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 03/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF DILLSBORO-ROSS MANOR THE	12803 LENOVER ST DILLSBORO, IN 47018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0000	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on February 2, 2012. This visit was in conjunction with the Investigation of Complaint IN00104402. Survey dates: March 23 and 24, 2012 Facility number: 000178 Provider number: 155280 AIM number: 100273840 Survey team: Jill Ross, RN, TC Cheryl Fielden, RN Census bed type: SNF/NF: 98 Total: 98 Census payor type: Medicare: 11 Medicaid: 73 Other: 14 Total: 98 Sample: 12 Supplemental: 3 These deficiencies also reflect state	F0000	Enclosed please find the plan of correction for The Waters of Dillsboro Ross Manor's recertification and state licensure survey revisit dated March 24, 2012. 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.	

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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	findings cited in accordance with 410 IAC 16.2. Quality review completed 3/28/12 Cathy Emswiller RN			

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F0441 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.	F0441	It is the intent of this facility to maintain an infection control	04/11/2012

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			program to help in the prevention and transmission of disease and infection and to ensure the proper cleaning, air drying, and storage of nebulizer masks, reservoirs, and other equipment used during a respiratory nebulizer treatment. 1. Action taken; a. In regard to Residents #66, 70, and 76, all nebulizer equipment (mask, tubing, reservoir, all disposable equipment) discarded. b. LPN #1 was in-serviced on appropriate re-bagging of equipment after air drying, which should happen within 2 hours on 3-24-12. 2. Others identified; All residents receiving nebulizer respiratory treatments would have the potential to be affected. 3. Measures taken; Licensed nurses were in-serviced by a Respiratory Therapist on 3/28/12, and on April 10, 2012 per America's Best Company, on proper cleaning and storage of a nebulizer mask, tubing, and reservoir used during a nebulizer treatment. 4. How monitored; a. The IDT/QA team will audit during QA rounds twice daily for appropriate re-bagging of nebulizer equipment. This will be an ongoing process with regular team rounds. b. The Administrator and/or designee will review QA round tools during daily stand up meetings. c. The DON and/or designee will complete a quarterly summary audit to be presented to the QA&A committee, related to	

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			licensed nurses' proper storage of nebulizer mask, mouthpiece, reservoir, and other resipiratory equipment used during a nebulizer treatment. d. The Administrator and/or designee will review all summary audits monthly, and also review quarterly in the QA meeting with the Medical Director. 5. This plan of correction constitutes our credible allegation of regulatory compliance. Our date of compliance is April 11, 2012.	
	Based on record review, observation and interview, the facility failed to establish and maintain an Infection Control Program to help in the prevention and transmission of disease and infection in that they failed to put the nebulizer canisters, after washed and dried, back in the plastic bag. This affected 3 out of 8 residents in a sample of 12 during two observations of nebulizer treatments. (Residents #66, #70, and #76) Findings include: During the observation of the nebulizer treatments on 3/24/12 from 7:45 a.m. to 8:20 a.m. there were 3 nebulizer canisters laying out on the table on a paper towel instead of being stored in the proper bag. These were for Residents #66, #70, and #76.			

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	In interview with LPN #1 on 3/24/12 at 8:40 a.m. she indicated that she would leave the canister on the paper towel until it dried and then put it back in the bag for storage. In interview with the DON of Ross Manor on 3/24/12 at 8:40 a.m. she indicated that the nebulizer canister should be placed on paper towels to dry for 1-2 hours and then placed back in the bag. "It should not be left out over night." In review of the facility policy titled "Nebulizer Therapy" that was received on 3/24/12 at 11:30 a.m. from the DON of The Waters of Dillsboro it indicated under "Procedure:...13. Store nebulizer and mouthpiece/mask in plastic bag..." This Federal Tag was cited on 2/2/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-18(a)			

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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.			
	Based on record review and interview the facility failed to document the application site of a medication patch as written in the physician recapitulation orders. This affected 1 of 15 residents reviewed for complete and accurate records in a sample of 15. (Resident #19) Findings include: Resident 19's record was reviewed on 3/23/12 at 2:30 p.m. The record indicated resident # 19 was admitted to the facility with diagnoses which included, but were not limited to, pain, L (left) sided weakness R/T (related to) CVA (cardiovascular accident), OA (osteoarthritis), and depression. Physician recapitulation orders dated 3/2012 which included, but were not	F0514	It is the intent of this facility to document the application site of a Lidoderm medication patch as written in the physician's orders. 1. Actions taken; In regard to resident # 19, the order and the medication administration record was reviewed, and nursing staff was re-educated on proper site documentation. 2. Others identified; 100% audit of all residents with orders for a Lidoderm medication patch was completed. 3. Measures taken; a. Licensed nurses and QMA's in-serviced on following physician's orders as written and auditing physician re-writes monthly for accuracy, and documenting site placement for Lidoderm medication patches per pharmacist on April 4, 2012. b. Medical records and/or designee will review all physician rewrites monthly for complete and accurate transcription of	04/11/2012

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	limited to, a handwritten notation dated 2-19-12 that indicated " lidoderm patch 5% patch, 1 patch topically to L (left) shoulder QD (every day)- Do not remove-res. (resident) wishes see diagram-write in 1-2-3 for site-pain". MAR (medication administration record) for 3/2012 which included but were not limited to, a handwritten order dated 2-19-2012 which indicated "lidoderm 5% patch apply topically to L shoulder QD-Do not remove-res. wishes. *See diagram-write in 1-2 or 3)*. Documentation on the MAR indicates on 3-1, 2, 3, 4 and 16, 2012 the dates are initialed but the site in not documented. During an interview on 3/24/2012 at 08:40 a.m. the QMA (qualified medication aid) #1 indicated that documentation of medications, sites and exceptions are noted on the MAR. 3.1-50(a)(1) 3.1-50(a)(2)		medication patch instructions, and audit monthly MARs. c. The DON and/or designee will audit all admissions for complete and accurate instructions for administering medications patch. 4. How monitored; a. The Administrator and/or designee will review all audits as completed in QA stand up meeting. b. Administrator and/or designee will review audits as completed in monthly meeting, and quarterly in the QA meeting with the Medical Director. 5. This plan of correction constitutes our credible allegation of compliance with regulatory compliance. Our date of compliance is April 11, 2012	