

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155483	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/28/2015
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NAME OF PROVIDER OR SUPPLIER WATERS OF RISING SUN, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 405 RIO VISTA LN RISING SUN, IN 47040
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00177802.</p> <p>Complaint IN00177802 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: July 22, 23, 24, 27, and 28, 2015</p> <p>Facility number: 000405 Provider number: 155483 AIM number: 100273800</p> <p>Census bed type: SNF/NF: 49 Total: 49</p> <p>Census payor type: Medicare: 6 Medicaid: 35 Other: 8 Total: 49</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of 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.</p> <p>Facility is requesting paper compliance for all deficiencies in this POC.</p>	
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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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F 0371 SS=E Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to remove, separate and discard dented cans from general food stock. This deficient practice had the potential to affect 48 residents who received meals prepared in the facility kitchen.</p> <p>Findings include:</p> <p>The initial kitchen tour was conducted with Dietary Aide (DA) #1 on 07/22/2015 at 10:22 A.M. In the food storage area, three large canned goods were observed with large dents. One six pound can of spinach, with received dated of 06/26/2015, had five large dents on three sides with the top of the can pressed down uneven from a crease in the side of the can. The second six pound can of spinach, with received dated of 07/16/2015, had two large dents on the sides of the can. The dents were three and four inches long. The third dented</p>	F 0371	<p>F_371F Food procure, store/prepare/serve - sanitary The facility's intent is to ensure all food is stored, prepared, distributed and served under sanitary conditions. ACTIONS TAKEN: All dented cans were immediately removed from the facility. Dietary staff were in-serviced on facility food storage policy. OTHERS IDENTIFIED: All residents have the potential to be affected. An audit of the storage room has been completed with no findings. MEASURES TAKEN: The Policy for storing food was reviewed with no changes. Dietary staff, including the Dietary Manager were in-serviced on food storage and storage of dented cans policy. HOW MONITORED: The Dietary Supervisor or her designee will monitor all food deliveries from the distributor to ensure all cans with dents are either returned or stored in a designated area per facility policy until the damaged items are returned for credit. The Dietary</p>	08/10/2015

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	<p>can containing diced carrots, with a received dated of 07/14/2015, had one large crease on the lower side that measured four and a half inches wide with a deep quarter-inch crease.</p> <p>During an interview on 07/22/2015 at 10:33 A.M., DA #1 indicated she was not aware of problems with using dented cans or if the facility had a policy concerning usage of dented can goods.</p> <p>During an interview on 07/22/2015 at 10:56 A.M., Cook #2 indicated the dented cans should have been disposed of and not on the shelf with the general canned goods.</p> <p>During an interview on 07/23/2015 at 10:48 A.M., the Dietary Manager indicated the canned goods were supposed to be in a box by the door for the vendor to return. She was unaware of how the cans ended up on the shelf with the general canned goods. She indicated the vendor had delivered products the day before and might have placed the dented cans back on the shelf.</p> <p>A current policy, titled, "Food Storage (Dry/Refrigerated/Frozen)", was received from the Director of Nursing on 07/22/2015 at 10:40 A.M. and was dated effective 2011. The policy indicated "...</p>		<p>supervisor or her designee will utilize the "Dietary Food Storage Audit Tool" weekly for 4 weeks, then every two weeks times two months, then every month for 3 months ensuring 100% compliance is obtained and maintained. The Administrator will review all audits weekly. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is: August 10, 2015.</p>	

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F 0431 SS=D Bldg. 00	<p>Dented cans are set aside in a separate labeled area of the storeroom to avoid using them and discarded according to vendor procedure..."</p> <p>3.1-21(i)(1) 3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked,</p>			

