

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155217	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/27/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF HUNTINGBURG, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542
--	--

(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
--------------------	--	---------------	---	----------------------

F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00IN00199954 and Complaint IN00203455.</p> <p>Complaint IN00199954- Substantiated. Federal/State deficiencies are cited at F323.</p> <p>Complaint IN00203455 - Substantiated. Federal/State deficiencies are cited at F328.</p> <p>Survey dates: June 24 and 27, 2016</p> <p>Facility number: 000122 Provider number: 155217 AIM number: 100290560</p> <p>Census bed type: SNF/NF: 67 Total: 67</p> <p>Census payor type: Medicare: 7 Medicaid: 47 Other: 13 Total: 67</p> <p>Sample: 5</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. Facility's date of alleged compliance is: July 17 , 2016.</p> <p><b>Facility is respectfully requesting paper compliance for all deficiencies in this POC.</b></p>	
------------------------	--	--------	---	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155217	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/27/2016
NAME OF PROVIDER OR SUPPLIER  WATERS OF HUNTINGBURG, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542		
(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	
F 0323 SS=D Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by #02748 on June 30, 2016.</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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who was transferred with a hoier (mechanical) lift had 2 staff members assisting the resident, resulting in the resident falling from the lift, for 1 of 4 residents reviewed requiring hoier lift transfers, in a sample of 5. Resident B</p> <p>Findings include:  The clinical record of Resident B was</p>	F 0323	<p><b>F-323</b></p> <p>It is the policy of the facility to ensure that residentstransferred via a mechanical lift have 2 staff members assisting in the transfers. Resident B has 2 staff members assisting whenever they transfer her using a mechanicallift.</p> <p>Any resident requiring the use of a mechanical lift fortransfers has the potential to be affected by this finding.</p> <p>An audit was completed to obtain a target list of residents who require the use of a mechanicallift for transfers. All of theseresidents were reviewed to make certain their</p>	07/16/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155217	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF HUNTINGBURG, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542
--	--

(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
	<p>reviewed on 6/24/16 at 11:45 A.M. Diagnoses included, but were not limited to, cerebral infarction and heart failure.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 2/26/16, indicated Resident B scored a 3 out of 15 for cognition, with 15 indicating no memory impairment. The resident required total dependence of two+ staff for transfer, and did not ambulate.</p> <p>A resident care plan, initially dated 7/9/15 and revised on 2/21/16, indicated, "Resident is at risk for falls D/T [due to] history of fall." The Interventions included: "Staff to use hooyer lift to transfer with 2 assist."</p> <p>Nurse's Notes included the following notations:</p> <p>4/17/16 at 4:25 P.M.: "Resident fell to floor when hooyer lift tipped over during a transfer in which a CNA attempted alone...Resident complained of neck pain and 'hurting all over' sent to [name of hospital] for evaluation and treatment..."</p> <p>A Hospital Emergency Room record, dated 4/17/16 at 4:45 P.M., indicated, "...Location of injuries - (unable to determine due to dementia patient states she hurts everywhere) Chief Complaint:</p>		<p>MDSs and care plans and CNA informationsheets were accurate. The DON/designee will monitor 10 mechanical lift transfers weekly. Those observations will be on various shifts by various nursing staff and will include some weekend days. Any concerns observed during this monitoring will be corrected prior to a breach in technique/procedure occurring and education will be given at the time. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, 5 transfers will be observed/monitored weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur.</p> <p><b>At an in-service held April 20, 2016,</b> for nursing staff the following was reviewed:</p> <ol style="list-style-type: none"> <li>1. Resident Rights—Safety and Freedom from Accidents/Hazards</li> <li>2. Mechanical Lift Transfers—Policy &amp; Procedure (Why? Who? When? Where? By Whom?)</li> <li>3. Care Plans—MDSs—CNA Assignment Information as related to Mechanical Lifts</li> <li>4. Return Demonstrations—Documented and signed off for all nursing staff by an Administrative Nurse</li> <li>5. Discussion</li> </ol> <p>Any staff who fail to comply with the points of their service will be</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155217		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/27/2016	
NAME OF PROVIDER OR SUPPLIER  WATERS OF HUNTINGBURG, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542			
(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
	<p>FALL...(patient was being picked up by a lift assist device and the machine toppled dropping her to the ground). The patient complaints of moderate pain...."</p> <p>Nurse's Notes, dated 4/19/16 at 7:29 A.M., indicated, "...pain med x 1 at hs [bedtime] given for complaints of pain et [and] effective...7 cm x 7.5 cm [sic] to rt [right] deltoid/shoulder noted et 2.5 cm x 3 cm bruise to rt calf noted. MD updated...notified of noted bruising from previous fall...."</p> <p>On 6/24/16 at 1:35 P.M., CNA # 3 and CNA # 4 indicated they were going to transfer Resident B from the chair to the bed. Resident B was observed being transferred with the hooyer lift and the assistance of both CNAs. CNA # 3 indicated staff "always use 2 staff for a hooyer lift."</p> <p>On 4/24/16 at 2:35 P.M., during an interview with CNA # 1, she indicated she was transferring Resident B from the bed to the chair. She indicated the resident was in the hooyer lift sling, and she was getting the resident aligned, when the hooyer lift tipped. CNA # 1 indicated she knew she was supposed to have 2 people to transfer the resident, but "was in a hurry."</p>				<p>further educated and/or progressively disciplined asindicated.</p> <p>At the monthly Q. A. meetings the results of themonitoring by the DON/Designee will be reviewed. Any concerns will have been corrected asobserved and prior to a breach being committed. Any patterns will be identified and ifnecessary an Action Plan will be written by the committee. Any Action Plan will be monitored weekly bythe Administrator until resolution.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155217	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/27/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF HUNTINGBURG, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542
--	--

