

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155275	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/14/2016
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NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates June 6, 7, 8, 9, 13, and 14, 2016.</p> <p>Facility number: 000175 Provider number: 155275 AIM number: 100274440</p> <p>Census bed type: SNF/NF: 77 Total: 77</p> <p>Census payor type: Medicare: 9 Medicaid: 57 Other: 11 Total: 77</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on June 20, 2016.</p>	F 0000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is: July 14, 2016.</p> <p>Facility is respectfully requesting paper compliance for all deficiencies in this POC.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0241 SS=E Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>Based on observation, interview, and record review, the facility failed to provide dignity for residents being served the noon meal. Staff failed to knock before entering resident rooms on 1 of 4 resident halls observed. (Rooms 102, 103, 105, 107, 108, 114)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 6/6/16 at 12:51 p.m., CNA #2 (Certified Nursing Assistant), entered Room 114 without knocking to deliver the noon meal tray. At 12:55 p.m., CNA #2 entered room 108 without knocking. At 1:00 p.m., CNA #2 entered room 107 without knocking. At 1:02 p.m., CNA #3 entered Room 105 without knocking. At 1:05 p.m., entered Room 103 without knocking. At 1:10 p.m., the Rehabilitation Aide entered Room 102 without knocking. On 6/14/16 at 8:29 a.m., CNA #3 indicated that before entering a resident's 	F 0241	<p>F-241 It is the policy of the facility to promote care and provide services to the residents in a manner that maintains and enhances their dignity. Residents in rooms 102, 103, 105, 107, 108 and 114 all have their doors knocked on prior to entry by the staff. Permission to enter and some identifying announcement of whom is entering is also made. Any resident who resides in the facility has the potential to be affected by this finding. The DON/Designee or SSD will make rounds 5 days weekly on various shifts to ensure that staff are knocking and announcing themselves prior to entrance into a resident's room. If the resident is able to respond, permission to enter will be sought, giving the resident time to ask for a delay due to a privacy issue before the staff makes entry. Any concerns noted on these rounds will be corrected immediately. These dignity rounds will continue until 4 consecutive weeks of zero negative findings is achieved. After that, these rounds will occur 3 days weekly for a period of not</p>	07/14/2016

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F 0248 SS=D Bldg. 00	<p>room to deliver a meal tray, staff should knock and announce themselves before entering.</p> <p>3. On 6/14/16 at 1:41 p.m., the Administrator brought a document titled Resident Rights, which indicated the facility will treat a resident with dignity and respect in full recognition of your individuality.</p> <p>3.1-3(t)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p>	F 0248	<p>less than 6 months to ensure ongoing compliance. After that, random dignity rounds (to monitor for appropriate room entry) will occur. At in-services held for all staff at varying times and dates prior to July 14th, the importance and necessity of respectful entry into a resident's room including knocking, announcing who is there and allowing for the resident (if able) to ask for a delay of entry due to a privacy issue will be reviewed. Resident Rights will be reviewed with an emphasis on dignity and privacy will be discussed. Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings, the results of the dignity rounds will be reviewed. Any patterns will be identified, however any concerns will have been halted and corrected as found. If needed, an Action Plan will be written by the committee. Any Action Plan will be monitored weekly by the Administrator until resolution.</p> <p>F-248 It is the policy of the facility</p>	07/14/2016

