

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 06/13/2014
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NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included the Investigation of Complaint IN00150235.</p> <p>Complaint IN00150235 - Unsubstantiated due to lack of evidence</p> <p>Survey dates: June 9, 10, 11, 12 and 13, 2014</p> <p>Facility number: 000478 Provider number: 155494 AIM number: 100290430</p> <p>Survey team: Toni Maley, BSW, TC Karen Lewis, RN Ginger McNamee, RN Tina Smith-Staats, RN Debra Barth, RN (June 9 and 10, 2014)</p> <p>Census bed type: SNF/NF: 76 Total: 76</p> <p>Census payor type: Medicare: 10 Medicaid: 61 Other: 5 Total: 76</p>	F000000	<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.</p> <p>** THE WATERS OF SCOTTSBURG RESPECTFULLY REQUESTS PAPER/DESK COMPLIANCE BE GRANTED FOR THESE CITATIONS **</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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F000159 SS=D	<p>These deficiencies also reflects State findings in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on June 20, 2014 by Randy Fry RN.</p> <p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p>			

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	<p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview and record review, the facility failed to ensure residents had access to residents funds on weekends and residents or their representatives received personal funds quarterly statements. This deficient practice impacted 3 of 7 residents who were</p>	F000159	<p><u>F159- Facility Management of Personal Funds</u></p> <p>It is the policy of this facility to make resident funds accessible during normal business hours, 7 days a week. It is also the policy of this facility to distribute</p>	07/13/2014

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	<p>interviewed regarding their resident personal funds account (Residents #6, #9 and #65).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During a 6/10/14, 8:46 a.m., interview, Resident #6 indicated access to resident personal funds was Monday through Friday only. There was no weekend access to funds. Resident #6 additionally indicated the facility did not provide quarterly statements regarding account balances. 2. During a 6/9/14, 3:22 p.m., interview, Resident #9 indicated resident personal funds were not available on the weekends. Resident #9 indicated residents must carry their money or put it in their own lock box for the weekend. 3. During a 6/10/14, 1:03 p.m., interview, Resident #65 indicated residents could not access resident personal funds on weekends because the Business Office Manager did not work weekends. Residents had to obtain funds for the weekend on Friday before the Business Office Manager left for the weekend. Residents did not receive quarterly statements for resident funds. 4. During a 6/11/14, 10:05 a.m., 		<p>quarterly trust statements to all residents that maintain funds with the facility.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>All quarterly trust statements from the second quarter have been provided to the residents or families.</p> <p>The entire staff was inserviced on the availability of resident funds, and the procedure to obtain these funds during the weekend. The facility will place money in an electronic safe prior to leaving for the weekend. The safe will be maintained in the secured medication room. On weekends, the nurses will have access to funds for the residents. If funds are depleted, management phone numbers are provided so they may ensure the funds will be replenished and available to our residents. These procedures were also published and distributed to our residents so they are aware they have daily access to their money, even on the weekends.</p> <p>Quarterly trust statements will be reviewed by the administrator as well as the Business Office Manager once received administrator as well as the Business Office Manager. The</p>				

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	<p>interview, the Business Office Manager indicated the weekend manager on duty would supply residents access to residents funds. She indicated the nurses would contact the weekend manager on duty when a resident desired funds. Then the manger would access the funds.</p> <p>On 6/11/14, at 3:00 p.m., a selection of quarterly statements were requested. The Business Office Manager indicated she would obtain and provide the statements. As of 6/12/14 at 10:00 a.m., no quarterly statements had been provided for review</p> <p>During a 6/11/14, 10:45 a.m., interview, the Activities Director indicated she was the weekend manager on duty about once a month. She additionally indicated she was unsure how residents got access to resident's funds on weekends but believed the nurses must have money in the medication carts.</p> <p>During a 6/11/14, 10:50 a.m., interview, the Food Services Supervisor indicated she worked as the weekend manager about once a month. She indicated she did not know the procedure for residents to get funds on the weekend.</p> <p>During a 6/11/14, 10:55 a.m., interview, RN #7 indicated she does work weekends at times. She additionally indicated no</p>		<p>business office manager will obtain administrator approval prior to sending statements.</p> <p><i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i></p> <p>All residents whom we manage funds for could be affected.</p> <p>The new resident fund weekend policy was published and copies were distributed to all residents that maintain funds with the facility. The entire staff was educated on weekend fund dispersement during a mandatory inservice. Additionally, these procedures have been permanently displayed in the medication room, as well as the employee time clock room.</p> <p><i>What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?</i></p> <p>The policy has been amended to address the perception that resident funds were not available on the weekend. This amended policy has been provided to all</p>	

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	<p>resident personal funds were available on weekends because the Business Office Manager does not work then.</p> <p>During a 6/11/14, 11:05 a.m., interview, LPN #6 indicated she worked weekends at times. She additionally indicated no residents funds were available on weekends.</p> <p>During a 6/11/14, 11:06 a.m., interview RN #5 indicated she was new to the position and had worked weekends. She indicated she did not know how residents got funds on the weekend. She would ask a more experienced nurse.</p> <p>During a 6/12/14, 10:25 a.m., interview, the Administrator indicated the Business Office Manager had just informed him that residents or their representatives had not been provided quarterly statements for the first quarter of 2014 and the second quarter statements had yet to be provided to residents and/or responsible parties. He additionally indicated that although the facility did have a procedure for resident funds on the weekend, the staff must not have had a working understanding of the process.</p> <p>5. A current, April 2011, facility policy titled "Resident Trust", which was provided by the Administrator on 6/12/14</p>		<p>staff and all resident who maintain funds within the facility.</p> <p>Quarterly trust statements will be copied to the administrator when emailed from the corporate office.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</i></p> <p>The Business Office Manager, or her designee, will audit by selecting 2 staff members and 5 residents weekly to ensure that they are familiar with the availability of funds. For the first 4 weeks the sample will be as stated above. Then, 5 residents weekly for 4 weeks. Then finally, 3 residents for 4 weeks.</p> <p>The administrator or designee will monitor these audits. The results of these audits will be submitted to the monthly and quarterly QA & A committee for further review and reassessment for further ongoing monitoring.</p>		

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F000161 SS=E	<p>at 3:40 p.m., indicated the following: " Statement Policy: It is understood that the designated below shall receive a quarterly accounting of all transactions to the above-named Resident's account..."</p> <p>A current, undated, facility policy titled "Weekend Resident Funds Policy and Procedure", which was provided by the Administrator on 6/11/14 at 12:30 p.m., indicated the following: "If there is a request for funds outside normal hours, please call management to make immediate arrangements..."</p> <p>3.1-6(f)(1) 3.1-6(g)</p> <p>483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS</p>			

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	<p>The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.</p> <p>Based on interview and record review, the facility failed to maintain a surety bond in sufficient amounts to cover the total daily balance of funds maintained in the resident personal funds accounts. This deficient practice had a potential to impact the 60 residents for whom the facility managed funds.</p> <p>Findings include:</p> <p>A 6/11/14, Trust Current Account Balance form, which was provided by the Business Office Manager on 6/11/14 at 9:43 a.m., indicated the facility managed resident funds accounts for 60 of the facilities 76 residents.</p> <p>A current, November 2013, "Patient Funds Bond", which was provided by the Business Office Manager on 6/11/14 at 9:43 a.m., indicated the Waters of Scottsburg had a resident trust surety bond for the amount of \$25,000.00 (twenty five thousand dollars).</p> <p>Review of the bank statements for resident funds for May 2014, April 2014 and March 2014 indicated the residents funds account had a daily balance in</p>	F000161	<p><u>F161- Surety Bond – Security of Personal Funds</u></p> <p>It is the practice of this facility to maintain a surety bond which matches or exceeds the highest monthly balance of resident funds.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>A \$60,000 Surety Bond was secured immediately upon notification that monthly trust balances had exceeded the previous bond's coverage. For a 6 month span, no balance has exceeded \$59,000.</p> <p><i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i></p> <p>Any resident for whom we manage funds could be affected.</p> <p>The monthly resident trust account balance will be reviewed and confirmed by the administrator, ensuring that no daily balance exceeds the</p>	07/13/2014

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	<p>excess of \$25,000.00 on the following dates:</p> <p>5/7/14 - \$54,221.92 5/6/14 - \$54, 221.92 5/2/14 - \$53,411.12 4/7/14 - \$51,813.67 4/4/14 - \$53,978.37 4/3/14 - \$54,414.60 3/4/14 - \$58,320.67 3/3/14 - \$58,515.50</p> <p>During a 6/11/14, 10:00 a.m., interview, the Administrator indicated the corporate office was assigned the task of overseeing balances in the resident funds accounts to ensure the surety bond covered the daily balance. He indicated he had not been aware the balance was in excess of the current surety bond.</p> <p>A current, April 2011, facility policy titled "Resident Trust", which was provided by the Administrator on 6/12/14 at 3:40 p.m., indicated the following: "...The Risk Management department is responsible for obtaining the surety bond and providing it to the Facility CEO. It is the Facility CEO's responsibility to review the bond to insure the amount covers the largest bank balance in the Resident Trust Fund account."</p> <p>3.1-6(i)</p>		<p>amount of the surety bond. Any discrepancy between the amount of the Surety Bond and the highest attained balance in this account will be immediately rectified by obtaining a new bond in excess of the highest daily balance attained.</p> <p><i>What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?</i></p> <p>The monthly resident trust account balance will be reviewed and confirmed by the administrator, ensuring that no daily balance exceeds the amount of the surety bond.. Any discrepancy between the amount of the Surety Bond and the highest attained balance in this account will be immediately rectified by obtaining a new bond in the proper amount.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</i></p> <p>The administrator will conduct quarterly accounting audits of the resident account balances. The administrator or designee will monitor these audits. The results of these audits will be submitted to the monthly and quarterly QA & A committee for further review and reassessment for further</p>				

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F000221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>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.</p> <p>Based on record review and interview, the facility failed to ensure physical restraints were removed every two hours for 1 of 1 resident reviewed for restraint use. (Resident #58)</p> <p>Finding include:</p> <p>The clinical record for Resident #58 was reviewed on 6/12/14 at 2:08 p.m. Diagnoses for Resident #58 included, but were not limited to, schizoaffective disorder, bipolar, and paranoia.</p> <p>Resident #58 had a signed physician order for Posey mittens (a hand restraint) dated 5/16/14.</p>	F000221	<p>ongoing monitoring.</p> <p><u>F221- Right to be free of physical restraints</u></p> <p>It is the practice and policy of this facility to ensure residents are free of any and all restraints unless deemed clinically required for their safety. If a restraint must be used, it is the policy of the facility to monitor and follow the care plan associated with the restraint, and to discontinue the orders for non-compliance. .</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>Resident #58 has had an order to</p>	07/13/2014	

