STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155238		12/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF YORKTOWN THE	2000 S ANDREWS RD YORKTOWN, IN 47396

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: December 15, 16, 17, 18, and 19, 2014. Facility number: 000143 Provider number: 155238 AIM number: 100283890 Survey team: Debra Holmes, RN, TC Angie Stallsworth, RN Toni Maley, BSW Karen Lewis, RN (December 15, 16, 17, and 18, 2014) Census bed type: SNF/NF: 65 Total: 65 Census payor type: Medicare: 6 Medicaid: 47 Other: 12 Total: 65 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December	F000000	ooo Preparation and/or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the facility of facts alleged or conclusions set forth in the 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 is to serve as The Waters of Yorktown's credible allegation of compliance.	

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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	30, 2014 by Randy Fry RN.			
F000221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, interview and record review, the facility failed to assess the use of a restraint device for 1 of 1 resident reviewed for restraints in a sample of 5 residents who met the criteria for restraints. (Resident #12) Findings include: The clinical record for Resident #12 was reviewed on 12/17/14 at 11:09 a.m. The diagnoses included, but were not limited to, anoxic brain damage, contracture (permanent shortening of a muscle or joint) of the hand, and aphasia (loss of ability to understand or express speech). The most recent MDS (Minimum Data Set) assessment, dated 10/30/14, indicated that restraints were not in use. A physician's order, dated 12/1/14, indicated the resident was to have a full lap tray attached to the wheelchair for positioning purposes.	F000221	F221 It is the policy of The Waters of Yorktown to ensure each resident is free from restraints that are not required to treat the resident's medical condition.1. On 12/17/14 a restraint assessment was completed for resident #12 which indicated the lap tray was not a restraint positioning and lap tray was re-evaluated on 12-17-14 and care plan updated to reflect the resident's use of lap tray for socialization and quality of life enhancement.2. No other residents utilize a lap tray and there are no restraints in use.3. All nursing staff will be in-serviced as to the restraint definition/process including assessment, and documentation. DON/designee will verify any pre-restraining assessments completed to include appropriate medical diagnosis and resident need. 4. DON/designee will audit any restraints being utilized on a monthly basis and provide report to QA Committee. Any identified patterns will be reviewed by the QA Committee. If needed, an	01/16/2015

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	The most recent care plan, dated 12/7/14, indicated the resident was to have a focus-Lap Tray attached to the wheelchair for positioning. The care plan goal indicated the resident would maintain comfort with positioning until next review and the care plan interventions included, but were not limited to, the purchase of a new lap tray 11/6/14 for positioning and evaluation by therapy as indicated. On 12/15/14 at 10:15 a.m., Resident #12 was observed sitting in a wheelchair with a lap tray attached to the arms of the wheelchair with Velcro straps. On 12/17/2014 at 2:20 p.m., Resident #12 was observed being transported from shower room to resident room by wheelchair with lap tray in place, attached with Velcro straps. During an interview on 12/17/2014 at 2:41 p.m., LPN #6 indicated that Resident #12's lap tray was in place for positioning purposes only and was strapped in place with Velcro on to the handrails of the wheelchair. LPN #6 further indicated the resident could not remove the lap tray. During an interview on 12/17/2014 at		Action Plan will be written by QA Committee and will be monitored weekly by the Administrator until resolved.5. Date of Compliance 01-16-15	

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	3:20 p.m., the Director of Nursing and the Assistant Director of Nursing indicated the lap tray was a restraint and further indicated that the lap tray was incorrectly labeled as a positioning device. 3.1-26(o)			
F000225 SS=C	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in			

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	progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to conduct a thorough pre-screening of hired employees including a complete criminal background check prior to starting employment for 4 of 5 new employees reviewed for complete employee files. (CNA #1, CNA #2, CNA #3, and Dietary Aide #4) Findings include: On 12/18/14, the employee files were reviewed for CNA #1, CNA #2, CNA#3, and Dietary Aide #4. The employee files did not contain criminal background checks. The date of hire for CNA #1 was 12-8-14. The date of hire for CNA #2 was 10-15-14. The date of hire for CNA #3 was 9-24-14. The date of hire for Dietary Aide #4 was	F000225	F225 It is the policy of The Waters of Yorktown to follow it's procedures for abuse prohibition. 1. On 12/18/14 criminal history records/criminal background checks for CNA #1, #2, #3, and Dietary Aide #4 were given to the surveyor. No residents were affected. 2. All residents had the potential to be affected. All employee files will be audited for any employees who do not have a criminal background check. 3. The payroll coordinator was in-serviced on 12-18-14 for required pre-employment screening/criminal background checks prior to employment. To prevent a reoccurrence, a new Hire Checklist will be completed by the payroll coordinator/designee and completion will be verified by the Business Office Manager. 4. The Quality Assurance Committee will oversee the payroll coordinator and Business Office Manager with ensuring completion of criminal background checks ongoing on a monthly basis. 5. Date of	01/16/2015

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	11-28-14. On 12/18/2014 at 2:20 p.m., criminal history records for CNA #1, CNA #2, CNA#3, and Dietary Aide #4 were provided by the Administrator (HFA). These reports were dated 12/18/14. During an interview at that time, the HFA indicated the reports were obtained from the State Police Repository on 12/18/14. The HFA further indicated the reports should have been obtained at the time of hire and prior to employees being added to the work schedule. 3.1-28(b)(1)(A) 3.1-28(b)(1)(B)		Compliance 01-16-15	
F000226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to implement written policies which indicated a complete criminal background check be completed at the time of hire for 4 of 5 new employees reviewed for criminal background checks. This deficient practice had the potential to impact 65 of 65 residents in the facility. (CNA #1,	F000226	F226 It is the policy of The Waters of Yorktown to follow its procedures for abuse prohibition.1. On 12/18/14 criminal history records/criminal background checks for CNA #1,#2,#3 and Dietary Aide #4 were given to the surveyor. No residents were affected.2. All residents had the potential to be affected. All employee files will	01/16/2015

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	CNA #2, CNA #3, and Dietary Aide #4) Findings include: On 12/15/14 at 9:05 a.m., the Administrator indicated the facility census was 65 residents. On 12/18/14 at 10:43 a.m., the employee files were reviewed for CNA #1 (date of hire 12/8/14), CNA #2 (date of hire 10/15/14), CNA#3 (date of hire 9/24/14), and Dietary Aide #4 (date of hire 11/28/14). The employee files did not contain criminal background checks. On 12/18/2014 at 2:20 p.m., criminal history records for CNA #1, CNA #2, CNA#3, and Dietary Aide #4 were provided by the Administrator (HFA). These reports were dated 12/18/14. During an interview at that time, the HFA indicated the reports were obtained from the State Police Repository on 12/18/14. On 12/18/2014 at 2:53 p.m., the Administrator provided page 13 from the employee handbook which indicated "Facility conducts background checks...on applicants considered for employment." On 12/18/2014 at 3:25 p.m., a policy labeled "Abuse Prohibition Policy and		be audited for any employees who do not have a criminal background check.3. A policy has been developed and implemented on the orientation of each employee. The Payroll Coordinator was in-serviced on 12/18/14 for required pre-employment screenings. All employees are required to have pre-employment screening/criminal background checks prior to employments. To prevent a reoccurrence, a New Hire Checklist will be completed by the Payroll Coordinator/designee and completion will be verified by Business Office Manager for all new hires.4. The Quality Assurance Committee will oversee The Payroll Coordinator and Business Office Manager with ensuring completion of criminal background checks, ongoing on a monthly basis.5. Date of Compliance 01-16-15	

