

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/30/2012
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NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG II LLC THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 24, 25, 26, 27, 30, 2012</p> <p>Facility number: 000478 Provider number: 155494 AIM number: 100290430</p> <p>Survey Team: Donna Groan, RN, TC Avona Connell, RN (January 24, 26, 27, 30, 2012) Gloria Reisert, MSW Dottie Navetta, RN (January 30, 2012)</p> <p>Census bed type: SNF/NF: 66 Total: 66</p> <p>Census payor type: Medicare: 02 Medicaid: 60 Other: 04 Total: 66</p> <p>Sample: 15 Supplemental sample: 14</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC</p>	F0000	<p>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 conclusion 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. Additionally, we request that this survey by reviewed for paper compliance.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	16.2. Quality review completed 2/5/12 Cathy Emswiller RN			
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F0164 SS=D	<p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation and interview the facility failed to ensure a resident's privacy during bathing for 1 of 1 residents in a sample of 15 reporting a concern with privacy during bathing and 1 of 1 resident observed receiving a bath in a supplemental sample of 14. (Resident #101 and 13)</p> <p>Findings include:</p>	F0164	<p>F164 Personal Privacy/Confidentiality of records</p> <p>It is the intent of this facility to ensure all resident's privacy during bathing.</p>	02/22/2012
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	<p>1. During the group meeting on 1/24/12 at 1:30 p.m., the Activity Director identified this resident as alert and oriented.</p> <p>On 1/26/12 at 1:30 p.m., in interview with Resident #101, the resident indicated there was no privacy during bathing as other staff come in and the curtains are not pulled.</p> <p>The clinical record for resident #101 was reviewed on 1/26/12 at 2:08 p.m. Resident Minimum Data Set Assessment most recent quarterly for December 2011 indicated the resident cognitive status was moderately impaired.</p> <p>2. On 1/26/12 at 11:15 a.m., a resident was heard calling out from the shower room. Having knocked on the door and getting permission to enter, CNA #3 was attempting to get Resident #13 to sit down to get the resident dressed. The resident had just been given a bath, was standing up with no clothes on and the curtain was not pulled to prevent anyone upon entering to view the resident.</p> <p>In interview with CNA #3 at this time, she indicated the nurse had taken residents out to smoke and the other CNA was on the hall monitoring the other residents.</p>		<p>1. Action Taken:</p> <p>A. Resident #13, staff in-serviced/educated on ensuring resident privacy during bathing.</p> <p>2. Others Identified:</p> <p>A. All other residents would have the potential to be affected.</p> <p>3. Measures Taken:</p> <p>A. In-service nursing staff on privacy during personal care on February 16, 2012.</p> <p>4. How Monitored:</p> <p>A. DON/Designee will audit personal care given by 2 staff members a day for one week then 3 times a week for 2 weeks then 1 time a week for 2 weeks until reviewed by the QA team for compliance. The IDT will monitor for privacy/dignity</p>				

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	<p>On 1/30/12 at 3:45 p.m., the Assistant Director of Nursing provided the steps for maintaining the resident's right to privacy and dignity, from the CNA training book, which indicated "close curtains, drapes and doors. Keep resident covered."</p> <p>3.1-3(t)</p>		<p>issues/concerns during daily QA rounds.</p> <p>B. The Administrator will review these daily QA rounds audits daily in QA stand-up meeting; monthly with QA team; and then quarterly with the Medical Director at the quarterly QA meeting.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: <u>February 22, 2012.</u></p>		