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	<p>Based on observation, interview, and record review, the facility failed to provide an ongoing program of activities to meet the interest and physical, mental and psychosocial well-being of 1 of 7 residents reviewed in a total sample of 18 who met the criteria. (Resident #80)</p> <p>Findings include:</p> <p>During an interview on 6/6/16 at 3:41 p.m., Resident #80's family member indicated the Crossings unit (a locked dementia unit) did not provide many activities for the residents. The family member indicated the staff usually would just walk the residents around the unit.</p> <p>During an observation on 6/6/16 at 3:45 p.m., Resident #80 was observed to be lying in bed. The activity calendar indicated a "bean bag toss" was to be in progress from 3:00 p.m. - 4:00 p.m. One female resident was tossing the bean bag to a young girl in the dining room. Four (4) residents were seated in the dining room, sleeping. No activity person was on the unit at this time.</p> <p>During an observation on 6/8/16 at 10:54 a.m., AA #1 was observed to be doing an activity involving making banana pudding. One (1) female resident was in attendance and the resident was observed</p>		<p>to see that an Activities Program is in place which meets the interests, physical, mental and psychosocial needs of the residents based on individual assessment. Resident #80 has been reassessed and his Activity Care Plan has been reviewed and updated. Resident #80 is engaging in activities regularly according to his interest to participate as well as his ability to participate. There is a presence of Activity staff on the Crossings Unit several hours a day/evening.</p> <p>Residents who reside in the facility especially on the Crossings unit have the potential to be affected by this finding. An established LTC consulting firm is doing specialized training for the Activity Department staff with a focus on assessment, care planning and formulating their Activity Program with emphasis on activities for residents with dementia. All residents had their Activity Assessments as well as their Activity Care Plans reviewed by the IDT for accuracy and appropriateness for each individual. Any needed revisions were made. Going forward, the Administrator/Designee will tour the facility and also the Crossings unit 2 times daily 5 days per week on various shifts including some week end days to see that appropriate and engaging activities are taking place. The Administrator/Designee will further review the monthly</p>		

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	<p>to be standing at the table observing AA #1. Resident #80 was walking in the hall. The activity calendar indicated the "Cooking Corner" activity was to be in progress from 10:00 a.m. - 11:00 a.m.</p> <p>During an observation on 6/14/16 at 10:20 a.m., three (3) female residents were observed to be sitting in the dining room on the Crossings unit, talking to each other. Resident #80 was observed to be sitting on a bench in the hall across from the nurse's desk. No activity was observed. The activity calendar indicated the "Snack Shack" was to be in progress from 10:00 a.m. - 11:00 a.m.</p> <p>The clinical record for Resident #80 was reviewed on 6/8/16 at 2:56 p.m. Resident #80 had diagnoses including, but not limited to paranoid schizophrenia, anxiety disorder, and dementia with behavioral disturbance. A quarterly MDS (Minimum Data Set) assessment, dated 5/31/16, indicated Resident #80 had moderate cognitive impairment. An annual MDS assessment, dated 10/12/15, indicated the resident enjoyed pets/animals, keeping up with the news, and doing her favorite activities.</p> <p>A care plan, dated 6/1/16, included interventions for activities as followed: - assist resident to program, sit with</p>		<p>calendar it being posted for appropriateness and time scheduling of activities to see that planned activities are suitable for the residents and that there are evening and weekend opportunities. The review of the monthly calendar will be ongoing. The rounds for monitoring of activities by the Administrator/Designee will continue until 4 consecutive weeks of zero negative findings is achieved. After that, the rounds will continue 3 days weekly at various times and days. After that, random rounds will occur. Any concerns will be addressed as found. Also, as part of the Guardian Angel Rounds, residents will be asked about their satisfaction with activities. Any concerns will be addressed as found. At in-services held for all staff at varying times and dates prior to July 14th, the following was reviewed: A.) Importance of a comprehensive Activity Program in a long-term care setting B.) Importance of assessing and care planning activities on an individual resident basis C.) Staff participation in the Activity Program D.) Guardian Angel Rounds—asking about satisfaction with activity offerings E.) Q & A Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as necessary. At the monthly QA meetings the results of the</p>		

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	<p>compatible resident to encourage socialization</p> <p>- provide resident with material for activities of interest.</p> <p>The clinical record lacked documentation of Resident #80's favorite activities.</p> <p>The activity calendar for the month of May, 2016, was obtained from the Activity Director on 6/9/16 at 9:15 a.m. The activity calendar indicated activities never started before 9:30 a.m. and there were no activities offered after 4:00 p.m. The calendar also indicated from 6/9/16 through 6/13/16, no activities were scheduled as this was "nursing home week" with different ideas daily.</p> <p>During an interview with the AD on 6/9/16 at 9:15 a.m., the AD indicated the unit did not offer activities on 6/21/16, 6/23/16, 6/28/16, and 6/30/16 after 3:00 p.m.</p> <p>The Activity Calendar procedure, dated 2010/2011 and obtained from the Administrator (Adm) on 6/14/16 at 2:10 p.m., indicate the activity department would be responsible for developing a monthly activity calendar that reflects the assessed needs and interests of the facility population.</p>		<p>rounds by the Administrator as well as the results of the Guardian Angel Rounds (with findings on activity concerns) will be reviewed. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored weekly by the Administrator until resolution.</p>		