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	<p>Resident #58 had a care plan for Posey mittens created on 5/19/14. An intervention for this focus was to "check resident q [every] hour and reposition q[every] 2 hours" created on 5/19/14. A revised intervention on 6/13/14, indicated "change, reposition, and remove restraint every 2 hours."</p> <p>Review of the May 2014, Medication Administration Record (MAR) for Resident #58 indicated at 7:00 a.m. and 7:00 p.m., "Res [resident] use Posey mittens r/t [related to] pulling tube out, check placement q [every] shift, only remove for personal care." The MAR was initialed on the following dates and times for Posey mittens in place:</p> <p>May 16, 2014 - 7:00 p.m. May 17, 2014 - 7:00 a.m. and 7:00 p.m. May 18, 2014 - 7:00 a.m. and 7:00 p.m. May 19, 2014 - 7:00 a.m. and 7:00 p.m. May 20, 2014 - 7:00 a.m. and 7:00 p.m. May 21, 2014 - 7:00 a.m. and 7:00 p.m. May 22, 2014 - 7:00 a.m. and 7:00 p.m. May 23, 2014 - 7:00 a.m. and 7:00 p.m. May 24, 2014 - 7:00 a.m. and 7:00 p.m. May 25, 2014 - 7:00 a.m. and 7:00 p.m. May 26, 2014 - 7:00 a.m. and 7:00 p.m. May 27, 2014 - 7:00 a.m. and 7:00 p.m. May 28, 2014 - 7:00 a.m. May 29, 2014 - 7:00 a.m. and 7:00 p.m.</p>		<p>discontinue the use of the posey mittens.</p> <p>Any restraint to be utilized will first be discussed and reviewed by the clinical IDT team. Once it is determined a restraint is an integral intervention for safety, the team will determine the appropriate monitoring, and review the use of the restraint and monitoring in the daily stand down meeting.</p> <p><i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i></p> <p>Any resident that requires a restraint could be affected. A chart audit was performed with one other resident having an order for a restraint. The order is PRN for a drop seat in her wheelchair. This resident is being monitored every hour, and reposition and/or removed from the seat every 2 hours.</p> <p>As restraints are a last option for safety, each and every instance of a restraint being placed will be highly scrutinized and monitored daily by the clinical IDT team. Any adverse reactions or behaviors will be addressed immediately, as well as any monitoring oversights. Once the device is no longer required, the clinical team will view the order to</p>	

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	<p>May 30, 2014 - 7:00 a.m. and 7:00 p.m. May 31, 2014 - 7:00 a.m. and 7:00 p.m.</p> <p>Review of the June 2014, Treatment Record indicated at 7:00 a.m. and 7:00 p.m., "Res [resident] use Posey mittens r/t [related to] pulling tube out, check placement q [every] shift, only remove for personal care." The Treatment Record was initialed on the following dates and times for Posey mittens in place:</p> <p>June 1, 2014 - 7:00 a.m. and 7:00 p.m. June 2, 2014 - 7:00 a.m. and 7:00 p.m. June 3, 2014 - 7:00 a.m. and 7:00 p.m. June 4, 2014 - 7:00 a.m. and 7:00 p.m. June 5, 2014 - 7:00 a.m. and 7:00 p.m. June 6, 2014 - 7:00 a.m. and 7:00 p.m. June 7, 2014 - 7:00 a.m. and 7:00 p.m. June 8, 2014 - 7:00 a.m. and 7:00 p.m. June 9, 2014 - 7:00 a.m. and 7:00 p.m. June 10, 2014 - 7:00 a.m. and 7:00 p.m. June 11, 2014 - 7:00 a.m. and 7:00 p.m. June 12, 2014 - 7:00 a.m. Resident will not use Posey mittens, takes them off.</p> <p>The clinical record for Resident #58 lacked any documentation of restraint release/removal from 5/16/14 to 6/12/14.</p> <p>During an interview with the Administrator on 6/12/14 at 4:05 p.m., additional information was requested</p>		<p>dis-continue to ensure the device is removed appropriately and expeditiously.</p> <p><i>What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?</i></p> <p>Once the device is no longer required, the clinical team will view the order to dis-continue to ensure the device is removed appropriately and expeditiously. Once the device is removed, the clinical IDT team will review the monitoring and ensure that the care plan, as well as removed from the clinical record.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</i></p> <p>The Director of Nursing will perform weekly restraint audits. Any resident currently using a restraint will be reviewed by the DON for proper monitoring and appropriate follow through with the plan of care. Any negative findings will be addressed immediately.</p> <p>The administrator or designee will monitor these audits. The results of these audits will be submitted to the monthly and quarterly QA & A committee for further review and reassessment for further</p>				

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F000241 SS=D	<p>related to the documentation of release/removal of restraints for Resident #58.</p> <p>During an interview with the Director of Nursing, the RN Consultant, and the Administrator on 6/13/14 at 11:30 a.m., the Director of Nursing indicated she had no documentation of restraint release/removal for Resident #58.</p> <p>Review of the current facility policy, dated 7/1/11, titled "Restraint Assessment and Reduction", provided by the RN Consultant on 6/13/14 at 10:58 a.m., included, but was not limited to, the following:</p> <p>"...9. Restraints are not to be left on a resident for more than two [2] hours without the resident being released from the restraint and the resident exercised and/or repositioned; the resident should be visualized every hour...."</p> <p>3.1-26(h)</p> <p>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</p>	F000241	ongoing monitoring.			07/13/2014	

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	<p>record review, the facility failed to ensure cognitively impaired and/or physically dependent residents were provided assistance with Activities of Daily Living in a manner that maintained or enhanced their dignity regarding the removal of facial hair for 1 of 6 female residents observed. (Resident #42).</p> <p>Findings include:</p> <p>The clinical record for Resident #42 was reviewed on 6/12/14 at 7:53 a.m. Diagnoses included, but not were limited to, depression, cerebral vascular accident with left hemiplegia, dementia with behaviors, bipolar disorder, psychosis, anxiety, constipation, anemia, osteoporosis, pneumonia and sepsis.</p> <p>During the resident interview and observation on 6/10/14 at 8:58 a.m., Resident #42 was observed to have facial hair covering her chin.</p> <p>During an observation on 6/11/14 at 2:30 p.m., Resident #42 was observed sitting in her wheelchair in the hallway and to have facial hair covering her chin. During an interview at this time, Resident #42 indicated she did not like having hair on her face.</p> <p>During an observation on 6/12/14 at 9:23</p>		<p><u>F241- Dignity and Respect of Individuality</u></p> <p>It is the practice of this facility and its' staff to promote at all times the practices and care that enhance the individuality and dignity of our residents.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>An electric razor has been purchased for resident #42. Huntington's disease is her primary diagnosis, and her extreme chorea makes it impossible to safely shave her with any type of blade. All efforts will be made to remove resident #42's facial hair without injury to her using an electric razor.</p> <p><i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i></p> <p>Any female resident that develops excessive facial hair could be affected..</p> <p>The ADON or their designee, will view all female residents on a bi-weekly basis to ensure they are free of any unwanted facial hair. If facial hair is noted, <i>and</i> the resident wants it removed, the ADON or designee will</p>				

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F000242 SS=E	<p>a.m., Resident #42 was observed resting in bed and had facial hair covering her chin.</p> <p>During an observation on 6/12/14 at 1:12 p.m., Resident #42 was observed resting in bed and had facial hair covering her chin.</p> <p>During an interview on 6/12/14 at 1:08 p.m., CNA #1 and CNA #2 indicated female residents who needed shaved due to facial hair were indeed shaved. CNA #1 stated, "Sometimes it is daily or every other day, depending on how bad it is. We try to hit all of them on shower days."</p> <p>Review of the Certified Nursing Assistant Assignment Sheet on 6/13/14 at 10:11 a.m., indicated Resident #42 was scheduled to receive showers on Monday and Thursday during the night shift.</p> <p>Review of the Shower/Bath Sheet indicated Resident #42 received a partial bed bath on Monday, 6/9/14 at 1:49 p.m. No other bathing or refusals of showers were documented for that date.</p> <p>3.1-3(t)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose</p>		<p>immediately get staff to shave the resident, or they will shave the resident themselves.</p> <p><i>What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?</i></p> <p>Guardian Angel rounds are conducted daily by the management team, thus any excess facial hair on female residents can be identified and remedied daily, and immediately. Additionally, the ADON or their designee will conduct bi-weekly visual audits of our female population to ensure unwanted facial hair is removed, and dignity promoted to its utmost.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</i></p> <p>The administrator or designee will monitor these audits. The results of these audits will be submitted to the monthly and quarterly QA & A committee for further review and reassessment for further ongoing monitoring.</p>	

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	<p>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.</p> <p>Based on interview and record review, the facility failed to ensure residents had the right to participate in decision making regarding the number of showers or baths they would desire each week for 6 of 13 residents interviewed regarding bathing choices. (Residents #65, #42, #91, #9, #53 and #6)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During a 6/10/14, 12:51 p.m., interview with Resident #65, who was deemed reliable during the stage 1 screening process, Resident #65 indicated he was assigned 2 showers a week and would like 3 or 4. He indicated he was not as fresh or clean as he would like to be because he sweats under his belly. He indicated residents are assigned 2 showers a week and the day they will be offered. 2. During a 6/10/14, 8:56 a.m., interview with Resident #42, who was deemed reliable during the stage 1 screening process, Resident #42 indicated residents are offered a bed bath or shower 2 times a 	F000242	<p><u>F242- Self Determination – Right to Make Choices</u></p> <p>It is the policy of this facility to always promote and respect resident rights and their right to choose to the utmost extreme.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>Shower preferences have been obtained by the Activity Director for all of our residents. This includes but is not limited to: The time they prefer to have a shower, day or night and if they prefer a bed bath, or an actual shower. The shower schedule will be adjusted accordingly to accommodate our resident's preferred times and method or cleansing.</p> <p><i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i></p> <p>All residents have the potential to be affected by the alleged</p>	07/13/2014

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	<p>week. Residents did not get to choose. It was assigned as 2 times.</p> <p>3. During a 6/9/14, 2:51 p.m., interview with Resident #91, who was deemed reliable during the stage 1 screening process, Resident #91 indicated residents get 2 showers a week, which is one every 3 or 4 days and he would like more showers than that.</p> <p>4. During a 6/10/14, 10:30 a.m., interview with Resident #53, who was deemed reliable during the stage 1 screening process, Resident #53 indicated residents get 2 showers or bed baths a week. She indicated residents do not get a choice they are assigned two.</p> <p>5. During a 6/10/14, 8:36 a.m., interview with Resident #6, who was deemed reliable during the stage 1 screening process, Resident #6 indicated the "rule" is residents get 2 showers a week. "I would like more showers. No one would like to smell like urine or sweat."</p> <p>6. During a 6/9/14, 2:58 p.m., interview with Resident #9, who was deemed reliable during the stage 1 screening process, Resident #9 indicated residents get only 2 showers a week. He "would be tickled to death with 3 showers a week." "I have body odors at time."</p>		<p>deficient practice.</p> <p>The Activity Director ensured that she spoke with all residents concerning their preference for showers. If they did not have a preference, that was noted as well.</p> <p><i>What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?</i></p> <p>The overall cleanliness and shower habits of our residents will be monitored through our daily Guardian Angel rounds. If someone is noted to be unkempt, unshaved, or carrying an odor, preferences and habits of that resident will be reviewed and updated by the SSD with the resident.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</i></p> <p>The SSD or their designee will audit this practice interviewing 3 residents weekly for 12 weeks to ensure their preferences are being met. If they are not being met, the SSD will bring the concern to the IDT team to review and correct. These interviews will continue until there have been 3 consecutive weeks in which all interviewed residents are having</p>	

