

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/26/2014
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NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
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F000000	<p>This visit was for the Investigation of Complaint IN00154716.</p> <p>Complaint IN00154716 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323 and F514.</p> <p>Unrelated deficiency is cited.</p> <p>Survey date: August 26, 2014</p> <p>Facility number: 000178 Provider number: 155280 AIM number: 100273840</p> <p>Survey team: Jennifer Carr, RN - TC Angie Halcomb, RN</p> <p>Census bed type: SNF/NF: 96</p> <p>Census payor type: Medicare: 10 Medicaid: 69 Other: 17 Total: 96</p> <p>Sample: 3</p> <p>These deficiencies also reflect State findings cited in accordance with 410</p>	F000000	<p>Enclosed please find the plan of correction for The Waters of Dillsboro/Ross Manor complaint survey IN00154716. We respectfully request a desk review for this complaint survey.</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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F000323 SS=E	<p>IAC 16.2-3.1.</p> <p>Quality Review completed on September 2, 2014, by Brenda Meredith, R.N.</p> <p>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, record review and interview, the facility failed to ensure that 2 of 3 residents reviewed for falls were as free of accident hazards as possible and to develop policies and procedures to prevent falls (Resident B and C).</p> <p>Findings include:</p> <p>Resident B was interviewed in her room on 8/26/2014 at 1:15 p.m. She indicated that she had fallen twice since being admitted to the facility 2/13/2013.</p>	F000323	<p>It is the intent of this facility to ensure residents are free of accident hazards as possible and to develop policies and procedures to prevent falls. A: ACTION TAKEN: 1. Resident B and C had a new fall risk assessment completed to accurately reflect current status. B: OTHERS IDENTIFIED: 1. 100% audit on all fall risk assessments was completed with no other residents identified. C: MEASURES TAKEN: 1: Nurses and CNA's were inserviced on fall prevention. 2: Nurses were inserviced on how to properly</p>	09/15/2014			

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	<p>Resident B's clinical record was reviewed on 8/26/2014 at 2:05 p.m. Diagnoses included, but were not limited to, obesity, schizophrenia, depression and diabetes. The 8/22/2014 Minimum Data Set (MDS) assessment indicated a Brief Interview for Mental Status (BIMS) score of 15 of 15; indicating Resident B was cognitively intact. The MDS assessment indicated 1 fall since her last quarterly MDS assessment.</p> <p>A 5/27/2014 Nurses Note indicated, "...resident was noted on floor...pain voiced to R) [right] hip, back and R) [right] upper leg....sent to [hospital] for evaluation and treatment....911 called for transport."</p> <p>Resident B's most recent Fall Risk Assessment, dated 2/12/2014, indicated that it was a "quarterly" assessment and did not quantify or indicate resident's fall risk.</p> <p>Resident B's Care Plan indicated, "Potential for falls...11/15/2013 - Res. [resident] sat self on floor d/t [due to] weakness. 5/27/14 - Res fell in room. Date initiated: 2/13/2014. Revision on: 5/28/2014." Interventions indicated the date each intervention was initiated and/or revised, and showed the most recent interventions initiated/revised was</p>		<p>complete a fall risk assessment. 3:Policy was developed on scoring of fall risk assessment results. 4:Fall risk assessments will be performed on all falls to ensure accuracy of current fall risk assessment. 5:Therapy will screen all residents with falls. 6:All falls and interventions will be placed on 24 hour report. D.HOW MONITORED: 1:DON/Designee will review all incidents through evaluation and determination of the root cause analysis for appropriate interventions daily in the CQI. 2:DON/Designee will discuss with MDS on completion and accuracy of fall risk assessments in the daily CQI. 3:All incidents will be reviewed in the monthly QA meeting with review for determination of ongoing actions/monitoring. E:This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is September 15, 2014.</p> <p>.....</p> <p>.....</p> <p>.....</p>	

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	<p>on 11/15/2013.</p> <p>Resident C's clinical record was reviewed on 8/26/2014 at 3:20 p.m. Diagnoses included, but were not limited to, Parkinson's disease, senile dementia, anxiety, cataract surgery, left eye removal, and vertigo.</p> <p>The 7/29/2014 Minimum Data Set (MDS) assessment indicated a Brief Interview for Mental Status (BIMS) score of 5 of 15; indicating Resident C was cognitively impaired. The MDS assessment indicated that she had 1 fall since the previous quarterly MDS assessment.</p> <p>The most recent Fall Risk Assessment, dated 6/4/2014, indicated that it was "quarterly" and did not quantify or indicate resident's fall risk. It further indicated, "No falls in last 3 months."</p> <p>Incident Reports related to falls were provided by Medical Records on 8/26/2014 at 3:10 p.m. The reports indicated that Resident C fell on 3/23/2014, 7/8/2014, 7/13/2014, 7/18/2014, 8/9/2014, 8/11/2014 and 8/14/2014.</p> <p>Resident C's Care Plan indicated, "Potential for falls R/T [related to]</p>						