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	Procedure" was reviewed. This policy was provided by the HFA on 12/15/14 at 9:45 a.m. The policy indicated, "This facility shall comply with all federal and state requirements to screen, train..." and "The facility will pre-screen all potential new employees... for a history of abusive behavior." 3.1-28(a)			
F000241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review, the facility failed to ensure residents' dignity was protected regarding hair care, lengthy meal waits, and assisting dependent residents in free time pursuits for 7 of 7 residents reviewed for care and services to promote dignity. (Resident #3, #26, #1, #75, #13, #53, and #18) Findings include: 1. A 12/15/14, 11:00 a.m., observation and review of the facility activity calendar posted in the 100 hall, indicated there were no scheduled pre-breakfast or pre-lunch activities on 12/15/14,	F000241	F241 It is the policy of The Waters of Yorktown to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.1. Resident's #1,#53,#3,#26,#75,#13, and #18 will no longer be taken to the dining room prior to 15 minutes before meal times.2. All residents who are not able to verbalize their preferences have the potential to be affected. Residents who prefer to go to dining room prior to 15 minutes will have their preferences care planned and the right to go to dining room at any time. Residents who are not able to	01/16/2015

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	12/16/14, 12/17/14 or 12/18/14. 2. During a 12/15/14, 11:28 a.m. to 12:19 p.m., lunch observation in the Back Dining Room (the assisted dining room) the following concerns regarding a dignified dining experience were observed: From 11:28 a.m. to 11:59 a.m. (31 minutes), nine dependent residents were seated in the dining room at dining room tables as if ready to dine. Dependent Residents #s 1, 53, 3, 26, 75 and 13 were in the group of nine. The room was void of audio, visual and tactile sensory materials. The TV was on but the volume was turned low enough that it could only be heard at distances of two feet away or closer. The residents sat in their wheelchairs. They did not converse with one another or engage in any free time pursuits. Resident #26 said "oh, God" and manipulated her clothing protector over and over throughout the 31 minute period. At 11:59 a.m., the Activity Director entered the room and began a singing activity. The residents remained seated in their chairs as if ready to dine, throughout the entire singing event. While waiting before the singing activity and throughout the singing activities residents napped on and off. Residents #s 1, 53, 3, 26, 75 and 13 were all observed to close their eyes and dip their chin to their chest at least one time		verbalize their preference will not be taken to the dining room prior to 15 minutes before meal time.3. To prevent a reoccurrence, all staff will be in-serviced related to F241 - Dignity and also promotion of grooming and resident choice/preferences at mealtime. All staff will be expected to ensure resident hair is groomed to resident's satisfaction, or in a style resident typically wears and if hair un-presentable will report to Director of Nursing/designee. The Director of Nursing/designee and Administrator/designee will utilize the Daily Rounds form, when rounding to ensure staff compliance with not bringing residents to dining room earlier than 15 minutes prior to meal and to ensure good hair grooming. Any concerns will be addressed and corrected upon discovery.4. The CQI committee meets daily and any noted dignity violations will be addressed on a daily basis. The QA Committee will oversee compliance by identifying any patterns. If needed, an Action Plan will be written by QA Committee to be monitored by the Administrator weekly until resolved.5. Date of Compliance 01-16-15	

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	each during the wait. The meal cart arrived in the Back Dining Room at 12:19 p.m. The dependent residents had sat facing the table before the meal from 11:28 a.m. to 12:19 p.m. (51 minutes). On 12/16/2014 from 10:39 a.m. to 10:54 a.m. (15 minutes) dependent Resident #26 was observed in the Back Dining Room in her wheelchair with her back to the TV. The TV volume was too low to hear. Resident #26 had a Christmas card in her hand. She manipulated the card and said "Oh, God" over and over. At 10:54 a.m., an unidentified staff member told Resident #26 she would move her to face the TV. Resident #26 was moved to face the TV but the volume was not turned up. Resident #26 sat facing the TV with no sound until 11:04 a.m. Dependent Resident #26 sat in the Back Dining Room without stimulation or interaction from 10:39 a.m. to 11:04 a.m. (a period of 23 minutes). During a 12/16/14, 7:05 a.m. to 8:03 a.m., breakfast observation in the Back Dining Room five dependent residents where seated in the dining room as if ready to dine. Residents #s 75, 13, 3 and 1 were included in the group of five. The room was void of visual and tactile sensory materials. The TV was on but the volume was turned low enough that it			

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	could only be heard at distances of two feet away or closer. The residents sat in their wheelchairs facing the table. They did not converse with one another or engage in any free time pursuits. The facility wide overhead sound system played Christmas music throughout the facility. The residents did not sing, smile, tap their feet, clap or show any indication of listening to the Christmas music. At 7:30 a.m. (a 25 minute period of sitting at the tables), Housekeeper #16 entered the area and read a newspaper to the residents. While waiting before the newspaper reading activity and throughout the newspaper activity residents napped on and off. Residents #s 75, 13, 3 and 1 were all observed to close their eyes and dip their chin to their chest at least one time each during the wait. The food carts arrived in the dining room at 8:08 a.m. The dependent residents sat facing the tables before the meal from 7:05 a.m. to 8:08 a.m. (1 hour and 3 minutes). During a 12/17/14, 7:08 a.m. to 8:14 a.m., breakfast observation in the Back Dining Room six dependent residents where seated in the dining room as if ready to dine. Residents #s 75, 13, 3, 1 and 18 were included in the group of six. The room was void of visual and tactile sensory materials. The TV was on but			

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	the volume was turned low enough that it could only be heard at distances of 2 feet away or closer. The residents sat in their wheelchairs facing the table. They did not converse with one another or engage in any free time pursuits. The facility wide overhead sound system played Christmas music throughout the facility. The residents did not sing, smile, tap their feet, clap or show any indication of listening to the Christmas music. At 7:29 a.m., the Administrator asked the Housekeep #16 to read to the residents. Housekeeper #16 indicated another housekeeper was not working today and the housekeeping staff would be short handed if she read to the residents. The Administrator asked Housekeep #16 to please begin and she would find someone to relieve her. Housekeeper #16 then began to read the paper to the residents (21 minutes after they were first observed seated at the tables). At 7:37 a.m., the Activity Director relieved the housekeeper and took over the task of reading to the residents. The meal tray service began at 8:14 a.m. The dependent residents sat facing the tables before the meal form 7:08 a.m. to 8:14 a.m. (1 hour and 6 minutes). During a 12/18/14, 6:20 a.m. to 7:50 a.m., breakfast observation in the Back Dining Room eight dependent residents			