(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
	<p>On 6/24/16 at 3:10 P.M., the MDS Coordinator provided the current facility "Policy and Procedure for Hoyer Lift Transfer Usage," dated 3/22/11. The policy included, "...All residents determined to require a two person transfer will be transferred with use of a Hoyer or Sit-to-Stand Lift...The Hoyer Lift should always be used with two people. One person should be helping control the mechanism and opens the legs of the lift for optimal stability...."</p> <p>This Federal tag relates to Complaint IN00199954.</p> <p>3.1-45(a)(1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155217	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF HUNTINGBURG, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542
--	--

(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
F 0328 SS=G Bldg. 00	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 0328	F-328	07/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155217	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF HUNTINGBURG, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542
--	--

(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
	<p>Based on interview and record review, the facility failed to ensure a resident with a tracheostomy received appropriate care in that the physician was not notified of the resident vomiting several times and the need for suctioning, did not have a Respiratory Therapist (RT) to care for the resident as ordered by the physician, did not assess the resident for respiratory complications when the resident was less responsive, and did not notify the physician when the resident exhibited decreased consciousness, resulting in the resident's admission to the hospital, for 1 of 1 residents reviewed with tracheostomies, in a sample of 5.</p> <p>Resident D</p> <p>Findings include:</p> <p>On 6/24/16 at 9:45 A.M., during the initial tour, the Assistant Director of Nursing (ADON) indicated the facility had recently become certified on taking tracheotomy residents.</p> <p>The closed clinical record of Resident D was reviewed on 6/24/16 at 1:45 P.M. Diagnoses included, but were not limited to, acute and chronic respiratory failure and COPD.</p> <p>An Admission Assessment, dated 6/17/16</p>		<p>It is the policy of the facility to see that residents who have a tracheostomy receive appropriate care and that the physician is notified of any changes or significant care needs as related to the tracheostomy. Resident D no longer resides at the facility.</p> <p>Any resident who has a tracheostomy and resides at the facility has the potential to be affected by this finding.</p> <p>There are currently no residents who reside in the facility who have a tracheostomy. If a resident with a tracheostomy is admitted to the facility, the DON/Designee will monitor care and documentation related to the tracheostomy 5 days weekly. This will be done on various shifts to include some weekend shifts with different nurses. This monitoring will be ongoing for residents who have a tracheostomy. Any concerns noted during the monitoring will be addressed and or corrected. No breaches in technique or procedure will be allowed to take place. On site and immediate education will take place as indicated.</p> <p><b>At an in-service held for nursing July 15, 2016,</b> the following was reviewed:</p> <ol style="list-style-type: none"> <li>1. Tracheostomy Care—Policy &amp; Procedure (Suctioning/Lung Sounds)</li> <li>2. O2 Sats/Vital Signs</li> </ol>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155217	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF HUNTINGBURG, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542
--	--