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	<p>Parkinson's, dementia, knee buckles." Interventions indicated the date each intervention was initiated and/or revised. The Care Plan indicated no interventions and/or revisions were made related to falls between 3/23/2014 and 7/8/2014.</p> <p>On 8/26/2014 at 4:20 p.m., Medical Records provided the following three documents, indicating that they were the current "Fall" policy and procedure:</p> <ol style="list-style-type: none"> "Incident Documentation and Investigation" "Incident Documentation and Investigation Tool" "Interventions That May Be Considered To Prevent Reoccurrence: Fall" <p>Incident Documentation and Investigation indicated, "POLICY: All incidents involving resident care will be investigated and documented on the Incident Documentation and Investigation Tool...." The document did not indicate any policy and procedure related specifically to falls or fall prevention.</p> <p>On 8/26/2014 at 4:50 p.m., the Administrator indicated, "We don't use this [Interventions That May Be Considered To Prevent Reoccurrence: Fall] anymore. They do it all in the</p>			

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	<p>computer."</p> <p>During an interview with the Administrator, the Director of Nursing (DON), and the Assistant Director of Nursing (ADON) on 8/26/2014 at 4:46 p.m., all three indicated that there were no additional written policies and/or procedures related to falls and/or fall prevention. The DON indicated that nurses are "taught during training" what to do in the event of a fall. The Administrator indicated the procedure following a fall included, "They'll [staff] call [DON] and let them know if someone falls. She'll [DON] say, 'Do this for now.' and then discuss it in morning meeting." The DON indicated that she determines which interventions to initiate or revise, "...depending on the situation and resident. I don't cookie-cutter everything. I look at previous interventions for falls and go from there. They may not have any new interventions....I may ask the family and doctor for suggestions....I care plan all interventions." The DON indicated that she does "not always" review resident medications related to falls. The ADON indicated, "We never have." The DON and ADON both indicated that Fall Risk Assessments are done quarterly and not following recent falls or significant changes in status. The Administrator</p>			

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	<p>confirmed that the Fall Risk Assessments do not quantify or indicate the resident's fall risk. The DON indicated that interventions she considers following falls include, "They do therapy screening...that's the big one." When queried as to how changes in residents' fall risk are relayed to staff, the Administrator indicated, "The new intervention would be on the care plan." Regarding how changes in residents' fall risk and/or interventions are relayed to nurses and CNAs providing care, the ADON indicated, "It would depend on what our interventions are as to where it goes...it may have gone to CNA duties." The Administrator indicated, "How can we prove what we did if it's not in the care plan? Don't they do a 24 hour report [after a fall]?" The ADON replied, "They should...I'm not saying that always happens."</p> <p>On 8/26/2014 at 5:32 p.m., the DON indicated that, although Resident B's Care Plan related to falls indicated, "Revision on: 5/2/2014," there were no Care Plan interventions related to falls initiated or revised after 11/15/2013. She further indicated that Resident C did not have any Care Plan interventions related to falls initiated or revised between 3/23/2014 and 7/8/2014.</p>			

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F000514 SS=D	<p>This Federal tag relates to Complaint IN00154716.</p> <p>3.1-45(a)(2)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to document blood</p>	F000514	It is the intent of this facility to maintain clinical records on each resident in accordance with	09/15/2014	

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	<p>sugar testing for 1 of 3 residents reviewed for medication administration (Resident A).</p> <p>Findings include:</p> <p>The clinical record for Resident A was reviewed on 8/26/2014 at 11:30 a.m. The diagnoses included, but were not limited to, anemia, hypertension, septicemia, urinary tract infection, wound infection, diabetes mellitus and below the knee lower limb amputation.</p> <p>Resident A's Physician Orders for the month of July, 2014 indicated, "Humalog insulin subq (subcutaneous injection) per sliding scale ac (before meals) and hs (at bedtime). Resident A's MAR (medication administration record) for the month of July, 2014 indicated no documentation of blood sugars on 7/1/2014 or 7/2/2014 at the scheduled times of 6 a.m., 11 a.m., 4 p.m., and 9 p.m.</p> <p>During an interview on 8/26/2014 at 5:14 p.m., the BOM (Business Office Manager) indicated Resident A was in the facility on July 1, 2014 and July 2, 2014.</p> <p>During an interview on 8/26/2014 at 5:20 p.m., the Administrator indicated there</p>		<p>accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized. A:ACTION TAKEN: 1.100% audit on current residents with blood sugars, including results and any amounts given to ensure all documentation is accurate and complete. B:OTHERS IDENTIFIED: 1:No others identified. C:MEASURES TAKEN: 1. Nurses were inserviced on importance of accurate and completed documentation concerning blood sugars, results and any amounts given. 2.DON/Designee will review blood sugars, results and any amounts given 5XweekX2weeks,3XweekX2weeks, then 1Xweek and ongoing. 3.All blood sugars placed on 24 hour report. D:HOW MONITORED: 1:DON/Designee will bring to morning stand up meeting results of blood sugar audits for accuracy and completeness. 2:All rounds/audits will be reviewed at the monthly and quarterly QA meetings with the IDT for on-going progress. E:This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is September 15, 2014.</p>		

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	<p>was no documentation that Resident A received blood sugar testing on July 1, 2014 and July 2, 2014 for the scheduled times of 6 a.m., 11 a.m., 4 p.m., and 9 p.m.</p> <p>The current Medication Administration Policy and Procedure, provided by the Administrator on 8/26/2014 at 11:41 a.m., was reviewed on 8/26/2014 at 5:40 p.m. The document indicated, "Policy: To administer all medications safely and appropriately....Procedure: ...16....document medication administration with initials in appropriate spaces on Medication Administration Record (MAR)...20. When giving an injection, site rotation is charted in the appropriate space on the MAR."</p> <p>This Federal tag relates to Complaint IN00154716.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			

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