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F0244 SS=E	<p>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>Based on record review and interviews, the facility failed to resolve resident concerns regarding staff's voice levels, timing of meals, food concerns and temperature of food served during 1 of 1 confidential group meeting with 12 residents (Residents # 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111) and 7 of 8 Resident Council minutes reviewed (July 2011 through January 2012).</p> <p>Findings include:</p> <p>During interview on 1/24/2012 at 2:30 p.m., the Activities Director indicated the 12 residents (Residents # 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111) who came to the confidential group meeting were capable of voicing their needs and concerns.</p> <p>During the confidential group meeting, the following concerns were voiced and agreed upon by all members of the group as being concerns:</p> <p>1. Food was often served cold or barely</p>			F0244	<p>F244 Listen/Act on group grievance /recommendation</p> <p>It is the intent of this facility to resolve resident concerns regarding staff's voice levels, timing of meals, food concerns and temperature of food served.</p> <p>1. Action Taken:</p> <p>A. Facility staff will be in-serviced by February 22, 2012 on importance of maintaining noise in the facility at an acceptable level.</p> <p>B. Dietary Staff will be in-serviced/educated on timeliness of meals per schedule, appropriate food temp monitoring, and food concerns as identified.</p>		02/22/2012

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	<p>warm - it did not matter which meal as all 3 meals were affected.</p> <p>2. Staff were loud and noisy during the day and at night. Staff would often stand outside the residents' door and carry on a conversation making it difficult to sleep or would yell up/down the hall.</p> <p>3. Meals were often served late - at times were served close to 6:00 p.m. when the first shift was getting ready to leave.</p> <p>4. Food is not cooked enough, especially carrots. All the meats are tough and of poor quality.</p> <p>On 1/26/2012 at 9:35 a.m., the Administrator presented a copy of the June 2011 through January 2012 Resident Council minutes. Review of these minutes included, but were not limited to:</p> <p>A." July 18, 2011: Residents on several units c/o [complain of] their food is cold at times". The 7/19/2011 reply by the Dietary Manager was "Inservice employees on measures to make sure food is hot when taken to halls, ex. timely service, correct use of insulating devices."</p> <p>B. "August 15, 2011: Residents on Ruby Bay c/o of r/t [related to] poor sleep at night r/t noisy and other residents</p>		<p>2. Others Identified:</p> <p>A. An audit of 100% of resident councils meeting minutes for the last three months will be conducted to validate all concerns have been addressed / resolved. These concerns would have the potential to affect all residents.</p> <p>3. Measures Taken:</p> <p>A. Conduct off hour visits by Administrator/DON or Designee to address resident concerns during evening hours 2 days a week for 4 weeks.</p> <p>B. All concerns discussed at the Resident Council Meeting will be distributed to the Department Manager the day of the Council Meeting. The Department Manger will, the next working day, bring the concern with a plan to correct to the daily QA stand-up meeting to be reviewed/discussed by the IDT.</p> <p>C. In-service all facility staff on appropriate noise levels to include;</p>		

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	<p>wandering in and out of their rooms". The 8/22/2011 reply by the Director of Nursing [DoN] was "Education done [with] staff R/T wandering residents and promoting a relaxing atmosphere for the residents".</p> <p>C. "September 19, 2011: 1. Approx [approximately] 2 - 3 days ago, chicken - n - dumplings were served. The chicken was too hard to chew." The 9/20/2011 response by the Dietary Manager was "Instructed cook on proper way to handle chicken so it doesn't get tough."</p> <p>"2. Ruby Bay residents still have concerns of not sleeping well due to noise level & wanderers at night". The 9/19/2011 response by the DoN was "Education done [with] staff r/t interventions [with] wandering & interventions to promote & facilitate sleep. Res. offered to have door shut".</p> <p>D. "October 17, 2011: 1. C/O noise level at night & radio on or TV on in a room on Sapphire Stream 24/7". The 10/18/2011 response by LPN #1 was "Staff is to do rounds to ensure calm and quiet environment is kept throughout the night".</p> <p>"2. Noise level - still c/o noise at night to include other residents who are loud on</p>		<p>overhead paging only as necessary, keeping voices at an appropriate level, answering call lights and alarms promptly, etc.</p> <p>4. How Monitored:</p> <p>A. The finalized plans to correct issues will be turned into the ADM/Designee no later than 2 working days after the monthly council meeting. This will be an on-going process.</p> <p>B. Department manager will interview resident that voiced concern approximately 1 week after interventions are initiated and bring outcomes to the daily QA stand-up meeting to determine effectiveness.</p> <p>This will be an on-going process.</p> <p>C. Concerns, plans and outcomes will be discussed by SSD/Designee at monthly Quality Assurance Meeting. This will be an on-going process.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory</p>		