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	where seated in the dining room as if ready to dine. Residents #s 13, 3, 1 and 18 were included in the group of eight. The room was void of visual and tactile sensory materials. The TV was on but the volume was turned low enough that it could only be heard at distances of 2 feet away or closer. The residents sat in their wheelchairs facing the table. They did not converse with one another or engage in any free time pursuits. The facility wide overhead sound system played Christmas music throughout the facility. The residents did not sing, smile, tap their feet, clap or show any indication of listening to the Christmas music. At 6:50 a.m., facility staff passed out news papers to residents who purchased news paper services. The residents looked at the news paper for 5 minutes or less. At 7:00 a.m., Housekeeper #16 began to read the paper to the residents (40 minutes after the resident were first observed seated facing the tables). The housekeeper read the news paper and short stories until the meal arrived at 7:52 a.m. While waiting before the reading activity and throughout the reading activity residents napped on and off. Residents #s 1, 13, 3 and 18 were all observed to close their eyes and deep their chin to their chest at least one time each during the wait. The dependent residents sat facing the table as if ready to dine from 6:20 a.m. until the			

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	meal was served at 7:52 a.m. (a period of 1 hour 32 minutes). 3. The "Meal Times" list, provided by the Administrator on 12/15/14 at 9:45 a.m., indicated meals in the "Back Dining Room" were scheduled for breakfast at 7:45 a.m., Lunch 12:45 a.m. (sic). A 12/15/14, 10: 30 a.m., observation of the posted meal times located outside the "Front Dining Room" indicated the posted schedule was consistent with the provided list. Review of the "Get Up List", provided by LPN #7 on 12/18/14 at 6:40 a.m., indicated nine residents were gotten up and ready for the day by 3rd shift staff (before 6:00 a.m.) and seven resident were assigned to be gotten up by 3rd shift staff dressed and returned to bed. Residents #3, #26, #1, #75, #13, #53 and #18 were included on the list of resident to get up and get ready before 6:00 a.m. or get up dress and put back to bed. 4. Resident #1's clinical record was reviewed on 12/18/2014 at 1:43 p.m. Resident #1's current diagnoses included, but were not limited to, Parkinson's disease, anxiety, Alzheimer's dementia, depression with psychotic features and macular degeneration.			

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	Resident #1 had a current,10/10/14 ,care plan problem/need regarding a diagnosis of depression. Resident #1 had a current,10/8/14 , care plan problem/need regarding dementia and cognitive impairment. Approaches to this problem, included but were not limited to,"encourage activities" and "offer support and reassurance." Resident #1 had a current, 10/8/14, care plan problem/need regarding dementia with short and long term memory problems. Resident #1 had a current, 10/10/14, care plan problem/need regarding impaired decision making skills. Resident #1 had a current,10/8/14,quarterly, MDS (Minimum Data Set) assessment which indicated the resident understood others and was understood by others, rarely or never made independent decisions, required staff assistance for mobility both on and off the unit and required limited assistance for eating. 5. Resident #3's clinical record was reviewed on 12/16/2014 at 2:53 p.m. Resident #3's current diagnoses included, but were not limited to, depression and fibromyalgia. Resident #3 had a current,10/28/14 , care			

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	plan problem/need regarding resistant depression. Resident #3 had a current, 10/28/14 , care plan problem/need regarding fibromyalgia. Approaches to this problem, included but were not limited to, observe for mood changes. Resident #3 had a current, 10/28/14, care plan problem/need regarding the need to be out of the room and socialize. Approaches to this problem, included but were not limited to,"offer activity program,sit with me one on one and socialize with me [and] address any concerns I may voice." Resident #3 had a current, 10/28/14, care plan problem/need regarding cognitive deficits. Approaches to this problem, included but were not limited to, "encourage activities" and "encourage resident to voice feelings." Resident #3 had a current, 10/28/14, quarter, MDS (Minimum Data Set) assessment which indicated the resident understood others and was understood by others, rarely or never made independent decisions, required staff assistance for mobility both on and off the unit and required extensive assistance for eating. During a 12/18/14, 7:02 a.m., interview, with cognitively impaired Resident #3, who was alert to self and had been			

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	waiting for breakfast since 6:20 a.m., the resident indicated she disliked waiting so long for breakfast. She also indicated she could not see or hear the TV when she waited in the Back Dining Room. She indicated she enjoyed watching TV. 6. Resident #18's clinical record was reviewed on 12/18/2014 at 1:41 p.m. Resident #18's current diagnoses included, but were not limited to, severe dementia, dementia with agitation and muscle weakness. Resident #18 had a current, 10/10/14, care plan problem/need regarding dementia with behavioral disturbances. Resident #18 had a current, 10/10/14, care plan problem/need regarding debility. Approaches to this problem, included but were not limited to, "observe for emotional stress and offer support as indicated." Resident #18 had a current, 10/10/14, care plan problem/need regarding cognitive deficit related to dementia. Approaches to this problem, included but were not limited to, "encourage activities" and "encourage to voice feelings." Resident #18 had a current,11/10/14, annual, MDS (Minimum Data Set)			

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	assessment which indicated the resident understood others and was understood by others, rarely or never made independent decisions, required staff assistance for mobility both on and off the unit and required limited assistance to eat. During a 12/18/14, 7:01 a.m. interview, with cognitively impaired Resident #18, who was alert to self and had been waiting for breakfast since 6:20 a.m., the resident indicated she had been waiting a long time for breakfast. She indicated she disliked waiting so long. 7. Resident #13's clinical record was reviewed on 12/17/2014 at 2:31 p.m. Resident #13's current diagnoses included, but were not limited to, depression Resident #13 had a current,10/10/14 , care plan problem/need regarding risk for delirium. Resident #13 had a current, 10/10/14, care plan problem/need regarding depression. Approaches to this problem, included but were not limited to, involve in activities of interest. Resident #13 had a current, 10/10/14, care plan problem/need regarding anxiety. Approaches to this problem, included but were not limited			

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	to,"encourage to vent feelings." Resident #13 had a current, 10/10/14, quarterly, MDS (Minimum Data Set) assessment which indicated the resident was understood by others and usually understood others, needed cueing for decision making, was dependent on staff assistance for mobility both on and off the unit and needed limited assistance to eat. During a 12/18/14, 7:00 a.m., interview, with cognitively impaired Resident #13, who was alert to self and had been waiting for breakfast since 6:20 a.m., the resident indicated he had been waiting a long time for breakfast. 8. Resident #26's clinical record was reviewed on 12/16/2014 at 3:23 p.m. Resident #26's current diagnoses included, but were not limited to, depression, dementia, debility and chronic pain. Resident #26 had a current, 11/28/14, care plan problem/need regarding cursing at staff. Approaches to this problem included, but were not limited to,"offer activities to keep me occupied." Resident #26 had a current, 11/28/14, care plan problem/need which indicated the resident could not focus on tasks for			