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	<p>7. During a 6/11/14, 10:58 a.m., interview, the Director of Nursing indicated residents generally get 2 showers a week. "Mostly generally we don't like to give more than 3 showers a week because it can lead to skin issues." When asked if that was true for residents under 55 years of age or obese residents she indicated not always. When questioned if residents were asked/assessed for how many times a week they would desire showers, she indicated no.</p> <p>During a 6/11/14, 10:45 a.m., interview, the Activity Director indicated she interviewed new residents regarding their life preferences. She indicated the questions asked if the resident would desire a shower or bed bath, but did not ask how many baths/showers they desired each week.</p> <p>During a 6/11/14, 10:37 a.m., interview, CNA #8 indicated most every resident gets 2 showers a week, but one resident gets 3 showers a week.</p> <p>During a 6/11/14, 10:25 a.m., interview, CNA #9 indicated all residents get 2 showers a week.</p> <p>During a 6/11/14, 10:26 a.m., interview,</p>		<p>their preferences met.</p> <p>The Activity Director will additionally pose this question as an added quality measure during Resident Council to ensure resident preferences are being honored.</p> <p>The administrator or designee will monitor these audits. The results of these audits will be submitted to the monthly and quarterly QA & A committee for further review and reassessment for further ongoing monitoring.</p>	

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F000253 SS=E	<p>LPN #6 indicated showers were assigned by room number, but changes could be made. Residents were given 2 showers a week.</p> <p>During a 6/11/14, 10:28 a.m., interview, CNA #10 indicated residents had 2 showers each week.</p> <p>8. Review of the, 6/9/14, shower schedules, which were provided by the Administrator on 6/11/14 at 9:30 a.m., indicated each room/bed has a pre-assigned shower schedule. The resident who resided in that room/bed was showered according to that schedule. Each bed was scheduled 2 showers a week.</p> <p>Review of the undated, "Nursing Assistant Pocket Worksheet" (a tool to identify resident needs and assignments), which was provided by the Administrator on 6/11/14 at 2:00 p.m., indicated 78 resident names and room numbers were listed on the sheet. Of the 78 residents 75 were assigned showers/baths two times a week.</p> <p>3.1-3(u)(1)</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p>				

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	<p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure resident rooms were clean, in good repair and odor free for 3 of 12 residents interviewed and 1 of 3 families interviewed for cleanliness and a homelike environment.</p> <p>Findings include:</p> <p>1. The following observations of resident rooms were made during the following dates and times during the Stage I survey:</p> <p>Room 147 on 6/10/14 at 8:44 a.m., the bathroom had a strong urine order. The shower threshold had sections of caulking missing. The caulking around the stool was stained. the inside of the bathroom door was gouged and rough.</p> <p>Room 109 on 6/10/14 at 8:45 a.m., the room door frame and bathroom door frame had chipped paint. The bathroom door had a patched hole that was rough to touch.</p> <p>Room 134 on 6/10/14 at 8:51 a.m., the floor had discoloration around the baseboards and debris in the corners.</p> <p>Room 116 on 6/10/14 at 9:06 a.m., the</p>	F000253	<p><u>F253- Housekeeping and Maintenance Services</u></p> <p>It is the policy of the this facility to provide the appropriate maintenance and housekeeping staff to maintain a homelike, clean, functional and safe environment.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>The facility staff will thoroughly address the cleanliness in the facility and the resident's rooms.</p> <p>The SSD and the Activity Director have begun the ongoing process of helping residents hang pictures and enhance the homelike environment within their space.</p> <p>An additional maintenance employee has been hired to assist in keeping up with the maintenance of the facility.</p> <p>Guardian Angel rounds have been adjusted to be conducted and reviewed daily, rather than weekly. These rounds place a department head in each resident's room daily. Items to be reviewed include but are not limited to: Dignity, cleanliness of</p>	07/13/2014

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	<p>floor in front of the closet had a gray discoloration from old wax. There was no caulking around the base of the toilet. The toilet was on a wood shim block. The bathroom had a strong urine odor. The second door in the bathroom was marred and rough to touch.</p> <p>Room 151 on 6/10/14 at 9:15 a.m., the bathroom had an odor of urine, the door frames had chipped paint and were marred and the closet door was missing a knob.</p> <p>Room 119 on 6/10/14 at 9:35 a.m., the floor in the corner behind the door was coated with a heavy dust build up and the bathroom had a strong urine odor.</p> <p>Room 104 on 6/10/14 at 9:46 a.m., the door frame was chipped and gouged. The hand held shower head was on the floor of the shower.</p> <p>Room 144 on 6/10/14 at 9:52 a.m., the bathroom had a strong urine odor. The non-slip strips were loose and coming up. The threshold to the shower and the floor around the toilet was discolored. The hand held shower head was on the shower floor. The outside of the door frame was gauged.</p> <p>Room 142 on 6/10/14 at 10:03 a.m., there</p>		<p>room, solicitation of any care concerns.</p> <p>An Autoscrubber has been purchased to reduce the time needed to clean the general areas of the facility and the hallways. The time saved by utilizing this automation will be redirected toward the cleansing of resident rooms and bathrooms.</p> <p>A long term plan to replace the flooring throughout the facility has been put into place. An outside contractor will be hired to lay the new flooring throughout the facility. This will eliminate many of the odors trapped under the old flooring, as well as adding a homelike aesthetic. The flooring will replace the existing flooring in all resident rooms and common areas. This will include replacing the flooring in resident restrooms. Tentative planning has completion of this project by January 1, 2015.</p> <p>A long term plan to repair the resident restrooms has been put into place. An outside contractor will be secured to repair all resident restrooms, to include but not be limited to: replacing all caulking, replacing old fixtures or tile in disrepair. Tentative planning has completion of this project by November 1, 2014.</p> <p>An audit of bathroom doors will be conducted by the Maintenance</p>	

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	<p>was a closet door missing and the corner protector of the closet was torn away from the wall.</p> <p>Room 149 on 6/10/14 at 10:10 a.m., the bathroom had a strong urine odor. The threshold to the shower was missing sections of caulking. The caulking around the toilet was stained. The inside of the bathroom door was gouged and rough.</p> <p>Room 130 on 6/10/14 at 1:03 p.m., the door frame was chipped and gouged and the floor had a brown residue on it.</p> <p>Room 150 on 6/10/14 at 1:27 p.m., the bathroom had a dark substance on multiple areas of the floor. The closet door was missing a knob.</p> <p>Room 151 on 6/10/14 at 12:51 p.m., the hand held shower head was on the floor of the shower. The threshold of the shower was cracked and discolored. The floor around the toilet was discolored and there was a build up of a dark substance on the floor.</p> <p>2. During an interview on 6/9/14 at 3:08 p.m., Resident #9, who was deemed reliable during the Stage I survey process, indicated his floors were sticky, dirty and dusty.</p>		<p>Director to determine how many doors need replaced. The bathroom doors will then be replaced.</p> <p><i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i></p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>The above measures will benefit and apply to all resident's wellbeing, and will add to the overall cleanliness and comfort needed to foster a homelike environment.</p> <p><i>What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?</i></p> <p>Environmental audits will be completed by the maintenance supervisor weekly until these tasks are completed. Following the completion of these tasks, maintenance will complete monthly audits to ensure an acceptable level of cleanliness is maintained.</p>	

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NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
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	<p>3. During an interview on 6/9/14 at 3:10 p.m., Resident #66, who was deemed reliable during the Stage I survey process, indicated the base boards are not clean. He indicated the big buffers are the cause of the problem through out the building.</p> <p>4. During an interview on 6/10/14 at 8:10 a.m., Resident #81, who was deemed reliable during the Stage I survey process, indicated he did not feel his room was clean. He pointed out areas on the floor where it had not been swept and at stains and discolorations around the edges and the baseboard.</p> <p>5. During a family interview on 6/10/14 at 1:50 p.m., Resident #87's family indicated the room is not as clean as they would like it to be. It was indicated the mats on the floor get sweaty and smell.</p> <p>6. The Environmental tour was conducted on 6/12/14 from 1:50 p.m. to 3:30 p.m. with the RN Consultant and the Maintenance Supervisor. The following observations and interviews were made:</p> <p>Room 101 had strings of dark gray dust hanging from the door hinges and could be seen when entering the room. The bathroom door and door frame was severely scratched and gouged on 1/4 of</p>		<p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</i></p> <p>The administrator or designee will monitor these audits. The results of these audits will be submitted to the monthly and quarterly QA & A committee for further review and reassessment for further ongoing monitoring.</p>	

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	<p>the door.</p> <p>During an interview with the RN Consultant and the Maintenance Supervisor at 2:10 p.m., they indicated all the door frames were marred. The RN Consultant indicated she noted the doors and frames being marred on her previous visits. The Maintenance Supervisor indicated he was going to get an estimate of the cost of having the door frames reclad.</p> <p>Room 109 was observed at 2:14 p.m., the air conditioning unit was dripping water and causing it to pool on the floor. The Maintenance Supervisor indicated he had received two new units and this unit was scheduled to be replaced in the next couple of days.</p> <p>The non-skid strips beside bed A in room 118 were worn and coming loose.</p> <p>The closet door in room 120 was missing a knob.</p> <p>Room 125 bed A's footboard was marred.</p> <p>Room 134 door, bathroom door and door frames marred and rough, debris in the corner and around the baseboard.</p> <p>Room 145 window blinds were missing</p>			
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F000282 SS=D	<p>two slats.</p> <p>7. An Environment tour with the Administrator was made on 6/13/14 from 8:45 a.m. to 10:10 a.m. The following observations were made:</p> <p>Room 104 on 6/13/14 at 8:58 a.m., with the Administrator present, the door frame was chipped and gouged. The hand held shower head was on the floor of the shower.</p> <p>The window in room 145 was dirty on the outside and was hazy looking.</p> <p>The bathroom of room 149 had a strong urine order. The caulking around the stool was stained. The inside of the bathroom door was gouged and rough. The hand held shower head was on the floor of the shower. The shower threshold had sections of caulking missing. The Administrator indicated the urine odor comes from under the floor tiles in the bathrooms. He indicated the floor tiles in the bathrooms needed to be removed to fix the odor problem.</p> <p>3.1-19(f)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER</p>				