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	<p>Ruby Bay". The 10/18/2011 response by LPN #1 was "Staff educated on alternative ways to redirect residents and educated on how to keep a calm environment at night".</p> <p>E. "November 21, 2011: 1. C/O meals late, food is cold,..." The 11/30/2011 response by the Dietary Manager was "New cooks in training and new processes put in place to ensure food stays hot". An Inservice Training was also held on 11/22/2011 by the Dietary Manager with the dietary workers to include timely service. Review of the "New Process For Keeping Food Hot For Service" developed by the Dietary Manager at this time included: "Problem - The food is sometimes cold when it is served on the halls. Possible Causes - The deep pans used on the steam table may not be keeping the top layer of food hot, especially when it is filled to the top. Solution: Either use shallower pans to maximize surface area heated by the steam table or separate subject foods into two batches and keep one in a warm oven until it is needed".</p> <p>"2. Noise level at night - Residents have repeat concern that noise level here at night is too loud. The halls which were included were Ruby Bay, Onyx, and Sapphire. C/O of staff</p>		<p>requirements. Our date of compliance is: <u>February 22, 2012.</u></p>	
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	<p>talking/socializing/other patients TV & radio on & hearing staff talk about other Resident & other resident issues". The 11/22/2011 response by LPN #1 was "Inserviced all 6 p - 6 a staff, educated all staff policy and procedure on socializing and gossiping. Educated on the importance of keeping a calm/quiet environment at all times on all units". On 12/5/2011, an inservice was help by the DoN and LPN #1 regarding the noise on third shift. The corrective action was "Inservice [with] staff; 3rd shift supervisor to do rounds et [and] make sure noise level is @ [at] a minimum".</p> <p>F. "December 19, 2011:1. Some meals late, food not hot enough for patients on unit". The 12/20/2011 response by the Dietary Manager was "Manpower changes in the kitchen as well as more training. Staff educated on processes to keep food hot until service".</p> <p>"2. Noise level at night - Patients still have concerns [with] noise level at night". The 12/20/2011 response by LPN #1 was "Staff inservices et educated on the importance of keeping a calm quiet environment for the residents. Staff educated to do rounds frequently to make sure all TVs et radios are either off or at a lower level. Staff also educated to not socialize in resident areas".</p>			

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	<p>G. "January 20, 2012: 2 patients c/o baked potatoes are not tender & meat is tough and dry". The 1/20/2012 response from the Dietary Manager was "Educate staff on procedure for making sure meat is properly cooked." A 1/21/2012 inservice was also held for the dietary workers - " Inserviced staff on proper procedures for cooking meat and proper cooking temperatures".</p> <p>On 1/24/2012 at 10:00 a.m., the Administrator presented a copy of the facility's meal times when the trays were served. Observation of the tray service on 1/24/2012 at lunch between Noon and 1:00 p.m., indicated the trays were served at the following times:</p> <ul style="list-style-type: none"> - Sapphire Hall served at 12:13 p.m. - meal time was to be 11:35 a.m. - Ruby Bay Hall was served at 12:40 p.m. - meal time was to be 12:15 p.m. - Emerald Hall was served at 12:46 p.m. - meal time was to be at 11:45 a.m. <p>Observation of the supper meal on 1/25/2012 between 5:00 p.m. and 6:10 p.m., indicated the trays were served at the following times:</p> <ul style="list-style-type: none"> - Onyx Hall was served at 5:35 p.m. - meal time was to be 5:30 p.m. - Emerald Hall was served at 5:50 p.m. - meal time was to be 5:15 p.m. 			
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	<p>- Ruby Bay Hall was served at 5:40 p.m. - meal time was to be 5:40 p.m.</p> <p>- Main Dining Room was served at 6:00 p.m. - meal time was to be 5:45 p.m.</p> <p>On 1/26/2012 at 2:30 p.m. during the daily exit meeting with the Administrator and the DoN, they were informed of the group's concerns with cold food being served, tray service late, and quality of meats served. The Administrator indicated the problem regarding the cold food had already been addressed as the facility had ordered awhile back warming plates for the bottom of the plates to go with the lids they already had. She indicated the facility was now waiting on them to come in.</p> <p>On 1/30/2012 at 12:15 p.m., the Administrator presented a copy of a purchase order dated 1/25/2012 in which she ordered 7 cases of Plate Underliners to keep the food warm.</p> <p>3.1-3(l)</p>						