(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
	<p>at 4:00 P.M., indicated, "Arrived via Wheelchair...Most Recent Blood Pressure: 114/60...Pulse: 52...Respiration: 20...Verbalizes/Demonstrates use of: Call bell, Bed controls, Side rails, TV...Color normal...LOC [level of consciousness] Alert, Orientation Person, Place...Breath Sounds, Clear Both...Tracheostomy Yes. Type/Size: 6. Cuff inflated, Unable to determine...."</p> <p>Admission Physician orders, dated 6/17/16, included: "Speaking valve as tolerated by RT [respiratory therapist]. Titrate O2 [oxygen] to keep sats above 88% per RT. Trach Care [tracheostomy] everyday and PRN [as needed] per RT one time a day."</p> <p>Nurse's Notes included the following notations:</p> <p>6/16/16 at 3:00 P.M.: "Res [resident] admitted into facility at this time per facility at this time per facility vehicle. Oriented to room. Trach care provided per nursing. Tranfered [sic] from w/c [wheelchair] to bed per hoyer lift. Resting in bed at this time...92% O2 with O2 per trach. Weight 254.5.</p> <p>6/17/16 at 1:24 A.M.: "DuoNeb Solution...for SOB [shortness of breath],</p>		<p>3.Following Physician Orders 4.Changes of Condition-Notifications (Who? When?How? By Whom?) 5.Care Planning Tracheostomy Care 6.Documentation 7.Q &amp; A/Discussion</p> <p>Any staff who fail to comply with the points of their-service will be further educated and/or progressively disciplined as indicated.</p> <p>At the monthly Q. A. meetings the results of the monitoring by the DON/Designee related to tracheostomy care and documentation will be reviewed. Any concerns will have been addressed as observed and prior to any breach in technique being committed. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored weekly by the Administrator until resolution.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155217	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/27/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF HUNTINGBURG, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542
--	--

(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
	<p>wheeze for SOA [shortness of air] with mucousy [sic]."</p> <p>6/17/16 at 1:41 A.M.: "DuoNeb Solution...Administration was effective."</p> <p>6/17/16 at 1:53 A.M.: "...SpO2 %92 [sic] Lung sounds dim. [diminished] bil. [bilaterally]...Res. suctioned several times and PRN neb tx [nebulizer treatment] administered and helpful for episode of SOA. Trach care performed."</p> <p>The next entry of Nurse's Notes, dated 6/17/16 at 9:00 A.M., indicated, "Nurse unable to administer 8am [sic] medications due to res current level of consciousness. Res is drowsy and difficult to wake. Don [Director of Nursing] notified."</p> <p>Documentation that vital signs were obtained, the resident's respiratory status was assessed, or that the physician was notified at that time of the resident's decreased of level of consciousness was not found in the clinical record.</p> <p>The next entry of Nurse's Notes, dated 6/17/16 at 12:00 P.M., indicated, "At 11:30 am Res showing s/s [signs and symptoms] of respiratory distress at this time. O2 between 78-80 % with 10 L per trach. Res indicated by gestures she is</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155217	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/27/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF HUNTINGBURG, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>having trouble breathing. Suctioned orally and via trach, thick pale green seceretions [sic] with scant amount of blood retrieved via trach. PRN neb treatment started. Continues to have difficulty despite suctioning. MD contacted at 11:50 am, orders received and noted to send res to ER for eval and treat at [name of hospital]. Family notified at 11:55 am. O2 remains between 80-85% at this time." [Two (2) hours and 50 minutes passed from the time the resident was unable to receive her 8:00 A.M. medications, and changes with her level of consciousness, until the physician was notified.]</p> <p>6/17/16 at 12:10 P.M.: "EMS here at this time to transport res to [name of hospital] ER...."</p> <p>A hospital ER record, dated 6/17/16 at 12:34 P.M., included: "Chief Complaint: Dyspnea [shortness of breath] and possible aspiration. (Patient was transferred to nursing home yesterday from another facility and reportedly vomited multiple times on the transferred [sic] down to nursing home. Nursing home and [sic] has had a difficult time obtaining good O2 sats and was sent for evaluation for possible aspiration). Is still present. The dyspnea is severe...Clinical Impression:...aspiration with acute</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155217	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/27/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF HUNTINGBURG, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542
--	--