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	<p>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.</p> <p>Based on record review and interview, the facility failed to ensure medication was given timely for 1 of 5 residents reviewed for unnecessary medications and physician orders (Resident #66). The facility further failed to ensure nursing staff obtained a laboratory test timely as ordered by the physician for 1 of 6 residents reviewed for laboratory testing. (Resident #9)</p> <p>Finding include:</p> <p>1. Resident #66's clinical record was reviewed on 6/11/14 at 9:15 a.m. The resident's diagnoses included, but were not limited to, schizophrenia, bipolar, and dementia with mania.</p> <p>The resident had a current physician's order for Invega Sustenna [an antipsychotic medication] injection 117/0.75 inject 0.75 ml (117 mg) intramuscularly monthly, chart and rotate site. This medication was to treat schizophrenia and was to start on 2/7/14.</p> <p>Review of the February, 2014, Medication Administration Record indicated the Invega Sustenna injection</p>	F000282	<p><u>F282- Services by a Qualified Persons/Per Care Plan</u></p> <p>It is our policy to always follow orders given by qualified persons, and to document properly any medication administration, as well as removing any orders as directed to do so by qualified persons.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>Resident #66 was given the outstanding shot required per physicians order.</p> <p>Resident #9 had labs drawn per order. No concerning results.</p> <p><i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i></p> <p>100% audit was completed on any resident receiving an injection and on any current lab orders. No others were affected.</p> <p><i>What measures or what systemic changes will be made to ensure</i></p>	07/13/2014			

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	<p>was administered on 2/11/14.</p> <p>The March, 2014, Medication Administration Record indicated the Invega Sustenna injection was administered on 3/11/14.</p> <p>The April, 2014, Medication Administration Record [MAR] indicated the Invega Sustenna injection was administered on 4/8/14.</p> <p>The May and June, 2014, Medication Administration Records lacked an indication of the Invega Sustenna injections being given.</p> <p>During an interview with the Director of Nursing on 6/12/14 at 4:30 p.m., she indicated she had reviewed the May, 2014, MAR and saw the Invega Sustenna had not been given. She indicated she had called the nurse and was told the medication had not been ordered from pharmacy until 5/30/14. The Director of Nursing indicated the medication was administered when it arrived from pharmacy on 5/30/14, but was not documented.</p> <p>2. The clinical record for Resident #9 was reviewed on 6/11/14 at 12:41 p.m. Diagnoses for Resident #9 included, but were not limited to, quadriplegia,</p>		<p><i>that the deficient practice does not reoccur?</i></p> <p>Nurses were inserviced on medication administration and lab scheduling and tracking.</p> <p>A weekly injection report is sent to the facility from the pharmacy. These reports are reviewed and addressed during the daily clinical CQI.</p> <p>A lab tracking binder has been incorporated, and is brought to CQI daily to review new orders, and place any new lab orders in the tracking binder. During CQI new lab orders will be entered into the lab system. Tracking binder has the day the lab is due to be drawn, and on a daily basis in CQI those labs can be reviewed and ensure they were drawn.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</i></p> <p>The DON/Designee will audit the injection report and lab tracking daily within the daily CQI process for compliance. Any and all discrepancies will be documented and resolved.</p> <p>The administrator or designee will monitor these audits. The results of these audits will be submitted</p>				

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	<p>neurogenic bladder, and osteomyelitis.</p> <p>A signed physician's order, dated 3/4/14, indicated Resident #9 was to have a Complete Blood Count (CBC), Erythrocyte Sedimentation Rate (ESR), Basic Metabolic Profile (BMP), and C-Reactive Protein (CRP) laboratory tests weekly.</p> <p>A treatment note from the wound clinic, dated 4/8/14, indicated "Facility was called today while patient was in clinic to ask for current labs. His nurse stated that weekly labs have not been drawn as the orders were never transcribed. They were just found this week."</p> <p>A fax sent to the physician, dated 4/8/14, indicated "... order was written on 3/14/14 [sic] to obtain CBC, ESR, BMP, and CRP weekly. Order was not taken off. Order added to TAR [Treatment Administration Record]. Will begin on 4/9/14."</p> <p>During an interview with the Administrator, the Director of Nursing and the RN consultant on 6/13/14 at 11:30 a.m., additional information was requested related to the weekly laboratory tests ordered on 3/4/14 for Resident #9.</p> <p>The facility did not provide any</p>		to the monthly and quarterly QA & A committee for further review and reassessment for further ongoing monitoring.	

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F000312 SS=D	<p>additional information as of final exit on 6/13/14.</p> <p>Review of the current facility policy, dated 1/07, titled "Lab Scheduling and Tracking", provided by the RN Consultant on 6/13/14 at 1:40 p.m., included, but was not limited to, the following:</p> <p>"POLICY: All laboratory tests ordered by the physician will be systematically scheduled and tracked to ensure that all lab work ordered is obtained and results are received....</p> <p>...PROCEDURE:...</p> <p>...8. For any newly ordered labs needing immediate attention, the above should be completed by the nurse on the unit.</p> <p>9. For new admissions and/or changes in lab orders, the nurse transcribing the orders is responsible to notify Medical Records of these changes. This should be communicated to Medical Records...."</p> <p>3.1-35(g)(2)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the</p>						

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	<p>necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents who needed assistance to groom where offered shaving and shampooing assistance as needed to maintain good hygiene and personal appearance for 3 of 4 residents reviewed for grooming assistance (Resident #76, #79 and #85).</p> <p>Findings Include:</p> <p>1. Resident #76's record was reviewed on 6/11/14 at 8:35 a.m. Resident #76's current diagnoses included, but were not limited to, dementia, depression and hypertension.</p> <p>Resident #76 had a current, 4/23/14, quarterly, Minimum Data Set (MDS) assessment which indicated the resident understood others and was understood by others, made independent choices and required cueing and assistance in new situations only and needed the assistance of one staff member for bathing, grooming and hygiene needs.</p> <p>Resident #76 had a, 4/23/14, current care plan problem/need regarding the need for assistance with activities of daily living. The goal for this need was for the</p>	F000312	<p><u>F312- ADL Care Provided for Dependent Residents</u></p> <p>It is the policy of this facility to always promote dignity and assistance with ADLs for those who require it.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>All residents found to be affected immediately were offered and provided a shave. A review of current care plans was conducted to make sure the preference of the family and resident were being honored.</p> <p>The Activity Director and SSD will conduct individual interviews with residents and families in conjunction with the reiteration of their shower preferences.</p> <p><i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i></p> <p>All male residents have the potential to be affected by the alleged deficiency.</p>	07/13/2014

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	<p>resident to be clean, odor free and appropriately dressed daily. An approach to this need was shower and shampoo 2 times a week and as needed.</p> <p>Resident #76 was observed with heavy beard stubble on 6/10/14 at 2:00 p.m., 6/11/14 at 10:30 a.m. and 6/12/14 at 8:10 a.m.</p> <p>During a 6/12/14, 8:10 a.m., interview, Resident #76, who was deemed reliable and had a 4/23/14 MDS which indicated he understood and made his own choices, indicated the facility only shaved him 2 times a week on shower days. He indicated he shaved daily at home prior to admission to the facility. He needed staff assistance to shave. He desired to be shaved daily. He indicated he was currently in need of a shave.</p> <p>2. Resident #79's record was reviewed on 6/12/14 at 9:45 a.m. Resident #79's current diagnoses included, dementia, dysphasia and depression.</p> <p>Resident #79 had a current, 5/16/14, quarterly MDS assessment which indicated he was severely cognitively impaired and rarely or never made choices and was totally dependent on staff assistance for bathing and grooming.</p>		<p>An initial interview will be conducted with each male resident to determine their shaving preference, if they have one. The SSD will update their care plans accordingly. These results will be published to the management team, thus during Guardian Angel rounds, they can ensure that resident shaving preferences are being honored and followed through with on a daily basis.</p> <p><i>What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?</i></p> <p>An initial interview will be conducted with each male resident to determine their shaving preference, if they have one. The SSD will update their care plans accordingly. These results will be published to the management team, thus during Guardian Angel rounds, they can ensure that resident shaving preferences are being honored and followed through with on a daily basis.</p> <p>Guardian Angel rounds will be the first line of defense in ensuring these preferences are honored moving forward. Daily rounds including audits of at least two males will be conducted for 12</p>	

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	<p>Resident #79 had a, 5/16/14, current, care plan problem/need regarding the need for assistance with activities of daily living. The goal for this need was for the resident to be clean, odor free and appropriately dressed daily. An approach to this need was shower and shampoo 2 times a week and as needed.</p> <p>During a 6/10/14, 2:10 p.m., interview, Resident #79's family indicated the resident liked to be shaved daily and had been clean shaven when he lived at home. The family indicated he currently only gets shaved on his shower days and that leaves him looking stubbly and unkept. The family indicated Resident #79 never liked to have whiskers.</p> <p>Resident #79 was observed with heavy whiskers on 6/11/14 at 10:35 a.m. and 6/12/14 at 10:00 a.m.</p> <p>3. During a 6/12/14, 10:00 a.m., interview, CNA #11 indicated residents are shaved on shower days and as needed in between. She indicated she does not always get her as needed shaves done because there was not enough time.</p> <p>During a 6/12/14, 10:05 a.m., interview, CNA #12 indicated residents get showered on shower days and the staff try to shave them Sundays and as needed.</p>		<p>weeks and reviewed by the administrator and the management team</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</i></p> <p>The administrator or designee will monitor these audits. The results of these audits will be submitted to the monthly and quarterly QA & A committee for further review and reassessment for further ongoing monitoring.</p>	

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	<p>She indicated as needed shaves don't get done if staff do not have enough time and most times there was not enough time to get all the as needed shaves done.</p> <p>During a 6/12/14, 10:10 a.m., interview, the Director of Nursing indicated residents were suppose to be shaved on shower days and as needed. When questioned she indicated the facility had no method to interview residents or families about each residents shaving preferences and how frequently they desired to be shaved.</p> <p>4. The clinical record for Resident #85 was reviewed on 6/10/14 at 10:40 a.m. Diagnoses included, but not limited to, cerebral vascular accident, immobility syndrome, dysphagia, neurogenic bladder, para and hemiplegia dementia with behavioral disturbances, depression, anxiety and muscle spasms.</p> <p>Review of medication orders for Resident #85 indicated an order for Ketoconazole 2% shampoo to be used on scalp and hair twice a week on shower days. Resident #85 was scheduled for showers on Mondays and Thursdays during the day shift.</p> <p>Review of the Shower/Bath Sheets provided by the Nurse Consultant on 6/13/14 at 11:22 a.m. indicated Resident</p>				

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F000323 SS=D	<p>#85 received showers on the following dates: 5/15/14 at 11:10 a.m., 5/26/14 at 8:58 a.m., 6/9/14 at 1:37 p.m. and 6/12/14 at 12:56 p.m. Resident #85 received a complete bed bath on the following date: 6/3/14 at 4:00 p.m. Resident #85 received partial bed baths for the remainder of the thirty day period between 5/15/14 through 6/13/14 (Totaling 28 partial bed baths).</p> <p>Review of the treatment record indicated Resident #85 received a shampoo on 5/17/14, 5/20/14, 5/27/14, 5/31/14, 6/2/14, 6/5/14, 6/9/14 and 6/12/14. Resident #85 did not have a shower documented for 5/17/14, 5/20/14, 5/27/14, 6/2/14 and 6/5/14</p> <p>During a family interview on 6/10/14 at 10:40 a.m., with Resident #85's family member, she stated "Sometimes I come in here and you can tell his hair hasn't been washed. I usually ask them if he has been bathed. You can tell when his special shampoo has been used and when it hasn't."</p> <p>3.1-38(a)(3)(B) 3.1-38(a)(3)(D)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident</p>			