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F 0282 SS=D Bldg. 00	<p>During an interview with the Activity Director (AD) on 6/9/16 at 9:20 a.m., the AD indicated the residents on the Crossings unit (a locked dementia unit) had a calendar with activities specifically for the residents on the unit. She indicated the residents needed more stimulation than reading and walking.</p> <p>3.1-33(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure the resident's written plan of care was followed for 1 of 5 residents reviewed for unnecessary medications, in that, medications that were discontinued were still being given. (Resident #56)</p> <p>Findings include: On 6/8/16 at 8:44 a.m., Resident #56 was</p>			F 0282	<p>F-282 It is the policy of the facility to provide and arrange services to be provided by qualified persons in accordance with each resident's written plan of care. Resident #56 is receiving meds as per physician order. Residents who reside in the facility and who receive medication have the potential to be affected by this finding. A facility wide audit was conducted to ensure that the ordered medications were accurately</p>		07/14/2016

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	<p>observed sitting in a wheelchair in the hallway. The resident's head was resting on the hallway handrail.</p> <p>On 6/8/16 at 8:49 a.m., Resident #56's clinical record was reviewed. Resident #56's diagnoses included, but were not limited to, hypertension.</p> <p>The electronic physicians orders, included, but were not limited to: Metoprolol (an anti-hypertensive medication) 25 mg (milligrams), by mouth, at bedtime, started on 11/23/15. Diflucan (an anti-fungal medication) 200 mg, by mouth, daily, started on 5/18/16.</p> <p>A handwritten signed order from the physician, dated 3/15/16, indicated: Hold Metoprolol 25 mg-may discontinue in one month. A Physician's Progress Note, dated 3/15/16, indicated the resident had intermittent hypotension (low blood pressure) and the physician had put the Metoprolol on hold.</p> <p>A handwritten signed order from the physician, dated 5/17/16, indicated: Diflucan 200 mg, by mouth, once a day, for seven days. A Physician's Progress Note, dated 5/17/16, indicated Resident #56 had a yeast infection and Diflucan had been ordered daily for seven days.</p>		<p>reflected on the emar (electronic medication administration record). Going forward, orders received for medications will be reviewed at the next CQI meeting to ensure that they have accurately been entered into the emar. This includes adding a med, discontinuation of a med, a change in dose, a change in the form of the med, a change in the time themed is to be administered or any other instruction per order. This process will be ongoing. At in-services held for nurses_ at varying times and dates prior to July 14th, the following was reviewed: A.) Following physician orders—such as not continuing to administer a discontinued med B.) Med Error Policy C.) —emphasis on as related to interventions that include medications D.) Documentation E.) Q & A Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly Q A meetings the results of the monitoring of medication orders at the daily CQI meetings will be reviewed. Any concerns will have been addressed as discovered. Any patterns will be identified and if needed an Action Plan will be written by the committee. Any Action Plan will be reviewed weekly by the Administrator until resolved.</p>	

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	<p>The MAR (Medication Administration Record) included, but was not limited to:</p> <p>April 2016: Metoprolol had been restarted on 4/14/16 and given daily, except 4/15/16</p> <p>May 2016: Metoprolol had been given every day except 5/19/16 and 5/27/16. Diflucan had been given 5/18/16 through 5/31/16.</p> <p>June 2016: Metoprolol and Diflucan had been given daily 6/1/16 through 6/8/16.</p> <p>The clinical record lacked a new order or clarification to continue the administration of the Metoprolol and the Diflucan.</p> <p>On 6/8/16 at 10:24 a.m., the DON indicated the Diflucan order had been entered into the electronic health record incorrectly. The DON further indicated she would have clarified the order for Metoprolol.</p> <p>On 6/14/16 at 1:41 p.m., the Administrator provided the "Physician Orders" policy, dated 2/5/15. The policy included, but was not limited to: Whenever telephone orders are received by physician, the order must be inputted in PCC or written on a Physician Telephone Order Form....The date ordered or date discontinued must appear....</p>			