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	<p>permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to follow current, acceptable practice for the disposal of expired medications for 1 of 1 medication refrigerators.</p> <p>Findings include:</p> <p>On 07/27/2015 at 10:22 A.M., an observation of the medication refrigerator was conducted with RN (Registered Nurse) #4. One open vial, labeled "Tuberculin, purified protein derivative, diluted/aplisol" was located in its medication box on the top shelf of the door. The medication's box was dated with an open date of 06/20/2015. RN #4 removed the barcode from the expired medication at this time and placed it on the pharmacy reorder form. She then placed the medication back into the refrigerator on the top shelf of the door.</p>	F 0431	<p>F_431E Drug records, Label/store drugs biological The facility's intent is to ensure to dispose of expired medications timely.</p> <p>ACTIONS TAKEN: Expired vial, "Tuberculin" was immediately removed and disposed of according to facility policy.</p> <p>OTHERS IDENTIFIED: 100% audit of all medication refrigerators and medication carts completed at the time of the occurrence with no findings. No others were affected. All medications in the facility were immediately audited for appropriate labels and expiration dates with no findings.</p> <p>MEASURES TAKEN: The Medication Labeling and Storage policy was reviewed with no changes made. An In-service was completed with nursing staff regarding expiration dates of medications as well as removal of expired medications from the refrigerator and medication cart.</p> <p>HOW MONITORED: The DON or her designee will monitor the results of Medication and Treatment cart evaluations. Each refrigerator and cart will be evaluated weekly for 4 weeks and</p>	08/10/2015

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	<p>During an interview on 07/27/2015 at 10:24 A.M., RN #4 indicated that when the Tuberculin medication expires, the nurse is supposed to pull the label from the box and put it on the reorder form. Then the nurse is supposed to put the medication back into the refrigerator until the replacement medication arrives. She further indicated that only nurses use the medication and they would know not to use it because they would see the open date and know it was expired.</p> <p>During an interview on 07/27/2015 at 11:22 A.M., RN #3 indicated when a medication expires it is destroyed. The nurse is supposed to take it out and fill out the form for pharmacy listing the patient and the name of the medication. Then the nurse wastes the medication with another nurse, sends a copy of the form to pharmacy, and gives the form to the DON (Director of Nursing). For the Tuberculin medication vial, RN #3 indicated that the nurse may leave the medication baggy in the refrigerator to show that a new vial has been ordered.</p> <p>The current medication storage policy,</p>		<p>every two weeks for two months, then every month for 3 months by the nurse on duty to ensure all medications are dated properly and any expired meds removed and disposed of according to facility policy. Pharmacy consultant will audit med carts quarterly. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is: August 10, 2015.</p>	

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F 0458 SS=D Bldg. 00	<p>titled "Medication Storage in the Facility", and dated 06/19/2012, was provided by the DON on 07/27/2015 at 10:39 A.M. The policy indicated, "...Outdated, contaminated, or deteriorated drugs ...will be immediately withdrawn from stock. They will be disposed of according to the drug disposal procedures, and reordered from the pharmacy if a current order exists."</p> <p>3.1-25(o)</p> <p>483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. Based on observation, interview and record review, the facility failed to provide at least 80 square feet per resident for 4 of 28 resident rooms. (Rooms 3, 4, 5 and 7). Findings include: During an environmental tour with the Administrator on 07/28/2014 at 1:15 P.M. and per facility documentation</p>			F 0458	<p>F_458D Bedrooms Measure at least 80 SQ FT/Resident ACTIONS TAKEN A letter requesting a room waiver for rooms 3,4, 5 and 7 was sent to Miriam Buffington, Enforcement Manager, Division of Long Term Care, in Indianapolis, Indiana on Friday 8/10/2015</p>		08/10/2015

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	<p>provided by the Administrator, the following rooms were observed to have less than 80 square feet per resident:</p> <p>*Room 3, SNF/NF, had the capacity of 3 resident beds and was 229 square feet, equaling 76.3 square feet per resident.</p> <p>*Room 4, SNF/NF, had the capacity of 3 resident beds and was 238 square feet, equaling 79.3 square feet per resident.</p> <p>*Room 5, SNF/NF, had 3 resident beds and was 202 square feet, equaling 67.3 square feet per resident.</p> <p>*Room 7, SNF/NF, had the capacity of 3 resident beds and was 207 square feet, equaling 69 square feet per resident.</p> <p>During an interview at the time of the facility tour, the Administrator indicated they would use the beds, if they got an admission, as last options and indicated he would like to continue the room waiver.</p> <p>3.1-19(1)(2)(A) 3.1-19(1)(3) 3.1-19(1)(8)</p>			