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F0252 SS=E	<p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>A. Based on observation and interview the facility failed to ensure the resident environment had articles from home for resident rooms for 4 of 15 sampled resident rooms observed and 2 of 2 residents rooms observed in a supplemental sample of 2. (Resident #5, 49, 67, 3, 50, 61)</p> <p>B. Based on observation and interview the facility failed to ensure the residents utilizing the smoking area were protected from the weather for 2 of 2 observations. This deficiency had the potential to affect 18 current residents who smoke. (Residents #6, 7, 8, 14, 20, 22, 23, 47, 48, 50, 51, 54, 55, 59, 61, 65, 66, 67).</p> <p>Findings include:</p> <p>A.1. On 1/24/12 between 2:40 p.m. and 3 p.m., Resident #5 was observed seated up in a recliner. No pictures and or wall coverings in room.</p> <p>On 1/25/12 between 10 a.m. and 3:45 p.m., the following was observed:</p> <p>A.1. Resident #5 was observed seated in a brown recliner which leaned to the</p>			F0252	<p>F252 Safe/Clean/Comfortable/Homelike Environment</p> <p>It is the intent of this facility to ensure the resident's environment has articles from home.</p> <p>1. Action Taken:</p> <p>A. Resident 5# -- pictures were hung in room and the recliner was replaced.</p> <p>B. Resident 49#-- picture frames were placed and pictures were hung.</p> <p>C. Resident 67# --homelike items placed in room.</p>		02/22/2012

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	<p>right. The head rest and foot rest had large areas where the leather had been worn off. No family pictures or wall hangings. The clinical record for resident #5 was reviewed on 1/24/12 at 1:35 p.m. The resident was admitted to the facility on 1/15/09.</p> <p>A.2. Resident #49 was seated up in a wheel chair in the Activity/Dining room. The resident's room had four 4 x 6 pictures taped over the bedside table with no picture frames and the wall next to the bed lacked any pictures. The clinical record for resident #49 was reviewed on 1/25/12 at 2:05 p.m. The resident was admitted to the facility on 8/7/09.</p> <p>A.3. Resident #67's lacked any items from home. The wall behind the bed and near the window lacked any items. The clinical record for resident #67 was reviewed on 1/25/12 at 10:35 a.m. The resident was admitted to the facility on 7/20/11.</p> <p>On 1/26/12 between 11:30 a.m. and 2:45 p.m., the following was observed:</p> <p>A. 4. Resident #3 was seated in a wheel chair in his room. His bed was to the left of the entry way. There were 3 small stuffed animals on the nightstand. There were no pictures nor wall hangings. The</p>		<p>D. Resident 3# --wall hangings were placed in room.</p> <p>E. Resident 50# picture frames placed in room.</p> <p>F. Resident 61# picture frames and wall hangings were placed.</p> <p>2. Others affected:</p> <p>A. All residents have the potential to be affected related to non-homelike environment.</p> <p>3. Measures Taken:</p> <p>A. All resident rooms will be inspected to validate a home like environment. Families/Significant Others will be encouraged to bring in personal items from home. If items are needed, facility will work with responsible party to obtain items.</p>		

