 and read 1/13/2014. 2nd step is due to be administered 1/24/14 - 1/31/14. CNA #1 and Laundry Staff #2 had been given the 1st and 2nd step PPD October 2013 & November 2013 when it was noted the new employment PPD's were missing. 2. Other resident with potential to be affected: All residents have the potential to be affected. 3. Measures to prevent reoccurrence: Business Office Manager/HR/designee to audit new employees hired in the past 12 months to ensure a 2 step PPD was completed. This audit	02/09/2014

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	work. The facility must assure the following: (1) At the time of employment, or within one (1) prior to employment, and at least annually thereafter, employees and non-paid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of testing of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record that includes the following: (A) a report of the pre-employment physical examination. (B) reports of all employment-related health examinations.		will then be completed on a monthly basis. 4. Monitoring of corrective action to ensure the practice will not recur: The Business Office Manager/HR/designee will complete a monthly summary audit to be presented to the Administrator during the quarterly QA meeting related to completion of 2 step PPD's at time of employment. 5. The date systematic changes will be completed: 2/9/2014	

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	This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure employees had a timely tuberculosis screening prior to employment. This deficient practice had the potential to adversely affect all residents. (Laundry Staff #1, Laundry Staff #2, CNA #1) Findings include: Employee records were reviewed on 1-10-14 at 10:50 a.m. 1. Review of Laundry Staff #1's employee record indicated she began employment on 2-20-13. It indicated she was administered her initial PPD on 2-20-13. It did not indicate the test had been read by facility staff, thus no results were documented. Documentation did not indicate any repeat PPD or second step PPD testing was conducted, nor a TB assessment was conducted. 2. Review of CNA #1's employee file indicated she began employment on 7-31-13. It indicated she was administered her initial PPD on 10-15-13 and her second step PPD			

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	on 11-5-13. In interview with the Dirctor of Nursing (DON) on 1-10-13 at 2:35 p.m., she indicated the employee had received an initial PPD on 7-31-13, but no one had read or documented the results. She indicated she was unable to locate a TB assessment for this employee. 3. Review of Laundry Staff #2's employee file indicated she began employment on 8-14-13. It indicated she was administered her initial PPD on 10-17-13 and her second step PPD on 11-5-13. In interview with the DON on 1-10-14 at 2:35 p.m., she indicated the employee had received an initial PPD on 8-14-13, but no one had read or documented the results. She indicated she was unable to locate a TB assessment for this employee. On 1-10-14 at 3:20 p.m., the DON provided a copy of a policy entitled, "Tuberculosis Surveillance." This policy indicated a risk assessment tool for TB shall be conducted annually for each employee or volunteer. It indicated employees and volunteers must be tested for TB prior to employment and annually thereafter with a one-step PPD administered to each employee			

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	and volunteer based upon the risk assessment tool. It indicated for those persons who have tested positive in the past or completed adequate prevention therapy or completed adequate therapy for active disease, those persons should not be tested with a PPD test.			