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	more than 1 or 2 minutes. Resident #26 had a current, 11/28/14, care plan problem/need regarding becoming easily agitated. Approaches to this problem included, but were not limited to, "observe for emotional stress and offer support as indicated." Resident #26 had a current,11/28/14, significant change, MDS (Minimum Data Set) assessment which indicated the resident had unclear speech, understood simple direct communication only, rarely or never made decisions, required staff assistance for mobility both on and off the unit and required staff assistance to eat 9. Resident #75's clinical record was reviewed on 12/17/2014 at 2:24 p.m. Resident #75's current diagnoses included, but were not limited to, dementia, anxiety and depression. Resident #75 had a current, 10/14/14, care plan problem/need regarding depression. Approaches to this problem, included but were not limited to, "listen for negative comments." Resident #75 had a current, 10/14/14 , care plan problem/need regarding the inability to stay in activities longer than 5 minutes			

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	due to anxiety. Resident #75 had a current 10/14/14, quarterly, MDS (Minimum Data Set) assessment which indicated understood others and was understood by others, rarely or never made independent choices, required staff assistance for mobility both on and off the unit and required supervision when eating. During a 12/16/14, 8:55 a.m., interview, cognitively impaired Resident #75, who was alert to self, indicated, she got tired when waiting a long time for meals. She indicated she had sat that morning " for what felt like 5 hours. I think they they were punishing me." 10. During a 12/16/14, 2:45 p.m., observation, Resident #53 was observed the have freshly styled hair with soft curls framing her face. During a 12/17/14, 9:05 a.m., observation, Resident #53 was observed to be lacking curls around her face and her hair was brushed out and no longer had curls. During a 12/17/14, 9:51 a.m., interview, the hair dresser indicated she had styled and set Resident #53's hair the day before (12/16/14).			

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	During a 12/17/14, 9:53 a.m., interview, CNA #17 indicated she had combed and picked Resident #53's hair that morning when she had got her ready for the day. She indicated the residents hair looked like it had already been combed back when she saw it that morning. During a 12/17/14, 10:54 a.m., interview, the Hairdresser indicated a soft fluff with a pick is all that is needed on a residents hair after it has been styled and set. She indicated she had never been asked to instruct staff regarding maintaining residents hair styles. She additionally indicated she often touched-up Resident #53's hair later in the week after it had been styled because the curl had been brushed out. During a 12/17/14, 11:06 a.m. interview, the Director of Nursing indicated many women in the facility have their hair styled at the hairdresser's. She indicated the facility had not formally trained the CNAs regarding how to maintain these set hairstyles. 11. Resident #53's clinical record was reviewed on 2/17/2014 at 2:50 p.m. Resident #53's current diagnoses included, but were not limited to, history of falls, muscle weakness, depression and			

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	anxiety. Resident #53 had a current, 11/30/14, care plan problem/need regarding debility. Approaches to this problem, included but were not limited to,"assist with ADLs [activities of daily living]." Resident #53 had a current, 11/30/14 , annual, MDS (Minimum Data Set) assessment which indicated the resident rarely or never made independent decisions, required extensive assistance for bathing, grooming and activities of daily living and required staff assistance for mobility both on and off the unit. 12. During a 12/18/14, 9:05 a.m., interview, the Social Services Designee indicated residents with dementia and/or short and long term memory loss should have group activities that were short in duration. She additionally indicated it was not accepted in our society to sit and wait for long times before meals During a 12/18/14, 12:45 p.m., interview, the Activity Director indicated she had been in the facility only one week. She indicated the December activity calendar did not have pre-meal activities scheduled for the Back Dining Room. She indicated activities for residents with dementia or memory issues should be			

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	short around 15 minutes because the residents have limited attention spans. 13. A current, 4/2013, facility policy, titled "Federal Resident/Patient Rights, which was provided by the Social Services Designee on 12/18/14 at 2:00 p.m., indicated the following: " The resident has the right to a dignified existence..." 3.1-3(t)			
F000242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, interview and record review, the facility failed to allow a resident or his/her representative the opportunity to choose the number of showers desired each week for 1 of 3 representatives interviewed regarding choices. (Resident #49) Findings include: During a 12/15/14, 11:13 a.m., interview,	F000242	F242 It is the policy of The Waters of Yorktown to ensure each resident has the right to choose activities, schedules, and healthcare consistent with his or her interest, assessments, and plans of care and make choic es about aspects of his or her life in the facility that are significant to the residents.1. Resident #49's preference for number of showers a week, was reviewed with her Power of Attorney/family member on 1/6/15. The family member	01/16/2015

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	Resident #49's family member indicated, Resident #49 would prefer to have more than two showers a week, but two was all the facility offered. At home resident #49 had showered daily. Resident #49's clinical record was reviewed on 12/17/2014 at 2:40 p.m. Resident #49's current diagnoses included, but were not limited to, dementia, history of falls, anxiety and depression. Resident #49 had a current, 10/1/14 , care plan problem/need regarding needing staff assistance for activities of daily living. Resident #49 had a current, 10/1/14, quarterly, MDS (Minimum Data Set) assessment which indicated she rarely or never made independent decisions and required extensive assistance form staff for bathing and hygiene. During a 12/18/14, 9:00 a.m., interview, the Director of Nursing indicated residents are not asked how many times a week they would desire a bath or shower. The are offered more if they request. She then indicated the facility currently had no resident who received more than two showers or baths a week. The Director of		indicated she did not have any concerns with the number of showers her family member (resident #49) was presently receiving. Resident #49's care plan has been updated with the preference of 2 showers per week.2. All residents had the potential to be affected and therefore, Social Services and Activity Director will be interviewing all of our residents regarding shower/bathing preferences. Care Plans and preference sheets will be updated to reflect any changes needed regarding bathing preferences. 3. To ensure bathing/shower preferences are met, upon admission the Activity Director will interview resident for bathing/shower preferences, in addition the Interdisciplinary team will ask each resident and/or resident representative for preferences during each Care conference.The Activity Director will be responsible for ensuring bathing/shower preferences are addressed at each Care Plan conference, care planned and resident preference sheets updated.4. The Social Service Director will audit to ensure the preference sheets and care plans are current and according to resident preferences. The Social Service Director will be required to report any errors in resident preference sheets to the QA Committee who will oversee compliance on a monthly basis.5.	