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	<p>clinical record was reviewed on 1/26/12 at 11:30 a.m. The resident was admitted to the facility on 4/8/11.</p> <p>On 1/30/12 between 7:30 a.m. and 11:30 a.m., the following was observed.</p> <p>A.2. Resident #49 was lying in bed with eyes closed. There was an 8 x 10 picture frame with family lying on the nightstand. No wall hangings were on the wall next to the bed.</p> <p>A.3. Resident #67 was lying in bed with his back to the door. The walls and nightstand lacked any items from home.</p> <p>A. 5. Resident #50 was out of the room, at this time. Two 4 x 6 pictures were taped to the wall over the headboard.</p> <p>A. 6. Resident #61 was out of the room at this time. One 4 x 6 picture taken in the facility was taped above the head of the residents bed. No other wall coverings noted.</p> <p>A copy of the "Your Rights as a Nursing Home Resident included" was provided by the administrator on 1/25/12, at 11:30 a.m.,which included, but was not limited to: "Living Accommodations and Care You have a right to: "a safe, clean, comfortable, home-like environment."</p>		<p>4. How Monitored:</p> <p>A. Administrator/SSD/Designee to complete monthly inspection of resident rooms to validate homelike items are in place.</p> <p>B. Inspection results will be discussed at the monthly Quality Assurance meeting and reviewed with the Medical Director at the Quarterly QA meeting.</p> <p>It is the intent of this facility to ensure residents utilizing the smoking area were protected from the weather.</p> <p>1B. Action taken:</p> <p>A. A Tarp was attached to the canopy providing protection from the elements.</p> <p>B. Maintenance removed pooling of water from canopy.</p>		

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	<p>In interview with Social Service on 1/26/12 she indicated she would contact resident families and have them bring in items from home.</p> <p>B. During observation, on 1/24/12 at 2:45 p.m., the smoking area was located outside of the side door. A canopy was on a concrete patio which had no sides to prevent, wind, rain, snow.</p> <p>On 1/25/12 between 3:30 p.m. and 4 p.m., 5 residents were observed outside smoking and wearing winter coats covered by the smoke aprons which were being blown by the wind. During the observation, the wind was blowing, it was cold and raining. Two staff members were supervising the residents.</p> <p>On 1/26/12 between 1:30 p.m. and 1:45 p.m., while walking off the distance between the building and the canopy, it was measured to be 6 feet from the building overhang to entrance for the canopy. Water was pooling on the concrete. There was water pocketing about 2 feet on the canopy which was dripping. There were 5 smokers, 7 small ash trays, smoke aprons, a fire extinguisher and fire blanket.</p> <p>On 1/26/12 at 8:57 a.m., the</p>		<p>2B. Others identified:</p> <p>A. All other residents who smoke have potential to be affected.</p> <p>3B. Measures taken:</p> <p>A. A tarp was attached to the canopy.</p> <p>B. The water was removed.</p> <p>4B. How monitored:</p> <p>A. Staff during smoke breaks will observe canopy and tarp for placement.</p> <p>B. Maintenance/IDT to monitor during inclement weather the pooling of water on tarp and cement. If indicated, water will be</p>				

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	<p>Administrator provided a letter provided to the residents/family members dated 9/1/11 which included, but was not limited to: "Change in smoking policy. Effective October 1, 2011 smoking will not be allowed inside the building. Residents will be able to smoke in the fenced in area outside. We will provide some type of shelter from the rain..."</p> <p>On 1/30/12 at 3:40 p.m., the Payroll Director provided a list of 18 residents who utilize the outside smoking area which included: Resident's #6, 7, 8, 14, 20, 22, 23, 47, 48, 50, 51, 54, 55, 59, 61, 65, 66, 67.</p> <p>3.1-19(f)(5)</p>		<p>removed.</p> <p>C. The Maintenance Director/Designee will inspect the Canopy for the smoking area monthly to validate it provides sufficient protection against weather elements.</p> <p>D. The effectiveness of the canopy and tarp will be discussed at the monthly Quality Assurance Meeting and reviewed with the Medical Director at the Quarterly QA meeting.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: <u>February 22, 2012.</u></p>				