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F 0364 SS=E Bldg. 00	<p>3.1-35(g)(2)</p> <p>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.</p> <p>Based on observation, interview, and record review, the facility failed to provide food at the proper temperatures for 2 of 4 meal observations.</p> <p>Findings include:</p> <p>During an interview on 6/7/16 at 10:34 a.m., Resident #107 indicated the food was cold and could be better. The resident indicated he ate in his room as well as in the dining room for meals.</p> <p>During an interview on 6/8/16 at 10:00 a.m., Resident #4 and Resident #17 indicated the food was often cold when they ate. Both residents ate in their room.</p>	F 0364	<p>F-364 It is the policy of the facility to provide food by methods that conserve nutritive value, flavor and appearance while being palatable, attractive and at the proper temperature. Residents #107, #4 and #17 all are satisfied with the temperatures of their meals as served. Residents who consume meals prepared in the facility's dietary department have the potential to be affected by this finding. Foods served hot and foods served cold as well as beverages are temped prior to serving. These temps are documented. Foods/beverages are only served when they "temp" within an acceptable degree reading as stated in the policy which is within the accepted parameters as stated in the state guidelines. The Dietary Manager</p>	07/14/2016

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	<p>During an observation on 6/9/16 at 9:50 a.m., Cook #1 was observed to obtain shredded chicken and kidney beans from a pan which was located on the stove. Cook #1 was observed to remove the chicken and kidney bean from the pan to puree for the chicken taco salad. Cook #1 was observed to place the shredded chicken and kidney beans onto the steam table and cover the pan. The pureed mixture was also placed onto the steam table and covered with a lid. Cook #1 was also observed to obtain several handfuls of lettuce and tomatoes from pans which were sitting on ice and covered with a lid on the steam table. Cook #1 was observed to puree the lettuce and tomatoes. After placing the pureed lettuce and tomatoes in a pan, Cook #1 was observed to place them on ice on the steam table and cover them with a lid.</p> <p>During an observation on 6/9/16 at 10:35 a.m., Cook #1 was observed to observe to obtain a pan of creamed corn from the oven. Cook #1 was observed to measure out the creamed corn to puree corn for the lunch meal. After obtaining the creamed corn, Cook #1 placed the corn on the steam table and covered it with a lid. After pureeing the corn, it was placed onto the steam table and covered with a lid, also.</p>		<p>will see that all hot foods are temped prior to being served and after having been placed on the steam table in preparation to being served. Foods served cold will also be temped prior to being served. Drinks (hot/cold) will be temped as well. All dietary food/drink temps will be documented. The Dietary Manager/Designee will monitor the temps associated with each meal. This practice will be ongoing. Any temps (hot or cold) that do not fall within acceptable parameters will be corrected by whatever dietary means necessary. Further, the Dietary Manager/Designee will temp the last tray from each cart for each meal to see that temps are within acceptable range per policy. Any concerns will be addressed as found. This temping of tray carts will continue until 4 consecutive weeks of zero negative findings is achieved. After that, tray carts will have the last tray from the carts temped 1 day weekly(all 3 meals) for a period of not less than 6 months to ensure ongoing compliance. Any concerns will be addressed as found. The Dietary Manager/Designee will interview 10 residents in various parts of the facility to see if they are satisfied with food temps. These interviews will include Residents #107, #4 and #17. Their responses will be documented. Any concerns will be addressed as discovered.</p>				