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	Nursing indicated the preference forms had been completed by the previous Activity Director. She indicated she had been unaware Resident #49 desired more baths or showers. 3.1-3(u)(1)		Date of Compliance 01-16-15	
F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to develop a care plan to address target behaviors for a resident who received anti-anxiety medications for 1 of 40 residents reviewed for care plan development. (Resident #94)	F000279	F279 It is the policy of The Waters of Yorktown to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's needs.1. Resident #94's care plan has been updated to	01/16/2015

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	Findings include: The clinical record for Resident #94 was reviewed on 12/16/14 at 2:53 p.m. Diagnoses for Resident #94 included, but were not limited to, anxiety, depression, and dementia with behavioral disturbances. Resident #94 had a current physician's order for Xanax (an anti-anxiety medication) 0.5 milligrams (mg) 1 tablet by mouth two times a day. This order originated 9/23/14. Resident #94 had a 11/10/14, quarterly Minimum Data Set (MDS) assessment which indicated the resident had moderate cognitive impairment. Resident #94 had "Behavior/Intervention Monthly Flow Records" for September, October, November and December 2014 which indicated the facility was monitoring the resident for anxiety. Resident #94's record lacked a care plan regarding targeted behaviors being treated by the use of an anti-anxiety medication. During an interview with the MDS Coordinator on 12/18/14 at 9:56 a.m., she indicated the Social Service Designee developed the anxiety care plan for Resident #94.		address targeted behaviors and use of anti-anxiety medication.2. All residents with behaviors which are being treated with medication have the potential to be affected. All resident's plan of care will be reviewed to ensure any targeted behaviors being tracked with the use of medication are care planned.3. The Social Service Director will be responsible for maintaining a list of residents who are utilizing medications for behaviors and perform quarterly audit to ensure medication use appropriate and care planned.4. The QA Committee will be responsible for oversight of the Social Service Director with quarterly oversight of Social Service compliance with audits and care planning of residents with behaviors being tracked and treated with medications. Any patterns will be reviewed by the QA Committee. If needed, an Action Plan will be written by the QA Committee and monitored weekly by the Administrator until resolved.5. Date of Compliance 01-16-15	

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	During an interview with the Social Services Designee on 12/18/14 at 11:06 a.m., she indicated restlessness from non use of his c-pap (continuous air pressure machine) was the targeted behavior for use of the anti-anxiety medication for Resident #94. Review of the current policy, dated 7/1/11, titled "Care Plans", provided by the Administrator on 12/18/14 at 12:21 p.m., included, but was not limited to, "GUIDELINES: It is the intent of the facility that each resident will have a plan of care to identify problems, needs, and strengths that will identify how the interdisciplinary team will provide care. RESPONSIBILITY: All members of the interdisciplinary team. Coordinated by the MDS Coordinator.... ...PROCEDURE:... ...5. For each problem, need or strength a resident-centered goal is developed. Whenever possible the goal should be measurable (i.e., walk from nurses station to room by the next review of care plan).... "			

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(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
	3.1-35(a)			
F000314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.			
	Based on observation, interview and record review, the facility failed to treat a pressure ulcer in a manner to promote healing for 1 of 1 residents reviewed for pressure ulcers in a sample of 1. (Resident #84, LPN #7) Findings include: Resident #84's dressing change to her pressure ulcer on her coccyx was observed on 12/18/14 at 9:00 a.m. by LPN #7. She was observed with gloved hands to remove the soiled dressing, then, discarded her gloves, and donned a new set of gloves. There was no hand washing or hand gel use observed. LPN #7 then cleansed the wound by spraying normal	F000314	F314 It is the policy of The Waters of Yorktown to ensure resident's having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.1. Nurse #7 has received education regarding infection control procedures, clean dressing changes techniques, preventing contamination, and proper glove use and hand-washing.2. All residents have the potential to be affected. All nursing will be in-serviced and required to return demonstration of proper technique regarding dressing changes including use/handling of all dressing supplies including tape, scissors and writing instruments for the dating of the dressings. 3. To ensure ongoing utilization of correct technique	01/16/2015

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	saline inside the open area. The same abdominal pad used to catch the saline solution from cleansing the open wound was also used to pat the remaining excess fluid from the open area. She then discarded her gloves and donned a new pair of gloves with no hand washing or hand gel use observed. After LPN #7 cut the kerlix with scissors, she then packed the wound with saline moistened kerlix. LPN #7 then donned her gloves with no hand washing or hand gel use observed. Next, LPN #7 reached in her pocket and removed a roll of tape. The tape was cut using the same scissors, then placed the tape on the abdominal pads used for the wound dressing. After changing her gloves with no hand washing or hand gel use observed, LPN #7 then reached in her pocket, removed a pen and signed and dated the wound dressing. After LPN #7 repositioned the resident, she cleaned her work space and placed her scissors back in her pocket. No disinfecting of these scissors was observed. She was observed repositioning a drinking class used by the CNA #8 to give the resident a drink. LPN #7 removed her gloves and was observed to hand wash for 10 seconds. At the same		during dressing changes, the Director of Nursing/designee will monitor dressing changes 1 x weekly for each resident with a dressing changes x 12 weeks and randomly thereafter, if any deficient practice identified. Any deficit practice will be addressed and prevented if at all possible at the time of dressing change. Further, any staff who fail to comply with the points of the in-service training will be further educated/or progressively disciplined as warranted.4. The QA Committee will oversee audits from the Director of Nursing/designee with weekly dressing change observations. Any patterns or concerns will be addressed by the QA Committee and if needed an Action Plan will be developed. The Action Plan will be reviewed by the Administrator weekly until resolved.5. Date of Compliance 01-16-15	

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	time during an interview LPN #7 indicated she would not have done anything differently during this dressing change. An interview was conducted on 12/18/14 at 3:15 p.m. with the DON (Director of Nursing). The DON indicated the facility does not have a dressing change policy, but the staff is to follow standard precautions during a dressing change. The DON also indicated the facility provided hand washing and infection control inservices to the staff. The clinical record of Resident #84 was reviewed on 12/19/14 at 8:30 a.m. This resident's diagnoses included, but were not limited to, renal neoplasm and lung metastasis. The admission skin assessment on 11/26/14 indicated the pressure ulcer on the coccyx was measured 3.0 cm x 2.5 cm x 1.0 cm. The skin assessment on 12/15/14 indicated the coccyx was measured at 4.1 cm x 5.0 cm x 2.0 cm. The treatment order on 12/8/14 indicated to pack the wound with moistened kerlix. Cover the wound with an abdominal pad and tape. The treatment order indicated to change the wound dressing every day.			

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	The Administrator provided the inservice related to hand washing on 9/25/14 at 10:30 a.m. titled "INSERVICE ATTENDANCE" and the current "Hand Hygiene Policy" indicated the following: "Purpose Hand hygiene is the single most efficient means of preventing the spread of infection. Indications for Hand Washing an Hand Antisepsis ...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 gold standard. ...Decontaminate hands after removing gloves." The same inservice indicated LPN #7			

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	had been provided hand washing inservice. 3.1-40(a)(2)			
F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to track and monitor behaviors to determine effectiveness for a resident who had an increase in an anti-anxiety medication for 1 of 5 residents reviewed for unnecessary drug regimen review. (Resident #94)	F000329	F329 It is the policy of The Waters of Yorktown to ensure each residents drug regiment is free from unnecessary drugs and ensure tracking and monitoring of behaviors prior to and during treatment with medication.1. On 01-08-15, Resident #94's medication regime was reviewed by resident's primary physician	01/16/2015