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	<p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure hand rails were smooth and had no rough splintered edges for 1 of 6 hallways.</p> <p>Findings include:</p> <p>During an observation on 6/9/14 at 12:40 p.m., the right hand mitered corner of the hand rail at the entrance to the Sapphire Stream hallway was rough, gouged and had sharp edges.</p> <p>The hand rail was observed on 6/12/14 at 3:05 p.m., with the Maintenance Supervisor present. The hand rail remained rough and gouged and the Maintenance Supervisor indicated the facility was looking into replacing the hand rails.</p> <p>During the exit conference on 6/13/14 at 1:30 p.m., the Administrator indicated he was aware of the rough, gouged hand rails on Sapphire Stream hall.</p> <p>3.1-45(a)(1)</p>	F000323	<p><u>F323- Free of Accident Hazards/Supervision/Devices</u></p> <p>It is the policy of this facility to maintain an environment that is free of accident hazards.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>The damaged area to the handrail has been repaired.</p> <p><i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i></p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>The damaged area to the handrail has been repaired.</p> <p><i>What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?</i></p> <p>The maintenance director will conduct weekly safety audits, as well as forming a safety committee to assist in identifying</p>	07/13/2014

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F000329 SS=D	<p>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.</p> <p>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</p>		<p>areas in poor repair or areas that create an immediate safety concern.</p> <p>Guardian Angel rounds will help to supplement the safety committee and maintenance director's efforts.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</i></p> <p>The administrator or designee will monitor these audits. The results of these audits will be submitted to the monthly and quarterly QA & A committee for further review and reassessment for further ongoing monitoring.</p>	

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	<p>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.</p> <p>Based on record review and interview, the facility failed to ensure a resident was monitored for constipation for 1 of 5 residents sampled for unnecessary medications and monitoring medications. (Resident #89)</p> <p>Findings include: The clinical record for Resident #89 was reviewed on 6/11/14 at 2:37 p.m. Diagnoses for Resident #89 included, but were not limited to, schizophrenia, anxiety, and constipation.</p> <p>A quarterly Minimum Data Set (MDS), dated 3/21/14, indicated Resident #89 was moderately cognitively impaired.</p> <p>Resident #89 had a current physician order for docusate sodium (a stool softener) 100 milligrams (mg) by mouth 4 times a day.</p> <p>Review of the bowel monitoring from March 1, 2014 to June 10, 2014, indicated Resident #89 did not have recorded bowel movement for the</p>	F000329	<p><u>F329- Drug Regimen is Free from Unnecessary Drugs</u></p> <p>It is the policy of this facility to keep our resident's drug regimen free of unnecessary drugs, ensuring we rule out any medical causes for any behaviors or disturbances prior to introducing a pharmaceutical intervention or remedy.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>Resident #89 received an order for a PRN constipation medication</p> <p><i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i></p> <p>100% audit was completed and no other residents were affected..</p> <p><i>What measures or what systemic changes will be made to ensure</i></p>	07/13/2014

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	<p>following time periods:</p> <p>March 6, 7, 8, 9, 10, 11, 12, 13, and 14, 2014, all ones recorded or blank spaces. A one indicated "none" for the size of the bowel movements. A time period of 9 days without a recorded bowel movement.</p> <p>April 4, 5, and 6, 2014, all ones recorded or blank spaces. A time period of 3 days without a recorded bowel movement.</p> <p>April 23, 24, and 25, 2014, all ones recorded or blank spaces. A time period of 3 days without a recorded bowel movement.</p> <p>May 29, 30, and 31, 2014, all ones recorded or blank spaces. A time period of 3 days without a recorded bowel movement.</p> <p>June 8, 9, and 10, 2014, all ones recorded or blank spaces. A time period of 3 days without a recorded bowel movement.</p> <p>The nursing notes lacked any information related to any interventions having been given or tried during these time periods.</p> <p>Review of the March 2014, Medication Administration Record (MAR) indicated the resident did not have an as needed</p>		<p><i>that the deficient practice does not reoccur?</i></p> <p>Nurses will be inserviced on Bowel Regiment, ruling out medical causes of behaviors and the BM alert in PCC.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</i></p> <p>DON/Designee will review the Dashboard of PCC daily in CQI for any alerts related to no bowel movement for 72hours. The SSD will maintain the identification and review of each new behavior from a resident. Along with this record, the SSD will maintain what medical causative factors have been ruled out prior to the introduction of a new medication. The checklist will also be maintained here. This process will be ongoing and completed during the weekly Behavioral Meeting.</p> <p>Any and all discrepancies will be documented/reeducated and resolved.</p> <p>The administrator or designee will monitor these audits. The results of these audits will be submitted to the monthly and quarterly QA & A committee for further review and reassessment for further ongoing monitoring.</p>	

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	<p>medication ordered for constipation.</p> <p>Review of the April 2014, MAR indicated the resident did not have an as needed medication ordered for constipation. A new order to give Risperdal Consta (an antipsychotic), 12.5 mg intramuscularly now for increased agitation was obtained from the physician on 4/20/14. A Behavior Note, dated 4/23/14, indicated a new order to obtain an urine analysis, and an urine culture and sensitivity due to an increase in agitation and behaviors.</p> <p>Review of the May 2014, MAR indicated the resident did not have an as needed medication ordered for constipation.</p> <p>Review of the June 2014, MAR indicated the resident did not have an as needed medication ordered for constipation. An as needed medication, Seroquel (an antipsychotic), 50 mg by mouth was given on 6/9/14 for anxiety and agitation.</p> <p>During an interview with the Social Services Director (SSD) on 6/13/14 at 10:05 a.m., she indicated "they do not normally look at constipation as a reason for an increase in behaviors, only if the resident has had a history of constipation."</p>			

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	<p>During an interview with the Director of Nursing and the RN Consultant on 6/13/14 at 10:32 a.m., additional information was requested related to the bowel monitoring for Resident #89.</p> <p>During an interview with the Administrator, the Director of Nursing, and the RN Consultant on 6/13/14 at 11:30 a.m., the Director of Nursing indicated they had no other information to provide related to the bowel monitoring for Resident #89.</p> <p>Review of the current facility policy, dated 7/1/11, titled "Bowel Elimination Policy", provided by the Director of Nursing on 6/11/14 at 11:26 a.m., included, but was not limited to, the following:</p> <p>"GUIDELINE: It is the intent of the facility nursing personnel to document, monitor and implement appropriate measures relative to the management of bowel function....</p> <p>...Procedure:</p> <p>1. CNA's will document resident bowel movements daily...</p> <p>...2. If a resident self-toilets, the CNA will inquire prior to the end of their shift if the resident had a bowel movements [sic] and record results...</p>			

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F000364 SS=E	<p>...5. The Charge Nurse will review the ADL sheet in regards to bowel movements. If a resident has no bowel movement by the third day, the Charge Nurse will notify the MD and follow ordered protocol.</p> <p>6. The Charge Nurse will document the intervention offered.</p> <p>7. The Charge Nurse will communicate with the RD and MD if irregularity persists.</p> <p>3.1-48(a)(3)</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. Based on observation and interview, the facility failed to ensure food was palatable and at a pleasant temperature for 7 of 12 residents interviewed regarding food palatability (Residents #6, #9, #81, #66, #36, #42 and #65).</p> <p>Findings include:</p> <p>During a 6/10/14, 8:41 a.m., interview,</p>	F000364	<p><u>F364- Nutritive Value/Appearance, Palatable/ Preferred Temperature</u></p> <p>It is the policy of this facility to serve food that is tasteful, aesthetically appealing and at the correct temperature.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by</i></p>	07/13/2014

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	<p>Resident #6, who was deemed reliable during the stage 1 survey process, indicated the food was never really hot. "It might be luke warm."</p> <p>During a 6/9/14, 3:15 p.m., interview, Resident #9, who was deemed reliable during the stage 1 survey process, indicated food was cold on a daily bases when served in the dining room or in the resident's room.</p> <p>During a 6/10/14, 8:22 a.m., interview, Resident #81, who was deemed reliable during the stage 1 survey process, indicated the food was not palatable.</p> <p>During a 6/9/14, 3:19 p.m., interview, Resident #66, who was deemed reliable during the stage 1 survey process, indicated the food was not palatable.</p> <p>During a 6/10/14, 1:34 p.m., interview, Resident #36, who was deemed reliable during the stage 1 survey process, indicated the food was usually cold and tasted "bad."</p> <p>During a 6/10/14, 9:09 a.m., interview, Resident #42, who was deemed reliable during the stage 1 survey process, indicated the food was not seasoned well and was not palatable.</p>		<p><i>the deficient practice?</i></p> <p>To ensure that food temperatures are appropriately maintained, insulated plate bases and covers will be purchased for the resident capacity of the facility. In addition, food temperatures will be monitored to determine if insulated bases and covers maintain the food temperature for the required amount of time.</p> <p><i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i></p> <p>All residents eating from the dining hall have the potential to be affected by the alleged deficient practice.</p> <p>To ensure that food temperatures are appropriately maintained, insulated plate bases and covers will be purchased for the resident capacity of the facility. In addition, food temperatures will be monitored to determine if insulated bases and covers maintain the food temperature for the required amount of time.</p> <p><i>What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?</i></p> <p>Audits reviewing food appearance, temperature and</p>		

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	<p>During a 6/10/14, 12:59 p.m., interview, Resident #65, who was deemed reliable during the stage 1 survey process, indicated food was cold when he ate in his room and food is often processed items which were not palatable.</p> <p>A taste test tray was obtained and tested with the Food Services Supervisor on 6/11/14 at 12:45 p.m. as follows: regular roast beef - cool, luke warm mechanical soft roast beef - cool, luke warm pureed beef - cold pureed vegetables - cool, luke warm regular vegetables- slightly cool mashed potatoes - hot</p> <p>During a 6/11/14, 12:48 p.m., interview, the Food Services Supervisor indicated all the hot food items with the exception of the mashed potatoes were cold and not enjoyable. She indicated she would look into the situation and find an answer as to why the food items were not maintaining the temperatures.</p> <p>During a 6/12/14, 8:30 a.m., interview, the Food Services Supervisor indicated she had discovered what she felt caused the food items to be cold on yesterdays test tray. She indicated the cook (Cook #13) had not put spacer pans in the steam table beside his smaller pans and all the steam was escaping instead of being held</p>		<p>taste will be performed during the meal service by the Dietary Manager a minimum of 2 meals per day , 5 days a week for 4 weeks, then 1 day per week for 4 weeks.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</i></p> <p>The administrator or designee will monitor these audits. The results of these audits will be submitted to the monthly and quarterly QA & A committee for further review and reassessment for further ongoing monitoring.</p>	