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	<p>During an observation on 6/9/16 at 11:20 a.m., Cook #1 was observed to be plating the chicken taco salad (including the lettuce and tomatoes, and the corn from the steam table for the noon meal. Cook #1 was also observed to plate the pureed foods for the residents from the steam table. Upon query, Cook #1 indicated she had temped the foods prior to pureeing the foods and the meat temped "around 175 degrees."</p> <p>During review of the temperature log on 6/9/16 at 1:43 p.m., no food temperatures were listed for breakfast or lunch on 6/9/16 and no temperatures were logged for supper on 6/8/16. Upon query, Cook #1 indicated she had forgot to document the temperatures.</p> <p>During an interview with the Adm (Administrator) on 6/9/15 at 2:15 p.m., the Adm indicated the food should have been temped and documented the temperatures prior to serving the foods.</p> <p>During an interview with the Dietary Manager (DM) on 6/9/16 at 3:30 p.m., the DM indicated Cook #1 had not temped any of the foods prior to serving the meals.</p> <p>A tray was obtained in the dining room,</p>		<p>These interviews will continue until 4 consecutive weeks of zero negative findings is achieved. After that, 5 residents will be interviewed weekly for a period of not less that 6 months to ensure ongoing compliance. After that, random monitoring will occur ongoing.</p>	

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	<p>from the steam table, at the end of the breakfast service on 6/14/16 at 8:20 a.m. The sausage/egg casserole had a temperature of 131 degrees Fahrenheit (F) which immediately decreased to 113 within 1 minute. The milk temperature was 50.5 degrees F and the cranberry juice temperature was 51.7 degrees F.</p> <p>During an interview on 6/13/16 at 9:22 a.m., the Dietary Manager indicated foods should only be temped when they are placed on the steam table. She indicated the food had not been temped when it was placed on the steam table on 6/9/16. The DM indicated she had an inservice with the dietary staff indicating the food temperatures should be documented immediately when they were obtained. She further indicated the temperatures of foods were not being obtained.</p> <p>A policy for monitoring food temperatures , dated 2011 and obtained from the Adm (Administrator) on 6/14/16 at 1:29 p.m., indicated prior to serving a meal, food temperatures would be taken and documented for all hot and cold food to ensure proper serving temperatures.</p> <p>3.1-21(a)(2)</p>			

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F 0371 SS=E Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observations, interview, and record review, the facility failed to prepare and serve food under sanitary conditions for 1 of 4 observations of the kitchen.</p> <p>Findings include:</p> <p>During an observation on 6/9/16 at 10:35 a.m., Cook #1 was observed to have gloves on and was pureeing the lunch meal. Cook #1 was observed to have dirty dishes soaking in soapy water in the first (1st) sink of the 3-compartment sink. Cook #2 was observed to be cleaning grapes in the second (2nd) compartment of the 3-compartment sink. Cook #1 was observed to obtain a wet cloth from the 1st compartment and wipe the prep area off. Cook #1 was observed to place a whisk into the 1st sink of soapy water. Cook #1 was observed to look for a scraper in the 1st compartment sink, but</p>	F 0371	<p>F-371 It is the policy of the facility to see that food is prepared and served under sanitary conditions including practicing proper hand hygiene as well as proper use of the 3 compartment sink and also washing fruits and vegetables. Residents who consume foods prepared in the facility's dietary kitchen have the potential to be affected by this finding. The Dietary manager/Designee will observe 3 dietary staff members daily on various shifts as they perform proper hand hygiene and proper glove usage. Further, the Dietary Manager/Designee will observe use of the 3 compartment sink and the proper cleaning of fruits or vegetables for one meal daily observing various meals. This monitoring will occur until 4 consecutive weeks of zero negative findings is achieved. After that, 3 staff members will be observed for proper hand hygiene weekly and 3 observations for proper use of the 3 compartment sink and the washing of fruits or vegetables will be done weekly.</p>	07/14/2016

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	<p>was unable to locate one in the soapy water. Cook #1 was observed to scrap the pureed corn into the pan using the processor blade and then placed the pan onto the steam table, covering it with a lid. Cook #1 was observed to remove her gloves. No hand hygiene was performed.</p> <p>During an interview on 6/14/16 at 10:35 a.m., the Dietary Manager (DM) indicated the 3-compartment sink is used to washed dishes prior to the dishes being placed into the dishwasher. The DM indicated the staff should not have been cleaning the grapes when dirty dishes were soaking in the 3-compartment sink.</p> <p>A policy titled "Dishwashing:Manual", dated 2011 and obtained from the Adm (Administrator) on 6/14/16 at 1:29 p.m., indicated each compartment of the three-compartment pot and pan sink would be cleaned prior to use. The policy indicated pots and pans would be washed in a hot detergent solution in the first compartment, rinsed well in the second compartment, and sanitized by either heat or chemicals in the third compartment.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>		<p>These will be documented. Any concerns will be corrected immediately as found. After that, random monitoring will occur ongoing. (See F-364 for plan for in-servicing and monitoring and quality assurance monitoring/ follow up)</p>	