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	Findings include: The clinical record for Resident #94 was reviewed on 12/16/14 at 2:53 p.m. Diagnoses for Resident #94 included, but were not limited to, anxiety, depression, and dementia with behavioral disturbances. Resident #94 had a current physician's order for Xanax (an anti-anxiety medication) 0.5 milligrams (mg) 1 tablet by mouth two times a day. This order was an increase on 9/15/14 from Xanax 0.5 mg by mouth at bedtime. Resident #94 had a 11/10/14, quarterly Minimum Data Set (MDS) assessment which indicated the resident had moderate cognitive impairment. Resident #94 had "Behavior/Intervention Monthly Flow Records" for September, October, November and December 2014, which indicated the facility was monitoring the resident for anxiety. No behaviors were documented on the September, October, November and December 2014 flow records. Review of a provider visit note dated 9/15/14, indicated Resident #94 was an 85 year old male with onset night terror, anxiety, and increased depression. The provider increased Resident #94's Xanax to 0.5 mg 1 tablet by mouth twice a day		and medication remains necessary and appropriate. The medication has been care planned and nurses are documenting behaviors in Point Click Care.2. All residents have the potential to be affected and the Social Service Director is assessing all residents currently being treated with medication.3. Nursing and Social Service staff were in-serviced as to the necessity of adherence to following all points of the behavior management psychotropic medication protocol. Residents with behaviors will have those behaviors immediately addressed and documented within progress notes, 24 hour report, shift to shift report and incident report if appropriate. Residents with behaviors will be address in the next CQI meeting. Residents with behaviors will have their care plans updated to address any new or escalated behaviors at the time of occurrence. The Social Service Director will perform a quarterly audit to identify behaviors being treated with medication to discuss at Quarterly Behavior Meetings. Quarterly Behavior Meetings will include Administrator, Director of Nursing, Staff Psychologist, and Social Service Director. 4. The QA Committee will be responsible for overseeing the audits completed by the Social Service Director. Any patterns identified will be reviewed by the QA	

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	from 0.5 mg at bedtime on 9/15/14. During an interview with the Social Services Designee on 12/18/14 at 11:06 a.m., additional information was requested regarding the documentation of behaviors for Resident #94 in September 2014, related to the increase in the resident's anti-anxiety medication. No additional behavior documentation was provided regarding behaviors prior to the increase of the anti-anxiety medication for Resident #94 on 9/15/14. During an interview with the Administrator on 12/18/14 at 12:40 p.m., she indicated the facility did not have a policy and followed the Federal guidelines and regulations for unnecessary medications and gradual dose reductions. 3.1--48(a)(6)		Committee, if needed an Action Plan will be written by the QA Committee and monitored weekly by the Administrator until resolved.5. Date of Compliance 01-16-15	
F000332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure	F000332	F332 It is the policy of The Waters of Yorktown to ensure medication error rates of 5% or	01/16/2015

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	medication administration was free of a medication error rate of greater than 5% for 3 of 25 opportunities observed. This resulted in a medication error rate of 12%. This deficient practice had the potential to impact 1 resident. (Resident #41) Findings include: During an observation on 12/16/14 at 3:54 p.m., LPN #5 was observed to administer Resident #41 her Aricept (an Alzheimer's medication), Flexeril (a muscle relaxer medication), and hydrocodone-acetaminophen (a pain medication). The Aricept, Flexeril, and hydrocodone-acetaminophen were crushed before administration. The clinical record for Resident #41 was reviewed on 12/17/14 at 7:28 a.m. Diagnoses for Resident #41 included, but was not limited to, dementia and chronic abdominal pain. Current signed physician's orders for Resident #41 included, but were not limited to, Aricept 10 milligrams (mg) - 1 tablet by mouth daily, Flexeril 5 mg - 1 tablet by mouth two times a day, and hydrocodone-acetaminophen 7.5 mg - 325 mg - 1 tablet by mouth two times a day. The physician orders lacked a may		less.1. Resident #41's physician was contacted and orders received to crush medications.2. All residents had the potential to be affected and all residents were reviewed for crushing of medications.3. Nurses will be in-serviced on the requirement to have MD order to crush medications, prior to any meds being crushed. Nurses who fail to comply with the points of the in-service will be further educated and disciplinary action if appropriate. FDA guidelines for crushing of medications will be strictly adhered to. The facility pharmacist will review all medications which are crushed monthly and make recommendations as appropriate. 4. The QA Committee will review the facility Pharmacist's findings to ensure safe medication crushing monthly. Any patterns will be reviewed by the QA Committee. If needed, an Action Plan will be written by the QA Committee and will be monitored weekly by the Administrator until resolved.5. Date of Compliance 01-16-15	

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	crush medication order. Review of the Medication Administration Record for December 2014, lacked any indication to crush the Aricept, Flexeril, or hydrocodone-acetaminophen medications. During an interview with the Assistant Director of Nursing on 12/18/14 at 10:29 a.m., additional information was requested related to the may crush medication order for Resident #41. Review of the current facility policy, updated 6/19/12, titled "Six [RIGHTS] FOR ADMINISTRATION OF MEDICATIONS", provided by the Director of Nursing on 12/18/14 at 12:20 p.m., included, but was not limited to, the following: "...The need for crushing medications is indicated on the resident's MAR [Mediation Administration Record] so that all personnel administering medications are aware of this need and the consultant pharmacist/nurse can advise about safety and alternatives, if appropriate, during DRR/MAR reviews...." Three errors divided by twenty-five opportunities for error times 100 resulted in a medication error rate of 12%.			

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	3.1-48(c)(1)			
F000364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to ensure food was served at a palatable temperature for 4 of 15 residents interviewed regarding food palatability. (Resident #87, #57, #94, and #90) Findings include: During interviews with residents, who were determined to be interviewable during the stage 1 process, 4 of 15 residents interviewed expressed concerns with cold food: During a 12/15/14, 2:17 p.m., interview, Resident #87 indicated during evening meals food was cold on a regular basis. During a 12/16/14, 12:32 p.m., interview, Resident #57 indicated food was cold almost every day. During a 2/16/14, 9:07 a.m., interview,	F000364	F364 It is the policy of The Waters of Yorktown to provide each resident with food that is palatable, attractive and at proper temperature.1. Resident #87, #57, #94 and #90 will be visited individually by Dietary Manager, 1 x weekly x 12 weeks to ensure food is being served at desired temperature.2. All residents receiving food trays have the potential to be affected. 3. The Dietary Manager in-serviced all dietary staff on proper food temps per regulations. Dietary Manager will conduct at least 5 test trays weekly rotating meals x 12 weeks. Dietary Manager will discuss food temperature satisfaction or lack thereof at Care Plan meetings and conduct food surveys at Resident Council Meetings.4. Dietary Manager will bring results from weekly test trays to QA Meetings and any reports of residents concerns with food temperatures. Any patterns will be reviewed by the QA Committee. If needed, an Action Plan will be written by the QA	01/16/2015

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	Resident #94 indicated food was not hot. It was "luke warm." During a 12/16/14, 9:59 a.m., interview, Resident #90 indicated food was cold about half of the time. Review of Resident Council Minutes for November 2014 through July 2014 (5 months), indicated residents had complaints regarding food temperatures 2 of 5 months 9/18/14 and 8/20/14. During a 12/17/14, 11:39 a.m., food palatability observation, the mechanical soft sweet and sour chicken was cold and not palatable. A second test tray was obtained and tasted and tested for temperature with the assistance of the Dietary Manager at 12/17/14 at 11:42 a.m. The Dietary Manager indicated the mechanical soft sweet and sour chicken was cold. She then tested the temperature of the chicken and indicated the product was 90 degrees Fahrenheit (F). She indicated the chicken should be 155 degrees before service. The Dietary Manager then went to the steam table stirred the mechanical soft check and checked the temperature. The chicken reached 135 degrees Fahrenheit. The Dietary Manager indicated the chicken would need to go back in the		Committee and will be monitored weekly by the Administrator until resolved.5. Date of Compliance 01-16-15	