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F000371 SS=F	<p>under the pans to keep them warm. This is why the food was warm enough before the meal, but lost temperature as it was held on the steam table.</p> <p>3.1-21(a)(2)</p> <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 Based on observation, interview and record review, the facility failed to distribute food under sanitary conditions regarding cleanliness and food handling. Of the facility's 76 residents this deficient practice had the potential to impact the 75 residents who ate food prepared in the facility kitchen.</p> <p>Findings include:</p> <p>During a 6/9/14, 12:00 p.m., kitchen sanitation tour the following concerns were observed:</p> <p>a. The caulk around the hand washing sink was stained with a brown, black</p>	F000371	<p><u>F371- Food Procure, Store/Prepare/Serve - Sanitary</u></p> <p>It is the policy of this facility to prepare and serve food in sanitary conditions at all times.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>The caulking around the sink was immediately removed and re-caulked.</p> <p>The backsplash of the oven, the front of the oven and the oven's drip pan were deep cleaned by the dietary staff immediately after identification by the surveyors.</p>	07/13/2014

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	<p>substance.</p> <p>b. The floor tiles under the oven and food preparation table were stained and discolored with a dark yellow and gray residue.</p> <p>c. The back splash of the stove behind the burners was covered with a thick black, brown, gold sticky residue.</p> <p>d. The front edge of the stove in front of the burners was covered with a thick black, brown, gold sticky residue.</p> <p>e. The stove drip pan located under the burners had baked and burned on food residue over the entire surface.</p> <p>During the 6/11/14, 11:25 a.m., observation of the pureed meat process, Cook #13 wore gloves. With his gloved hand he touched containers, utensils and counter tops resulting in soiled gloves. With his soiled gloved hands he touched the roast beef as he placed it in the food processor.</p> <p>A current, undated, facility policy titled "Glove and Hand washing Procedures", which was provided by the Administrator in 6/12/14 at 1:50 p.m., indicated the following: " Gloves are changed anytime hand</p>		<p>The flooring has been quoted to be replaced in the kitchen.</p> <p>The entire dietary staff were inserviced and re-educated on proper glove use and food handling in the kitchen.</p> <p><i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i></p> <p>All residents who dine in the dining hall have the potential to be affected by the alleged deficient practice.</p> <p>The caulking around the sink was immediately removed and re-caulked.</p> <p>The backsplash of the oven, the front of the oven and the oven's drip pan were deep cleaned by the dietary staff immediately after identification by the surveyors.</p> <p>The flooring has been quoted to be replaced in the kitchen</p> <p>The entire dietary staff were inserviced and re-educated on proper glove use and food handling in the kitchen.</p> <p><i>What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?</i></p>	

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F000431 SS=E	<p>washing would be required such as ...if gloves become contaminated by touching the face, hair, uniform, or non-food contact surface such as door handles and equipment."</p> <p>3.1-21(i)(3)</p> <p>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 records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and</p>		<p>The dietary manager will perform audits by conducting daily sanitation rounds 5 days per week for 4 weeks, then weekly thereafter. Any unacceptable areas will be addressed immediately, prior to her departure.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</i></p> <p>The administrator or designee will monitor these audits. The results of these audits will be submitted to the monthly and quarterly QA & A committee for further review and reassessment for further ongoing monitoring.</p>	

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	<p>cautionary instructions, and the expiration date when applicable.</p> <p>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.</p> <p>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.</p> <p>Based on observation and interview the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with the accepted professional principles, and recognized the appropriate expiration date.</p> <p>Findings include:</p> <p>During the medication storage observation on 6/12/14 at 2:24 p.m., the following concerns were noted:</p> <ol style="list-style-type: none"> 1. Two opened bottles of Tuberculin were noted with no open date. The date arrived in the facility from the pharmacy was 4/21/14. 2. One opened bottle of Tuberculin was noted with no open date. The date 	F000431	<p><u>F431- Drug Records, Label/Store Drugs and Biologicals</u></p> <p>It is the policy of this facility to properly manage and audit our medication carts to ensure no expired medications are available for use, and they are discarded per policy.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>An initial audit of all medication and treatment carts has been performed by the DON and ADON. Any expired medications or supplies were immediately removed from the cart and</p>	07/13/2014

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	<p>arrived in facility from pharmacy was 3/4/14.</p> <p>All the Tuberculin bottles had the "discard 30 days after opening" statement on the bottles.</p> <p>The Emerald Hall cart had the following concerns:</p> <p>1. Five packs of Gluco Chlor wipes with an expiration date of 4/11.</p> <p>The Sapphire Hall cart #1 had the following concerns:</p> <p>1. One bottle of Nitrostat with an expiration date of 5/24/14. The Nitrostat order was current for a current resident.</p> <p>The treatment cart had the following concerns:</p> <p>1. Two packets of Saniwipes with an expiration date of 01/2013.</p> <p>During an interview on 6/12/14 at 2:24 p.m., Unit Manager was not aware the Tuberculin was expired and indicated it may have been administered to newly admitted residents and recent new employee hires.</p> <p>3.1-25(o)</p>		<p>discarded appropriately, per policy.</p> <p><i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i></p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>An initial audit of all medication and treatment carts has been performed by the DON and ADON. Any expired medications or supplies were immediately removed from the cart and discarded appropriately, per policy.</p> <p><i>What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?</i></p> <p>Nurses were in serviced on drug records, label/store of drugs.</p> <p>Night Nurse will audit the medication cart nightly for any expired medications.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</i></p> <p>DON/Designee will do 3 random cart audits a week for 3 weeks,</p>				

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F000441 SS=D	<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</p>		<p>then 2 times a week for 2 weeks and then weekly thereafter..</p> <p>Any and all discrepancies will be reeducated and resolved.</p> <p>The administrator or designee will monitor these audits. The results of these audits will be submitted to the monthly and quarterly QA & A committee for further review and reassessment for further ongoing monitoring.</p>	

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	<p>a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(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 transport linens so as to prevent the spread of infection.</p> <p>Based on observation and record review, the facility failed to ensure sanitary conditions were followed during medication administration. This deficient practice had the potential to effect all 26 residents during the observation.</p> <p>Finds Include;</p> <p>During observation of the medication administration for residents residing on Sapphire Hall on 6/11/14 at 8:21 a.m., with RN #7, the RN was observed popping medication from the medication sleeves into her hand and placing the medication into the medicine cup. RN #7 was not wearing gloves.</p> <p>A 6/11/14, Midnight Census form, which was provided by the Director of Nursing on 6/11/14 at 2:00 p.m., indicated 26 residents resided on Sapphire Hall.</p>	F000441	<p><u>F441- Infection Control, Prevent Spread, Linens</u></p> <p>It is the policy of this facility to always follow Universal Precautions when combating infection control. This facility trains and promotes proper infection control, medication passing, food handling and biohazard controls based on the parameters set forth by Universal Precautions.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>All nurses were observed completing a medication pass with no negative outcomes. No other residents were found to be affected through the medication pass.</p> <p><i>How will other residents having the potential to be affected by the</i></p>	07/13/2014

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	<p>Review of the current facility policy dated June 19, 2012, titled "5.1: Drug Administration--General Guidelines", provided by the Nurse Consultant on 6/13/14 at 1:35 p.m., included, but was not limited to, the following:</p> <p>"Policy: Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medication do so only after sufficient information regarding the resident's condition and expected outcomes of medication therapy is known. The licensed nurse is aware of an indication for the resident receiving medication, usual dose, parameters and routes, contraindications, allergies, sensitivities, and side effects.</p> <p>...2. Follow good infection control practices.... Never touch any of the medication with fingers. ...3. Accurately dispense medications to residents. Punch medications directly into cup and never into your hand..."</p> <p>3.1-18(a)</p>		<p><i>same deficient practice will be identified and what corrective actions will be taken?</i></p> <p>All nurses were observed completing a medication pass with no negative outcomes.</p> <p><i>What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?</i></p> <p>The nursing staff was inserviced and re-educated on universal precautions/handwashing/infection control</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</i></p> <p>DON/Designee will observe a Medication pass observations 3 times weekly for 3 weeks, 2 times a week for 2 weeks and then weekly. Any negative observations will be corrected immediately The results of the medication observation will be submitted to the administrator or designee weekly. The results of these audits will be submitted to the monthly and quarterly QA & A committee for further review and reassessment for further ongoing monitoring.</p>	

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F000465 SS=F	<p>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 facility failed to ensure the environment was clean and well maintained for 5 of 5 halls.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Five window sills in the dining room were observed on 6/9/14 at 12:20 p.m., and the sills contained dead flying insects. The Environmental tour was conducted on 6/12/14 from 1:50 p.m. to 3:30 p.m. with the RN Consultant and the Maintenance Supervisor. The following observations and interviews were made: 16 florescent light bulbs were burned out around the nurses station. The ceiling tiles had brown water stains. The floor/wall baseboard on Ruby Hall was discolored and looked dirty. The RN Consultant indicated she had 	F000465	<p><u>F465- Safe/Functional/Comfortable Environment</u></p> <p>It is the policy of this facility to provide the safest, most comfortable, functional, homelike environment possible.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>All window sills were immediately checked and cleaned.</p> <p>All light bulbs have been replaced by the maintenance supervisor. While replacing light bulbs, the maintenance director also cleaned the fixtures.</p> <p>The gap that was identified in the drywall next to room 123 has been filled in and repaired.</p> <p>An Autoscrubber was purchased that also buffs and cleans the cove base/base boards, as well</p>	07/13/2014

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	<p>made a note on her previous visit the of the wax build up along the baseboards.</p> <p>The floor around the the refrigerator in the nourishment pantry had a dirty looking brown wax build up around it.</p> <p>The light fixture at the end of Ruby hallway was dim. The inside of the cover was dirty. The Maintenance Supervisor indicated it had debris in it from having insulation blown in. The next light fixture's cover had a corner hanging loose.</p> <p>The plaster at the corners of the walls around the nurse station was chipped.</p> <p>The ceiling of the hall leading to the dining room had a cracked area in the plaster. The Maintenance Supervisor indicated it had been caused by a leak in the sprinkler system. Two lights in the hallway had cracked covers and the Maintenance Supervisor indicated he had replacements for them, but he had not had time to change them.</p> <p>The five window sills in the dining room were littered with dead flying insects.</p> <p>The kick plate on the bottom half of the door to the handicap bathroom in the hallway leading to the dining room was</p>		<p>as scrubbing a 20" path of flooring. This machine will be utilized to ensure all of the cove base and flooring is cleaned to the fullest extent possible until the flooring can be replace. Once the flooring is replaced, this machine will be integral in maintaining the new flooring.</p> <p>Kick plates, wall protectors, and doorframe protectors are being priced and will be purchased to maintain the repairs and work being done. The most worn, dirty, and/or below standard will be replaced first.</p> <p>The flooring in the handicap restroom located adjacent to the main dining hall has had the flooring replaced.</p> <p>We currently have a contractor addressing any imperfections or damage in the plaster throughout the building. They are also painting the facility for us as well.</p> <p>The area at the end of Sapphire hall has been cleaned out, and bids will be solicited to have a wall built to add additional storage space, so equipment may be stored in that area if needed.</p> <p><i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i></p>	