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F 0441 SS=D Bldg. 00	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and</p>			

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	<p>transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to provide a sanitary, safe, and comfortable environment by following isolation precautions for 1 of 2 residents on isolation. (Resident #107)</p> <p>Findings include:</p> <p>During an observation on 6/7/16 at 10:45 a.m., Resident #107 was observed to being sitting in a wheelchair on the patio of the facility. Resident #107 indicated he had 2 (two) toes amputated and was being treated for MRSA (Methicillin Resistant Staphylococcus Aureus). The resident further indicated he received dialysis 3 (three) times per week.</p> <p>The clinical record for Resident #107 was reviewed on 6/8/16 at 12:36 p.m. Resident #107 had diagnoses including, but no limited to partial amputation of 2 or more right lesser toes, diabetes mellitus type 2, and end stage renal disease.</p> <p>Resident #107 had a physician's order, dated 6/1/16, for Bactrim DS (an antibiotic) tablet 1 (one) qd (once a day)</p>	F 0441	<p>F-441 It is the policy of the facility to provide a sanitary, safe and comfortable environment by following isolation precautions for residents who require isolation precautions. Resident #7 receives care with proper isolation practices being carried out. Residents who have an order for Contact Isolation have the potential to be affected by this finding. All necessary signage, supplies and equipment are accessible to care givers for the practice of contact isolation care. The DON/Designee will monitor daily to see that any resident who has orders for Contact Isolation will have all of the proper signage, supplies and equipment accessible to care givers for the practice of Contact Isolation. The Don/Designee will monitor 5 staff members daily as they render care to a resident in Contact Isolation to see that they don the proper protective wear prior to entry and administration of care as indicated. Any concerns related to this monitoring will be immediately corrected prior to a breach in practice being committed. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. After that, room isolation setups will be monitored 3 days weekly by the DON/Designee and 3 staff members will be monitored</p>	07/14/2016

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	<p>for wound infection.</p> <p>Resident #107 had a physician's order, dated 6/3/16, for contact isolation for MRSA of the toes.</p> <p>During an observation of Resident #107's room on 6/7/16 at 1:15 p.m., no information or personal protective wear for the contact isolation was noted.</p> <p>On 6/9/16 at 9:35 a.m., RN #1 and RN #2 were observed to change a dressing for Resident #107. RN #1 and RN #2 were not observed to don a gown in observation of contact isolation precautions. RN #1 and RN #2 changed the dressing to Resident #107's right foot.</p> <p>During an interview with on 6/13/16 at 11:35 a.m., the Director of Nursing (DON) indicated she was unsure what the facility policy indicated for contact information. The DON further indicated the facility had been doing universal precautions for the resident.</p> <p>A policy for contact isolation, obtained from the DON on 6/13/16 at 1:00 p.m., indicated residents with isolated organisms that required contact isolation included MRSA. The policy indicated the facility should place a "Contact Isolation" sign on the doorframe of the</p>		<p>weekly to see that they don proper protective wear prior to entry and rendering care as indicated. This monitoring will continue for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur. Again, any potential breach observed will not be allowed to take place. At in-services held for staff at varying times and dates prior to July 14, 2016 the following was reviewed: A.) What is Contact Isolation? B.) Who needs to practice the precautions? Staff? Family? Visitors? C.) What do I need to wear in Contact Isolation? D.) Proper donning and removing protective wear E.) Hand hygiene/glove usage as related to Contact Isolation F.) Q and A Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly Q. A. meetings the results of the monitoring by the DON/Designee will be reviewed. Any patterns will be identified, however any concerns will have been corrected as found. If necessary, an Action Plan will be written by the committee. Any Action Plan will be followed up on and monitored by the Administrator weekly until resolution.</p>				