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	oven until hot. Review of the current policy, dated 2011, titled "Monitoring Food Temperature for Meal Service", provided by the Administrator on 12/18/14 at 3:30 p.m., included, but was not limited to, "4. If the serving/holding temperature of a hot food item is not at 135 degrees F or higher [check your state specific regulations: some states require 140 degrees F minimum hot holding temperature] when checked prior to meal service, the item will be reheated to at least 165 degrees F for a minimum of 15 seconds.... ...7. Food temperatures of hot foods on room trays at the point of service are preferred to be at 120 degrees F or greater to promote palatability for the resident. Any complaint regarding food temperatures by residents will be documented on the food temperature log...." 3.1-21(a)(2)			
F000431 SS=E	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			

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	records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. The facility must provide separately locked, 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.			
	Based on observation, interview and record review, the facility failed to ensure the security and disposal of medications for 1 of 1 medication storage rooms observed and 1 of 4 medication carts observed. (200 Hall medication cart and storage room) This deficient practice had the potential to impact 20 residents that resided on the 200 hall.	F000431	F432 It is the policy of The Waters of Yorktown to ensure proper and safe storage of medications.1. No residents were affected and 100% audit of all med storage areas was completed to ensure all medications locked up and secure. All discontinued medications have been destroyed.2. Nurses were in-serviced regarding medication safety and security and the proper disposition of discontinued	01/16/2015

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	Findings included: During a medication storage observation on 12/18/14 at 12:38 p.m., an unlabeled heparin flush and a bottle of Tums for a discharge resident was observed in the storage cabinet. During this time an interview was conducted with LPN #7 and the DON (Director of Nursing). LPN #7 indicated she did not know why the medication had not been thrown away. The medication belonged to a resident who had been discharged on 8/20/14. LPN #7 indicated medications should be thrown away 7 days after discharge. The DON indicated she was unaware the medication was up in the cabinet. On 12/18/14 at 1:52 p.m., an unattended medication cart on hallway 200 was observed with the second drawer not fully closed. An interview was conducted on 12/18/14 at 1:58 p.m. with LPN #6. She indicated she thought the drawer was closed. LPN #6 indicated there was unsafe medication in the drawer including, but not limited to, antihypertensives and diuretics. During an interview with the Administrator, Director of Nursing, and the Assistant Director of Nursing on 12/18/14 at 3:30 p.m., they indicated		medications within 7 days. New Policy and Procedure implemented for drug destruction within 7 days of discharge. Any nursing staff that fail to comply with the points of the in-service will be further educated and disciplinary action taken if appropriate.3. The Director of Nursing/designee will monitor/audit all med storage areas as well as the security 3 days weekly (various shifts) until 4 consecutive weeks of zero negative findings are achieved. Afterwards random weekly will continue ongoing. Note any concerns will be corrected as discovered within the monitorings.4. The med storage/med cart monitorings will be reviewed at the QA meetings. Any patterns identified will be reviewed at QA meetings. If needed, an Action Plan created and will be monitored weekly by the Administrator until resolved.Date of Compliance 01-16-15	

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	155238		12/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF YORKTOWN THE	2000 S ANDREWS RD YORKTOWN, IN 47396

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	medication should be discarded after 7 days of the resident's discharge. The policy title "3.1: MEDICATION STORAGE IN THE FACILITY" was provided by the Administrator on 12/18/14 at 2:30 p.m. This current policy indicated, "medication carts are to be locked or attended by a person with authorized access". During an interview on 12/19/14 at 11:00 a.m., LPN #10 indicated there was 20 residents on the 200 hall. 3.1-25(j) 3.1-25(r)			
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			

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	(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, interview and record review, the facility failed to ensure hand washing practices were followed in the prevention of the development and spread of infection for 1 of 3 direct care observations. (Resident #84, LPN #7) Findings include: Resident #84's dressing change to her pressure ulcer on her coccyx was observed on 12/18/14 at 9:00 a.m. by LPN #7. She was observed with gloved hands to remove the soiled dressing, then, discarded her gloves, and donned a new set of gloves. There was no hand washing	F000441	F441 It is the policy of The Waters of Yorktown to establish and maintain an Infection Control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.1. Nurse #7 has received education regarding infection control procedures, clean dressing changes techniques, preventing contamination, and proper glove use and hand-washing.2. All residents have the potential to be affected. All nursing will be in-serviced and required to return demonstration of proper technique regarding dressing	01/16/2015

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	or hand gel use observed. LPN #7 then cleansed the wound by spraying normal saline inside the open area. The same abdominal pad used to catch the saline solution from cleansing the open wound was also used to pat the remaining excess fluid from the open area. She then discarded her gloves and donned a new pair of gloves with no hand washing or hand gel use observed. After LPN #7 cut the kerlix with scissors, she then packed the wound with saline moistened kerlix. LPN #7 then donned her gloves with no hand washing or hand gel use observed. Next, LPN #7 reached in her pocket and removed a roll of tape. The tape was cut using the same scissors, then placed the tape on the abdominal pads used for the wound dressing. After changing her gloves with no hand washing or hand gel use observed, LPN #7 then reached in her pocket, removed a pen and signed and dated the wound dressing. After LPN #7 repositioned the resident, she cleaned her work space and placed her scissors back in her pocket. No disinfecting of these scissors was observed. She was observed repositioning a drinking class used by the CNA #8 to give the resident a drink. LPN		changes including use/handling of all dressing supplies including tape, scissors and writing instruments for the dating of the dressings. 3. To ensure ongoing utilization of correct technique during dressing changes, the Director of Nursing/designee will monitor dressing changes 1 x weekly for each resident with a dressing changes x 12 weeks and randomly thereafter, if any deficient practice identified. Any deficit practice will be addressed and prevented if at all possible at the time of dressing change. Further, any staff who fail to comply with the points of the in-service training will be further educated/or progressively disciplined as warranted.4. The QA Committee will oversee audits from the Director of Nursing/designee with weekly dressing change observations. Any patterns or concerns will be addressed by the QA Committee and if needed an Action Plan will be developed. The Action Plan will be reviewed by the Administrator weekly until resolved.5. Date of Compliance 01-16-15	

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	#7 removed her gloves and was observed to hand wash for 10 seconds. At the same time during an interview LPN #7 indicated she would not have done anything differently during this dressing change. An interview was conducted on 12/18/14 at 3:15 p.m. with the DON (Director of Nursing). The DON indicated the facility does not have a dressing change policy, but the staff is to follow standard precautions during a dressing change. The DON also indicated the facility provided hand washing and infection control inservices to the staff. The clinical record of Resident #84 was reviewed on 12/19/14 at 8:30 a.m. This resident's diagnoses included, but were not limited to, renal neoplasm and lung metastasis. The Administrator provided the inservice related to hand washing on 9/25/14 at 10:30 a.m. This inservice titled "INSERVICE ATTENDANCE" and the current "Hand Hygiene Policy" indicated the following: "Purpose Hand hygiene is the single most efficient means of preventing the spread of			