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	<p>discolored. Housekeeper #14 indicated the discoloration was from wax build up. She demonstrated the area could be cleaned with a green scrubber. She indicated she cleans the window sills in the dining room at least weekly.</p> <p>There were two resident rooms at the end of Sapphire hall. The area to the left of the resident rooms was used as a storage area. The area contained two large scales, a lift and multiple wheelchairs. The Maintenance Supervisor indicated it had been discussed about building a wall to make a storage area.</p> <p>3. An Environment tour with the Administrator was made on 6/13/14 from 8:45 a.m. to 10:10 a.m. The following observations were made:</p> <p>During an observation of the handicap bathroom outside of the dining room the Administrator indicated there was urine odor. He indicated the urine odor comes from under the floor tiles in the bathrooms. He indicated the floor tiles in the bathrooms needed to be removed to fix the odor problem.</p> <p>An observation was made of a 1/4 inch gap between the end of the wallboard and the door frame on the left side of the door frame at the entrance to room 123.</p>		<p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>All window sills were immediately checked and cleaned.</p> <p>All light bulbs have been replaced by the maintenance supervisor. While replacing light bulbs, the maintenance director also cleaned the fixtures.</p> <p>An Autoscrubber was purchased that also buffs and cleans the cove base/base boards, as well as scrubbing a 20" path of flooring. This machine will be utilized to ensure all of the cove base and flooring is cleaned to the fullest extent possible until the flooring can be replace. Once the flooring is replaced, this machine will be integral in maintaining the new flooring.</p> <p>Kick plates, wall protectors, and doorframe protectors are being priced and will be purchased to maintain the repairs and work being done. The most worn, dirty, and/or below standard will be replaced first.</p> <p>The flooring in the handicap restroom located adjacent to the main dining hall has had the flooring replaced.</p> <p>We currently have a contractor addressing any imperfections or damage in the plaster throughout</p>	

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	3.1-19(f)		<p>the building. They are also painting the facility for us as well.</p> <p>The area at the end of Sapphire hall has been cleaned out, and bids will be solicited to have a wall built to add additional storage space, so equipment may be stored in that area if needed.</p> <p><i>What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?</i></p> <p>An additional maintenance employee was hired to assist in the upkeep, repair and cleanliness of the lighting in the facility.</p> <p>Areas deemed to be below standard will take precedent with contractors being employed to expedite the installation of the new flooring, fixtures, and any other larger concerns requiring permanent fixes.</p> <p>Guardian Angel rounds will be paramount in maintaining what is replaced, and also keeping areas clean and comfortable. These rounds/audits are conducted daily, and reviewed daily by the management team, and the administrator. Thus, any negative observations can be addressed immediately.</p>	

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F000504 SS=D	<p>483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN</p> <p>The facility must provide or obtain laboratory services only when ordered by the attending physician.</p> <p>Based on record review and interview, the facility failed to ensure the laboratory services were provided as ordered for 1 of 5 residents reviewed for unnecessary medications. (Resident #66)</p> <p>Findings include:</p>	F000504	<p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</i></p> <p>Sanitation/Cleanliness rounds/audits will be conducted by the Housekeeping Supervisor 5 days a week for 4 weeks, then 3 days per week for 4 weeks, then weekly thereafter. The results of these inspections will be provided to the administrator daily, and audited a minimum of one time weekly.</p> <p>The administrator or designee will monitor these audits. The results of these audits will be submitted to the monthly and quarterly QA & A committee for further review and reassessment for further ongoing monitoring.</p> <p><u>F504- Lab Services Only when Ordered by Physician</u></p> <p>It is the policy of this facility to partner with vendors who will follow physician orders, as well as requests from the facility level to ensure all labs are drawn when ordered and all screens</p>	07/13/2014

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	<p>1. Resident #66's clinical record was reviewed on 6/11/14 at 9:15 a.m. The resident's diagnoses included, but were not limited to, schizophrenia, bipolar, and dementia with mania.</p> <p>The resident had a 5/28/14, order for a lipid panel and liver function laboratory [lab] test to be completed on 6/1/14.</p> <p>The clinical record lacked any indication of the test being completed.</p> <p>During an interview on 6/12/14 at 4:15 p.m., with the Director of Nursing and the Nurse Manager, they indicated the lab did not perform the test on 6/1/14. The Nurse Manager indicated the lab was notified of the order on 5/28/14, but the lab said it wasn't due to be drawn until 12/9/14, instead of 6/1/14. The Nurse Manager indicated the resident had an order for a lipid profile to be drawn on 6/10/14 and the lab just did the one test at that time.</p> <p>3.1-49(f)(1)</p>		<p>requested are performed.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>Resident #66 has had his lab work done per physicians order. No adverse results.</p> <p><i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i></p> <p>100% audit completed and no other residents with outstanding lab orders.</p> <p><i>What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?</i></p> <p>Nurses were in serviced of physician orders and lab tracking.</p> <p>A lab tracking binder has been incorporated, and is brought to CQI daily to review new orders, and place any new lab orders in the tracking binder. During CQI new lab orders will be entered into the lab system. Tracking binder has the day the lab is due to be drawn, and on a daily basis in CQI those labs can be</p>	

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p>		<p>reviewed and ensure they were drawn.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</i></p> <p>The DON/Designee will audit all new orders and the lab tracking daily within the daily CQI process for compliance. Any and all discrepancies will be documented and resolved.</p> <p>All results of the audits will be taken to the monthly and Quarterly QA meeting for review and reassessment for further ongoing monitoring.</p>	

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	<p>Based on clinical record review and interview, the facility failed to ensure residents' clinical records were complete and accurate for 2 of 25 residents reviewed for complete and accurate clinical records (Residents #66 and #81).</p> <p>Findings include:</p> <p>1. Resident #66's clinical record was reviewed on 6/11/14 at 9:15 a.m. The resident's diagnoses included, but were not limited to, schizophrenia, bipolar, and dementia with mania.</p> <p>The resident had a current physician's order for Invega Sustenna [an antipsychotic medication] injection 117/0.75 inject 0.75 ml (117 mg) intramuscularly monthly, chart and rotate site. This medication was to treat schizophrenia.</p> <p>The May and June, 2014, Medication Administration Records lacked an indication of the Invega Sustenna injections being given.</p> <p>During an interview with the Director of Nursing on 6/12/14 at 4:30 p.m., she indicated she had reviewed the May, 2014, MAR and saw the Invega Sustenna had not been given. She indicated she had called the nurse and was told the</p>	F000514	<p><u>F514- Resident Records-Complete/Accurate/Accessible</u></p> <p>It is the policy of this facility to follow any and all physician orders to maintain the utmost wellbeing for our residents.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>Resident #66 was administered his Invega Sustenna injection per physicians order.</p> <p>Resident #81 had a daily order to check bruit and thrill added to his TAR.</p> <p><i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i></p> <p>100% audit completed and no other residents were affected.</p> <p><i>What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?</i></p> <p>Nurses were in serviced on following MD orders. To include Injections per order and checking of a bruit and thrill related to dialysis patients.</p>	07/13/2014

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NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
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	<p>medication had not been ordered from pharmacy until 5/30/14. The Director of Nursing indicated the medication was administered when it arrived from pharmacy on 5/30/14, but was not documented.</p> <p>2. The clinical record for Resident #81 was reviewed on 6/11/14 at 9:30 a.m. Diagnoses included, but were not limited to, depression, chronic renal failure, sleep apnea, hypertension, asthma and anxiety.</p> <p>Orders included, but were not limited to, "Resident to receive dialysis Tues/Thurs/Sat. Call [name of company] Dialysis to find out times start 04/30/14".</p> <p>Review of the treatment record provided by the Director of Nursing on 6/13/14 at 10:11 a.m., indicated an order to check the bruit and thrill of the fistula in the left arm once a shift (7a-7p and 7p-7a). No documentation was noted for the month of June 2014 until 6/11/14.</p> <p>Review of the care plan for Resident #81 indicated the resident had a care plan initiated 5/9/14 for the diagnosis of End Stage Renal Disease (ESRD) with need for dialysis. The interventions included, but not limited to, observe shunt site after return from dialysis and monitor shunt for bruit and thrill.</p>		<p>A weekly injection report is sent to the facility from the pharmacy. These reports are reviewed and addressed during the daily clinical CQI.</p> <p>Any resident receiving dialysis will have these orders added to their TAR.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</i></p> <p>DON/Designee will audit the injection report and all new orders in the daily CQI. Any discrepancies will be addressed appropriately and immediately.</p> <p>Results will be reviewed in the monthly and Quarterly QA meeting for review/ compliance and ongoing monitoring.</p>	

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F000520 SS=F	<p>During an interview on 6/13/14 at 10:33 a.m., the Director of Nursing indicated she had no further information regarding the missing documentation for the monitoring of the fistula for Resident #81.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>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.</p> <p>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.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview and record review, the facility failed to</p>	F000520	<u>F520- QAA</u> <u>Committee-Members/Meet</u>	07/13/2014

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	<p>identify concerns and successfully implement a plan of action to address environmental cleanliness and ensure the surety bond was sufficient to cover the balance of resident funds. This deficient practice had the potential to impact 76 of 76 residents who resided in the facility regarding environmental cleanliness and 60 of 60 residents for whom the facility managed funds.</p> <p>Findings include:</p> <p>A Resident's Funds Review was completed on 6/11/14 and concerns were noted regarding surety bond coverage.</p> <p>A 6/11/14, Trust Current Account Balance form, which was provided by the Business Office Manager on 6/11/14 at 9:43 a.m., indicated the facility managed resident funds accounts for 60 of the facilities 76 residents.</p> <p>A current, November 2013, "Patient Funds Bond", which was provided by the Business Office Manager on 6/11/14 at 9:43 a.m., indicated the Waters of Scottsburg had a resident trust surety bond for the amount of \$25,000.00 (twenty five thousand dollars).</p> <p>Review of the bank statements for resident funds for May 2014, April 2014</p>		<p><u>Quarterly/Plans</u></p> <p>It is the policy of this facility to develop quality measures that are measurable, attainable and repeatable.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>A \$60,000 Surety Bond was secured immediately upon notification that monthly trust balances had exceeded the previous bond's coverage. For a 6 month span, no balance has exceeded \$59,000.</p> <p>The monthly resident trust account balance will be reviewed and confirmed by the administrator, ensuring that no daily balance exceeds the amount of the surety bond. Any discrepancy between the amount of the Surety Bond and the highest attained balance in this account will be immediately rectified by obtaining a new bond in excess of the highest daily balance attained.</p> <p>Environmental audits will be completed by the maintenance supervisor weekly until these tasks are completed. Following the completion of these tasks, maintenance will complete monthly audits to ensure an acceptable level of cleanliness is</p>	