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F 0465 SS=E Bldg. 00	<p>resident's room. The policy indicated the resident, family and visitors should be educated regarding the isolation precautions. The policy further indicated the person entering the room should don appropriate personal protective equipment before entering the resident's room.</p> <p>3.1-18(b)(2) 3.1-18(j)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 7 of 30 resident rooms. (Room #106, Room #116, Room #124, Room #125, Room #201, Room #204, Room #216)</p> <p>Findings include:</p> <p>1. On 6/7/16 at 9:37 a.m., Room #106</p>	F 0465	<p>F-465 It is the policy of the facility to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. Residents in rooms #106, #116, #124, #125, #201, #204 and #216 have had the issues cited in the survey addressed and repaired/replaced. Residents, staff and the public have the potential to be affected by this finding. The bathroom shared by rooms #106 and #108 has had the floor deep cleaned including the corners and along the edges. The caulking at the base of the toilet in the bathroom in room #116 has been</p>	07/14/2016

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	<p>was observed. Dirt and debris was observed to be built up in the corners and along the edges of the bathroom. On 6/14/16 at 8:40 a.m., the same was observed. The bathroom was shared with Room #108.</p> <p>2. During an observation on 6/7/16 at 1:45 p.m., Room #116 was observed to have a brown stain around the base of the commode on the caulking. The same was observed on 6/13/16 at 9:04 a.m.</p> <p>3. During an observation on 6/7/16 at 1:45 p.m., Room #124 was observed to have the bathroom door frame broken off and chipped paint behind the sink. The bathroom is shared with the residents in Room 125. The same was observed on 6/13/16 at 9:05 a.m.</p> <p>4. During an observation on 6/7/16 at 1:46 p.m., Room #125 was observed to have a hole in the wall behind the bedroom door. The same was observed on 6/13/16 at :06 a.m.</p> <p>5. During an observation on 6/7/16 at 9:29 a.m., Room #201 was observed to have a commode lid that was on backwards and a brown stain around the base of the commode on the caulking. The same was observed on 6/13/16 at 10:36 a.m.</p>		<p>replaced. In room # 124, the bathroom door frame has been repaired and the chipped paint behind the sink has been repaired. The hole in the wall behind the door in room #125 has been repaired. The commode lid in room #201 has been replaced and the caulking at the base of the toilet in that room has been replaced. The caulking around the base of the commode in room #204 has been replaced. The chipped paint on the bathroom wall in room #216 has been repaired and the caulking at the base of the commode in that room's bathroom has been replaced. Residents who reside in the facility have the potential to be affected by this finding. The Administrator, Housekeeping Supervisor and Maintenance Director will make a facility wide tour of resident rooms and common areas noting needed repairs or needed cleaning and listing these concerns. The Maintenance staff will complete at least 5 repairs off of the list weekly as well as to continue to perform day to day maintenance duties. Likewise, the Housekeeping Supervisor will see that 5 areas requiring (deep) cleaning will see that 5 of these areas are completed weekly. The listed areas for both Maintenance and Housekeeping will continue until all areas have been addressed. The Administrator and the Housekeeping</p>	

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	<p>6. During an observation on 6/7/16 at 10:57 a.m., Room #204 was observed to have the caulking around the commode cracked and a brown stain on the caulking. The same was observed on 6/13/16 at 10:39 a.m.</p> <p>7. During an observation on 6/7/16 at 11:01 a.m., Room #216 was observed to have chipped paint on the bathroom wall. The caulking around the base of the commode was cracked and had a brown stain. The same was observed on 6/13/16 at 6/13/16 at 10:40 a.m.</p> <p>During an interview on 6/13/16 at 2:15 p.m., the Housekeeping Supervisor indicated rooms were cleaned daily. She indicated if a room requires maintenance, a request is submitted to the maintenance department who then takes care of the problem. She further indicated a housekeeper is assigned a hall a piece to clean daily.</p> <p>During an interview on 6/14/16 at 1:55 p.m., the Adm (Administrator) indicated the facility had a plan of action in place to update the rooms. The Adm indicated the facility had been working on the plan but it would take time.</p> <p>On 6/14/16 at 1:29 p.m., the</p>		<p>Supervisor and the Maintenance Director will tour the facility weekly to verify that the repairs and cleaning have been completed. Any newly discovered concerns will be added to the list. This weekly touring will be ongoing as part of the Preventive Maintenance and Quality Assurance Programs. NOTE: The facility is planning on a remodeling project to begin soon. At in-services held for staff at varying times and dates prior to July 14,2016, the following was reviewed: A.) What makes as afe, functional, sanitary and comfortable environment? B.) How to report a Maintenance request C.) How to report a deep cleaning need D.) Who is responsible to report a Maintenance issue or a Hskpg. Issue? E.) Why should these types of concerns be reported timely? F.) Discussion Additional in-servicing for the Maintenance staff and Housekeeping staff included a review of the Preventive Maintenance Program (for Maintenance) and review of the role/duties of the housekeepers (for Housekeeping) as well as planning and discussion of the weekly tours by the Administrator, Maintenance Director and Housekeeping Supervisor to verify repairs and cleaning as well as adding any new concerns. These tours will be ongoing. Any staff who fail to comply with the</p>	