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	infection. Indications for Hand Washing an Hand Antisepsis ...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 gold standard. ...Decontaminate hands after removing gloves." The same inservice indicated LPN #7 had been provided hand washing inservice. 3.1-18(l)			
F000465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the	F000465	F465 It is the policy of The	01/16/2015

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	facility failed to ensure resident rooms were clean and in good repair for 9 of 35 resident rooms reviewed. (Rooms 104, 106, 108, 111, 201, 202, 207, 208, and 213) Findings include: During stage one resident room observations from 12/15/14, 10:00 a.m., to 12/16/14, 2:00 p.m., the following concerns were noted: Room 104 - Brown stain on tile around base of commode in bathroom. (One resident in the room) Room 106 - The walls in the bathroom had white patched areas the size of dinner plates above the grab bar. The floor around the base of the commode had yellow-brown substance on it. (One resident in the room) Room 108 - Scratches on the wall behind the recliner. The sink in the bathroom had loose caulking, leaning slightly down and separating from the wall. (Room shared by 2 residents) Room 111 - A brown stain, approximately the size of a dinner plate, on the ceiling in the corner to the right of the window. (One resident in the room)		Waters of Yorktown to provide a safe, functional, sanitary and comfortable environment for our residents.1. All rooms identified during environmental tour 104, 106, 108, 111, 201, 202, 207, 208, and 213 have been assessed, repaired and/or replaced.2. 100% audit of rooms and bathrooms will be conducted for potential environmental concerns and appropriate repairs will be scheduled.3. Maintenance will perform a weekly hall audit (1 hall per week). Any identified findings will be scheduled for repair.4. Results of the weekly hall audits will be brought to QA meetings. Any patterns identified will be reviewed by the QA committee. If needed, an Action Plan will be written and monitored weekly by the Administrator until resolved.5. Date of Compliance 01-16-15	

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	Room 201 - The corner of the ceiling above the left side of the window had a brown stained area. (Room shared by 2 residents) Room 202 - The corner of the closet to the left (across from bathroom door) was scratched and missing paint. The doorframe and walls of bathroom had dark scuff marks and scratches. The cove base on wall next to the sink had pulled away from the wall. (One resident in the room) Room 207 - A brown discoloration on the tiles near the stool in the bathroom. (Room shared by 2 residents) Room 208 - A substance on the bathroom wall next to the mirror, which looked like residue from a previous soap dispenser. (Room shared by 2 residents) Room 213 - No cover for bolts at the base of stool in the bathroom. The bolts were approximately 1/2 inch to 1 inch in height. (Room shared by 2 residents) During an interview with the Maintenance Supervisor on 12/18/14 at 10:02 a.m., a copy of work plan and room checks/repairs for the last 3 months was requested.			

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	No maintenance requests had been turned in for the rooms identified in stage one. During an tour of hallways 100 and 200 with the Maintenance Supervisor on 12/18/14 at 1:09 p.m. concerns observed in stage one were brought to his attention. He indicated call lights (in resident rooms and bathrooms) are checked monthly. He indicated he observes rooms for any other issues when performing the monthly checks. He indicated he works full- time and has an additional maintenance part-time staff. He indicated he was not aware of these environmental concerns. He indicated he believed some of the concerns in the bathrooms were related to housekeeping and not stained tiles. During an interview with the Housekeeping Supervisor on 12/18/14 at 1:52 p.m., she indicated if housekeeping staff were not able to get the floor clean then the floors were stripped and waxed. If a floor problem was not resolved then a request to replace the tiles was submitted to the Administrator. She indicated the housekeeping staff were to complete a maintenance request if a problem is observed in any of the resident rooms or bathrooms, such as a loose sink. Additional information was requested related to cleaning logs and maintenance			

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	repairs. The Housekeeping Supervisor indicated all maintenance requests had been given to the Maintenance Supervisor. During an interview with the Administrator on 12/18/14 at 1:59 p.m., any additional information regarding the environment and the policy on environment/maintenance was requested. The facility did not provide any other information related to the environmental concerns as of exit on 12/19/14. 3.1-19(f)			
F000520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee			

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	except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.			
	1. Based on observation, interview and record review the facility QAA Committee failed to identify and address a repeat quality issue regarding dignity and the dining experience. The facility failed to develop and implement an effective plan of action to address this concern. This deficient practice impacted 6 of 7 residents reviewed for dignified care and services. (Resident #3, #26, #1, #75, #13, and #18) 2. The facility QAA Committee further failed to implement an action plan to address dignity issues for residents regarding long waits for meal service and lack of activities while waiting for meals to be served. Findings include: 1. During an interview on 12/19/14 at 10:45 a.m., the Administrator (HFA) indicated the Quality Assessment and Assurance (QAA) committee meets quarterly. The HFA indicated the topics for discussion at QAA meetings included, but were not limited to, plans of	F000520	F 520 It is the policy of The Waters of Yorktown to maintain a Quality Assurance Committee who oversees facility compliance and identifies quality deficiencies which might affect residents and staff. 1. Resident's #1, #53, #3, #26, #75, #13 and #18 will no longer be taken to the dining room prior to 15 minutes before meal times. 2. All residents who are not able to verbalize their preferences have the potential to be affected. Residents who prefer to go to dining room prior to 15 minutes will have their preferences care planned and the right to go to dining room at any time. Residents who are not able to verbalize their preference will not be taken to dining room prior to 15 minutes before meal time. 3. To prevent a reoccurrence, all staff will be in-serviced to F241 - Dignity and resident choice/preferences at meal times. 4. Director of Nursing/designee and Administrator/designee will utilize the Daily Rounds form, when rounding to ensure staff compliance with not bringing residents to dining room earlier than 15 minutes prior to meals. The Administrator and Regional Vice President of Operations	01/16/2015

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	correction from prior State Recertification and Licensure surveys. The HFA indicated after each meeting, goals are set by the HFA and designated department heads, to correct problem areas identified during the QAA meeting. The HFA further indicated plans of action to correct these deficiencies are implemented from these goals. The HFA indicated evaluation of the effectiveness of the action plans was not completed. The HFA was questioned regarding the dignity concerns observed during meal times during the current survey and during the previous survey and indicated she did not think they were the same concern. The HFA indicated dignity concerns during the dining experience had not been addressed by the QAA committee.		have reviewed the duties and process of QA Committee including the meeting agenda, action plans and overall expected functions of the QA committee per Federal Guidelines. The CQI Committee meets daily and any noted dignity violations will be addressed on a daily basis. The QA committee will oversee compliance by reviewing any noted violations on the Daily Walking Rounds forms at QA meetings. Any patterns identified will be reviewed by the QA committee. If needed, an Action Plan will be written by the QA committee and monitored weekly by the Administrator until resolved. 5. Date of Compliance 01-16-15	