(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
	<p>respiratory difficulty and hypoxia [low oxygen in the blood]...."</p> <p>On 6/24/16 at 3:00 P.M., during an interview with the Director of Nursing (DON), she indicated the Assistant Director of Nursing (ADON) accompanied the resident from her previous facility to this facility. She indicated the other facility was 4 hours away. The DON indicated the resident "vomited frequently on the way and was suctioned several times." The DON indicated the resident was suctioned "every 30 minutes throughout the night." The DON indicated, "We couldn't maintain her O2 sats, so I made the decision to send her to the hospital." The DON indicated she thought the resident was unstable, and the van drive "did her in." She indicated she was unsure if the physician had been notified that the resident had vomited several times. She indicated the facility did not have a respiratory therapist in the facility or contracted for daily services to the facility.</p> <p>On 6/24/16 at 3:05 P.M., during an interview with the ADON, she indicated she accompanied Resident D to the facility. She indicated the resident vomited several times in the van, and that she suctioned the resident "3-4 times."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155217	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/27/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF HUNTINGBURG, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542
--	--

(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
	<p>She indicated she had a portable suction machine in the van with her.</p> <p>On 6/24/16 at 3:10 P.M., during an interview with the Clinical Education Nurse, she indicated staff had been inserviced on trach care on 5/13/16. She indicated there had not been any new staff hired since that date. When it was brought to the Clinical Education Nurse's attention that LPN # 2 had worked the night of 6/16/16 and her name was not on the list of staff inserviced, she indicated, "She was on vacation." She indicated she did not know if LPN # 2 had been inserviced on trach care.</p> <p>On 6/27/16 at 9:35 A.M., the DON was again interviewed. The DON indicated that on the morning on 6/17/16, Resident D was "difficult to arouse, not unresponsive." The DON indicated the staff didn't notify the physician on the morning of 6/17/16, because "they were busy working with the resident in her room." She indicated the staff suctioned the resident several times, and were busy trying to care for her.</p> <p>On 6/27/16 at 9:45 A.M., during an interview with LPN # 1, she indicated she was the admitting nurse for Resident D. She indicated she "heard" the resident got car sick and vomited. She indicated on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155217	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/27/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF HUNTINGBURG, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542
--	--

(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
	<p>6/17/16, the resident was drowsy, and "she didn't feel like it was safe" to give the resident her medications. She indicated she notified the DON of the resident's status. LPN # 1 indicated she suctioned the resident a few times between 9:00 A.M. and 12:00 P.M., and was obtaining thick secretions. She indicated they kept trying to clear the resident's airway, and then finally called 911. LPN # 1 indicated the facility did not have a respiratory therapist.</p> <p>On 6/27/16 at 10:20 A.M., during an interview with the Clinical Education Nurse, she indicated she was "in and out" of Resident D's room. She indicated, "We couldn't get her O2 sats to stay up." She indicated the resident kept saying she couldn't catch her breath. She indicated she was trying to keep the oxygen mask on her while LPN # 1 was suctioning her, but the resident remained short of breath. She indicated another nurse called 911 and the resident was transferred to the hospital.</p> <p>This Federal tag relates to Complaint IN00203455.</p> <p>3.1-47(a)(4)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155217	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF HUNTINGBURG, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542
--	--

(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