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F 0499 SS=D Bldg. 00	<p>Administrator provided the "Policy and Procedure on Deep Cleaning" policy, dated 3/2011. The policy included, but was not limited to:</p> <p>Resident rooms will be deep cleaned monthly and as needed. Strip and wax floor if needed Bathrooms cleaned and sanitized</p> <p>3.1-19(f)</p> <p>483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.</p> <p>Professional staff must be licensed, certified, or registered in accordance with applicable State laws.</p> <p>Based on interview and record review, the facility failed to ensure a CNA had an active certification for 1 of 33 CNA certifications reviewed. (CNA #5)</p> <p>Findings include:</p> <p>On 6/13/16 at 11:00 a.m., the licenses and certifications of the professional staff was reviewed. CNA #5's certification</p>	F 0499	<p>points of the in-servicing as related to their role in their department will be further educated and/or progressively disciplined as indicated. At the monthly Q. A.meetings the results of the monitoring by the Administrator, Housekeeping Supervisor and the Maintenance Director will be reviewed. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored by the facility weekly until resolution.</p> <p>F-499 It is the policy of the facility to ensure that staff are licensed, certified or registered in CNA #5 renewed her expired certification while the survey was in progress. Residents who reside in the facility have the potential to be affected by this finding. An audit was conducted to ensure that all staff who require a license, certification or registration did in fact have a copy of it (in good standing) in their file. No staff will be placed on the schedule</p>	07/14/2016

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	<p>had expired on 5/15/16.</p> <p>On 6/13/16 at 3:50 p.m., the Administrator was notified CNA #5's certification was expired.</p> <p>On 6/14/16 at 8:15 a.m., the Administrator indicated CNA #5 had renewed the expired certification on 6/13/16.</p> <p>On 6/14/16 at 9:33 a.m., the Administrator indicated CNA #5 had worked while the certification was expired.</p> <p>On 6/14/16 at 1:41 p.m., the Administrator provided a section of the "Employee Handbook" which included, but was not limited to: All evidence of appropriate licensure, certifications and/or registration must be furnished to Facility before starting employment. All employees must renew their licenses as required by law, provide verification of such renewal to supervisors.....</p> <p>3.1-14(q)(5) 3.1-14(s)</p>		<p>without proper and current credentials. The HR staff in the facility will do an audit monthly to ensure that any staff who are approaching the need for a renewal get the renewed credential to HR timely. Otherwise, the staff member will not be scheduled to work. Further, upon hire, new employees will be asked for a copy of the necessary credential for their job description prior to being scheduled. Further, the authenticity and good standing will be obtained prior to them working as well. All in-services held for staff at varying times and dates prior to July 14, 2016 the responsibility of maintaining credentials required for working in the facility was reviewed. This included the fact of not being able to be scheduled without it. The HR staff was in-serviced by the Administrator as to their role in keeping a running record of credentials with monthly audits. Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly Q. A. meetings the results of the HR monitoring for timely credential submission by the staff to the HR staff will be reviewed. Any concerns will be addressed. However, any staff who have lapsed, will have been taken off of the schedule until they have renewed and submitted the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155275	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/14/2016
NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670		
(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	
			renewed, required credential. Any patterns will be identified. If-necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored by the Administrator until resolution.		