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F0258 SS=E	<p>The facility must provide for the maintenance of comfortable sound levels.</p> <p>Based on interview and observation the facility failed to maintain noise levels that were at a comfortable level related to the overhead paging system and staff voice levels. This affected 2 of 15 in a sample (Resident # 100, 101) and 11 of 13 in a supplemental sample. (Resident # 43, 102, 103, 104, 105, 106, 107, 108, 109, 110, and 111)</p> <p>Findings include:</p> <p>On 1/24/2012 at 2:36 p.m., during the confidential group meeting residents indicated, but not limited to; the "overhead paging system is loud".</p> <p>During the same group meeting, the overhead paging system was so loud, that at frequent intervals the meeting conversation had to pause until the paging stopped. This meeting was held for approximately 1 hour.</p> <p>On 1/30/2012 at 12:30 p.m., in an interview with Resident # 43 he stated "it is noisy both in the morning and at night".</p>	F0258	<p>F258 Maintenance of comfortable Sound levels</p> <p>It is the intent of this facility to maintain noise level at a comfortable setting.</p> <p>1. Action Taken:</p> <p>A. In-service staff to the importance of maintaining a noise level in the facility at all hours that is appropriate and comfortable to residents. In-service will include information on resident confidentiality and protecting residents information.</p> <p>B. The overhead paging system is now to be used in emergencies only.</p> <p>C. Conduct off hour visits by ADM/DON/Designee to evaluate</p>	02/22/2012			

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			<p>noise level during evening hours 2 days a week.</p> <p>2. Others affected:</p> <p>A. All residents have the potential to be affected.</p> <p>3. Measures Taken:</p> <p>A. Conduct off hour visits by ADM/DON/Designee to evaluate noise level during evening hours 2 days a week.</p> <p>B. If employee is found to be excessively noisy it will be treated as an incident suitable for counseling and will be documented in the employee file.</p> <p>4. How monitored:</p> <p>A. Five randomly selected residents will be interviewed weekly to track improvement of sound levels.</p>		

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	<p>During an interview on 1/24/2012 at 2:30 p.m., the Activities Director indicated the 12 residents (Residents # 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, and 111) who came to the confidential group meeting were capable of voicing their needs and concerns.</p> <p>During the confidential group meeting, the following concern was voiced: Staff were loud and noisy during the day and at night. Staff would often stand outside the residents' door and carry on a conversation making it difficult to sleep or would yell up/down the hall.</p> <p>On 1/26/2012 at 9:35 a.m., the Administrator presented a copy of the June 2011 through January 2012 Resident</p>		<p>B. Outcomes of resident interviews will be discussed at the monthly Quality Assurance Committee meeting and reviewed with the Medical Director at the Quarterly QA meeting.</p> <p>5. This plan of correction constitutes our credible allegation on compliance with all regulatory requirements. Our date of compliance is: <u>February 22, 2012.</u></p>		

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	<p>Council minutes. Review of these minutes included, but were not limited to:</p> <p>A. "August 15, 2011: Residents on Ruby Bay c/o r/t [related to] poor sleep at night r/t noisy and other residents wandering in and out of their rooms". The 8/22/2011 reply by the Director of Nursing [DoN] was "Education done [with] staff R/T wandering residents and promoting a relaxing atmosphere for the residents".</p> <p>B. "September 19, 2011: 2. Ruby Bay residents still have concerns of not sleeping well due to noise level & wanderers at night". The 9/19/2011 response by the DoN was "Education done [with] staff r/t interventions [with] wandering & interventions to promote & facilitate sleep. Res. offered to have door shut".</p> <p>C. "October 17, 2011: 1. C/O noise level at night & radio on or TV on in a room on Sapphire Stream 24/7". The 10/18/2011 response by LPN #1 was "Staff is to do rounds to ensure calm and quiet environment is kept throughout the night".</p> <p>"2. Noise level - still c/o noise at night to include other residents who are loud on Ruby Bay". The 10/18/2011 response by</p>			
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	<p>LPN #1 was "Staff educated on alternative ways to redirect residents and educated on how to keep a calm environment at night".</p> <p>D. "November 21, 2011: 2. Noise level at night - Residents have repeat concern that noise level here at night is too loud. The halls which were included were Ruby Bay, Onyx, and Sapphire. C/O of staff talking/socializing/other patients TV & radio on & hearing staff talk about other Resident & other resident issues". The 11/22/2011 response by LPN #1 was "Inserviced all 6 p - 6 a staff, educated all staff policy and procedure on socializing and gossipping. Educated on the importance of keeping a calm/quiet environment at all times on all units". On 12/5/2011, an inservice was help by the DoN and LPN #1 regarding the noise on third shift. The corrective action was "Inservice [with] staff; 3rd shift supervisor to do rounds et [and] make sure noise level is @ [at] a minimum".</p> <p>E. "December 19, 2011: 2. Noise level at night - Patients still have concerns [with] noise level at night". The 12/20/2011 response by LPN #1 was "Staff inservices et educated on the importance of keeping a calm quiet environment for the residents. Staff educated to do rounds frequently to make sure all TVs et radios</p>			
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	<p>are either off or at a lower level. Staff also educated to not socialize in resident areas".</p> <p>During an interview with LPN #1 on 1/26/2012 at 2:20 p.m., he indicated he had been the 3rd shift supervisor during the past several months and had inserviced and addressed the noise issues several times after it would come up in Resident Council Meetings.</p> <p>3.1-19(f)</p>			
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F0285 SS=D	<p>A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.</p> <p>A nursing facility must not admit, on or after January 1, 1989, any new residents with:</p> <p>(i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission;</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)</p>			
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	<p>(3) or is a person with a related condition as described in 42 CFR 1009.</p> <p>Based on record review, observation and interview, the facility failed to ensure an annual Level II screening [PASRR - pre-admission screening and resident review] recommendation for personal affects from home was completed for 1 of 2 residents reviewed with a Level II Evaluation in a sample of 15. (Resident #3)</p> <p>Finding includes:</p> <p>The clinical record for Resident #3 was reviewed on 1/26/12 at 11:30 a.m. The resident was admitted to the facility on 4/8/11. The Level II PASRR was certified on 3/21/11. Recommendations included, but were not limited to: #3. "Resident would benefit from having his familiar personal affects from home to help him acclimate to a new residential setting..."</p> <p>On 1/26/12 between 11:30 a.m. and 2:45 p.m., the following was observed:</p> <p>Resident #3 was seated in a wheel chair in his room. His bed was to the left of the entry way. There were 3 small stuffed animals on the nightstand. There were no pictures nor wall hangings.</p>	F0285	<p>F285 PASRR Requirements for MI/MR</p> <p>It is the intent of this facility to ensure all recommendations in the annual PASRR Screenings are followed.</p> <p>1. Action taken:</p> <p>A. Resident # 3's family did not supply items as requested. The facility purchased items to place in the room to make it more homelike.</p> <p>2. Others identified:</p> <p>A. A 100% audit has been completed for those residents that require Level II screening and a D&E. No other residents were identified.</p> <p>3. Measures taken:</p> <p>A. Upon receipt of any Level II or D&E, the SSD/Designee will take the document to the next morning IDT meeting for review.</p>	02/22/2012			

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	In interview with Social Service on 1/26/12 at she indicated she would contact resident families and have them bring in items from home. 3.1-29(a)		B. The IDT will develop a plan to address all recommendations. 4. How monitored: A. Compliance with all recommendations will be tracked via a log maintained by SSD or designee. B. The log will be reviewed monthly at the QA Committee to validate compliance and reviewed with the Medical Director at the Quarterly QA meeting. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: <u>February 22, 2012.</u>		

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F0363 SS=E	<p>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>Based on observation, record review and interview the facility failed to ensure the planned menu was followed/served for 1 of 2 meals observed in that the margarine was not served. This deficient practice had the potential to affect 44 of 66 residents who received foods prepared in the facility kitchen in a census of 66. (Resident #5, 6)</p> <p>Findings include:</p> <p>During interview with the Dietary Manager on 01/24/12 at 9:24 a.m., he provided a copy of the menu and diet spreadsheet for 1/24/12.</p> <p>During observation of the cook pureeing at 11:04 a.m., on 01/24/12 the cook indicated she was pureeing for 30 to allow for the 20 pureed diets to have double portions/seconds. Margarine and bread were added to the purees.</p> <p>The posted menu for the noon meal on 01/24/12, indicated the following: "Spaghetti w/Meat Sauce, Mixed vegetables, Fruit Cobbler, Bread of</p>			F0363	<p>1. Action Taken: F363 Menus meet res needs/prep In advance/followed It is the intent of this facility to ensure the planned menu is followed and served.</p> <p>A. Incident had already occurred. Facility was not able to immediately correct due to not realizing there was a problem.</p> <p>B. All dietary staff in-serviced on following the planned menu including the planned condiments such as: butter, etc.</p> <p>2. Others affected:</p> <p>A. All other residents being served a non-pureed diet had the ability to be affected.</p> <p>3. Measures Taken:</p>		02/22/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/30/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG II LLC THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170			
(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>Choice/Marg., Beverage." The spreadsheet also indicated all diets were to receive "Bread of Choice/Margarine".</p> <p>During observation of the tray line on 01/24/12 at 12:04 p.m., and ending at 1:03 p.m., margarine was not served with the bread to any other resident.</p> <p>During observation of the noon meal on the Emerald unit 01/26/12 between 11:45 and 11:50 a.m., resident #6 requested margarine and #5 failed to have margarine on his tray. The menu for the noon meal indicated the following: "Roast turkey, Turkey Gravy, Herb Stuffing, Creamed Corn, Apple Streusel Cake, Bread of Choice/Marg."</p> <p>Interview with Certified Nursing Assistant (CNA) #2, between 11:50 a.m. and 12:00 p.m., indicated she did not see margarine on any tray passed on the Sapphire unit.</p> <p>On 01/30/12 at 12:41 p.m., the Dietary Manager provided a list of residents who did not receive the margarine at the noon meal on 01/24/12. The list included the names of 44 residents who failed to receive margarine.</p> <p>3.1-21(a)(1)</p>		<p>A. The cook/aide or designee now have a copy of the menu which is utilized for auditing the food on the line to ensure all items/condiments are in place.</p> <p>A. All dietary staff in-serviced on following the planned menu including the planned condiments such as: butter, etc.</p> <p>4. How monitored:</p> <p>A. The Dietary Director collects the audit sheets (menu copies) daily and reviews for compliance.</p> <p>B. The Dietary Director/ designee will conduct random audits of the tray service to validate all food items are included during meal service. Audits will be done 3 times a daily for 2 weeks, then (1) one time a week thereafter. This will be an on-going process.</p> <p>C. All audit results will be discussed</p>				

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			<p>at the monthly QA Meeting and changes made as necessary; audits will also be reviewed with the Medical Director at the Quarterly QA meeting.</p> <p>This plan of correction constitutes our</p> <p>credible allegation of compliance with all regulatory requirements. Our date of</p> <p>compliance is <u>February 22, 2012.</u></p>	