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	<p>and March 2014 indicated the residents funds account had a daily balance in excess of \$25,000.00 on the following dates:</p> <p>5/7/14 - \$54,221.92 5/6/14 - \$54, 221.92 5/2/14 - \$53,411.12 4/7/14 - \$51,813.67 4/4/14 - \$53,978.37 4/3/14 - \$54,414.60 3/4/14 - \$58,320.67 3/3/14 - \$58,515.50</p> <p>Environmental tours and resident environmental interviews were completed with concerns noted.</p> <p>The following observations of resident rooms were made during the following dates and times during the Stage I survey:</p> <p>Room 147 on 6/10/14 at 8:44 a.m., the bathroom had a strong urine order. The shower threshold had sections of caulking missing. The caulking around the stool was stained. The inside of the bathroom door was gouged and rough.</p> <p>Room 109 on 6/10/14 at 8:45 a.m., the room door frame and bathroom door frame had chipped paint. The bathroom door had a patched hole that was rough to touch.</p>		<p>maintained.</p> <p><i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i></p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>A \$60,000 Surety Bond was secured immediately upon notification that monthly trust balances had exceeded the previous bond's coverage. For a 6 month span, no balance has exceeded \$59,000.</p> <p>The monthly resident trust account balance will be reviewed and confirmed by the administrator, ensuring that no daily balance exceeds the amount of the surety bond. Any discrepancy between the amount of the Surety Bond and the highest attained balance in this account will be immediately rectified by obtaining a new bond in excess of the highest daily balance attained.</p> <p>Environmental audits will be completed by the maintenance supervisor weekly until these tasks are completed. Following the completion of these tasks, maintenance will complete monthly audits to ensure an acceptable level of cleanliness is</p>	

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	<p>Room 134 on 6/10/14 at 8:51 a.m., the floor had discoloration around the baseboards and debris in the corners.</p> <p>Room 116 on 6/10/14 at 9:06 a.m., the floor in front of the closet had a gray discoloration from old wax. There was no caulking around the base of the toilet. The toilet was sitting up on a wood shim block. The bathroom had a strong urine odor. The second door in the bathroom was marred and rough to touch.</p> <p>Room 151 on 6/10/14 at 9:15 a.m., the bathroom had an odor of urine, the door frames had chipped paint and were marred and the closet door was missing a knob.</p> <p>Room 119 on 6/10/14 at 9:35 a.m., the floor in the corner behind the door was coated with a heavy dust build up and the bathroom had a strong urine odor.</p> <p>Room 104 on 6/10/14 at 9:46 a.m., the door frame was chipped and gouged. The hand held shower head was on the floor of the shower.</p> <p>Room 144 on 6/10/14 at 9:52 a.m., the bathroom had a strong urine odor. The non-slip strips were loose and coming up. The threshold to the shower and the floor around the toilet was discolored. The</p>		<p>maintained.</p> <p><i>What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?</i></p> <p>The monthly resident trust account balance will be reviewed and confirmed by the administrator, ensuring that no daily balance exceeds the amount of the surety bond. Any discrepancy between the amount of the Surety Bond and the highest attained balance in this account will be immediately rectified by obtaining a new bond in the proper amount.</p> <p>The administrator will conduct quarterly accounting audits of the resident account balances. At this point, there will be an additional opportunity to identify and address any shortfall from the Surety Bond. If any daily balance exceeds the amount of coverage on the surety bond, it will be rectified immediately by attaining a new bond in excess of the highest daily balance.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</i></p> <p>The administrator will conduct quarterly accounting audits of the resident account balances. At</p>	

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	<p>hand held shower head was lying on the shower floor. The outside of the door frame was gauged.</p> <p>Room 142 on 6/10/14 at 10:03 a.m., there was a closet door missing and the corner protector of the closet was torn away from the wall.</p> <p>Room 149 on 6/10/14 at 10:10 a.m., the bathroom had a strong urine odor. The threshold to the shower was missing sections of caulking. The caulking around the toilet was stained. The inside of the bathroom door was gouged and rough.</p> <p>Room 130 on 6/10/14 at 1:03 p.m., the door frame was chipped and gouged and the floor had a brown residue on it.</p> <p>Room 150 on 6/10/14 at 1:27 p.m., the bathroom had a dark substance on multiple areas of the floor. The closet door was missing a knob.</p> <p>Room 151 on 6/10/14 at 12:51 p.m., the hand held shower head was lying on the floor of the shower. The threshold of the shower was cracked and discolored. The floor around the toilet was discolored and there was a build up of a dark substance on the floor.</p>		<p>this point, there will be an additional opportunity to identify and address any shortfall from the Surety Bond. If any daily balance exceeds the amount of coverage on the surety bond, it will be rectified immediately by attaining a new bond in excess of the highest daily balance.</p> <p>Any audits relating to the facility environmental condition, or any specific or ongoing QA & A review will be addressed by the QA & A committee to determine what, if any, next steps should be taken to achieve the desired goals in that area of concern.</p> <p>The administrator or designee will monitor these audits. The results of these audits will be submitted to the monthly and quarterly QA & A committee for further review and reassessment for further ongoing monitoring.</p>				

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	<p>The Environmental tour was conducted on 6/12/14 from 1:50 p.m. to 3:30 p.m. with the RN Consultant and the Maintenance Supervisor. The following observations and interviews were made:</p> <p>Room 101 had strings of dark gray dust hanging from the door hinges and could be seen when entering the room. The bathroom door and door frame was severely scratched and gouged on 1/4 of the door.</p> <p>During an interview with the RN Consultant and the Maintenance Supervisor at 2:10 p.m., they indicated all the door frames were marred. The RN Consultant indicated she noted the doors and frames being marred on her previous visits. The Maintenance Supervisor indicated he was going to get an estimate of the cost of having the door frames reclad.</p> <p>Room 109 was observed at 2:14 p.m., the air conditioning unit was dripping water and causing it to pool on the floor. The Maintenance Supervisor indicated he had received two new units and this unit was scheduled to be replaced in the next couple of days.</p> <p>The non-skid strips beside bed A in room 118 were worn and coming loose.</p>			

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	<p>The closet door in room 120 was missing a knob.</p> <p>Room 125 bed A's footboard is marred.</p> <p>Room 134 door, bathroom door and door frames marred and rough, debris in the corner and around the baseboard.</p> <p>Room 145 window blinds were missing two slats.</p> <p>An Environment tour with the Administrator was made on 6/13/14 from 8:45 a.m. to 10:10 a.m. The following observations were made:</p> <p>Room 104 on 6/13/14 at 8:58 a.m., with the Administrator present, the door frame was chipped and gouged. The hand held shower head was on the floor of the shower.</p> <p>The window in room 145 was dirty on the outside and was hazy looking.</p> <p>The bathroom of room 149 had a strong urine order. The caulking around the stool was stained. The inside of the bathroom door was gouged and rough. The hand held shower head was lying on the floor of the shower. The shower threshold had sections of caulking</p>			

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	<p>missing. The Administrator indicated the urine odor comes from under the floor tiles in the bathrooms. He indicated the floor tiles in the bathrooms needed to be removed to fix the odor problem.</p> <p>Five window sills in the dining room were observed on 6/9/14 at 12:20 p.m., the sills contained dead flying insects.</p> <p>The Environmental tour was conducted on 6/12/14 from 1:50 p.m. to 3:30 p.m. with the RN Consultant and the Maintenance Supervisor. The following observations and interviews were made:</p> <p>16 florescent light bulbs were burned out around the nurses station. The ceiling tiles had brown water stains.</p> <p>The floor along baseboard on Ruby Hall was discolored and looked dirty. The RN Consultant indicated she had made a note on her previous visit the of the wax build up along the baseboards.</p> <p>The floor around the the refrigerator in the nourishment pantry had a dirty looking brown wax build up around it.</p> <p>The light fixture at the end of Ruby hallway was dim. The inside of the cover was dirty. The Maintenance Supervisor indicated it had debris in it from having</p>			

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	<p>insulation blown in. The next light fixture's cover had a corner hanging loose.</p> <p>The plaster at the corners of the walls around the nurse station was chipped.</p> <p>The ceiling of the hall leading to the dining room had a cracked area in the plaster. The Maintenance Supervisor indicated it had been caused by a leak in the sprinkler system. Two lights in the hallway had cracked covers and the Maintenance Supervisor indicated he had replacements for them, but he had not had time to change them.</p> <p>The five window sills in the dining room were littered with dead flying insects.</p> <p>The kick plate on the bottom half of the door to the handicap bathroom in the hallway leading to the dining room was discolored. Housekeeper #14 indicated the discoloration was from wax build up. She demonstrated the area could be cleaned with a green scrubber. She indicated she cleans the window sills in the dining room at least weekly.</p> <p>There were two resident rooms at the end of Sapphire hall. The area to the left of the resident rooms was used as a storage area. The area contained two large</p>			

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	<p>scales, a lift and multiple wheelchairs. The Maintenance Supervisor indicated it had been discussed about building a wall to make a storage area.</p> <p>An Environment tour with the Administrator was made on 6/13/14 from 8:45 a.m. to 10:10 a.m. The following observations were made:</p> <p>During an observation of the handicap bathroom outside of the dining room the Administrator indicated there was urine odor. He indicated the urine odor comes from under the floor tiles in the bathrooms. He indicated the floor tiles in the bathrooms needed to be removed to fix the odor problem.</p> <p>An observation was made of a 1/4 inch gap between the end of the wallboard and the door frame on the left side of the door frame at the entrance to room 123.</p> <p>The above systemic concerns with environment and resident funds were discussed with the Administrator on 6/11/14 at 10:00 a.m. During a 6/11/14, 10:00 a.m., interview, the Administrator indicated the corporate office was assigned the task of overseeing balances in the resident funds accounts to ensure the surety bond covered the daily balance. He indicated he had not been</p>			

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F009999	<p>aware the balance was in excess of the current surety bond.</p> <p>During a 6/13/14, 12:05 p.m., interview, the Administrator indicated the facility had reviewed the amount of the surety bond to ensure in covered the total balance in August 2013 as part of QAA. However the facility had not continued to review to ensure the amount remained sufficient. He additionally indicated the QAA committee had identified a problem with environmental cleanliness, but the action plan had failed to correct the concern and revisions to the action plan continue to be needed.</p> <p>3.1-52(b)(2)</p>	F009999	<p><u>F9999- Final Observations</u></p> <p>Multiple dementia training sessions have been established with employee check lists to ensure those who did not receive 6 hours of annual dementia training are back in compliance. These sessions will continue until all staff have received their 6</p>	07/13/2014
	<p>3.1-14(u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia training within six (6) months of initial employment, to within thirty (30) days for personnel assigned to the Alzheimer's and dementia specialty care units, and three (3) hours annually</p>			

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 06/13/2014	
NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG 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>thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>This state rule was not met as evidence by:</p> <p>Based on interview and record review, the facility failed to ensure employees received the required Dementia training.</p> <p>Findings include:</p> <p>The employee record review was completed on 6/10/14 at 1:15 p.m. The review of 71 employee records indicated 42 employees did not receive dementia training. Additional information regarding the missing dementia training documentation was requested from the Business Office Manager.</p> <p>During an interview on 6/10/14 at 1:30 p.m., the Business Office Manager indicated the annual dementia training had not been done. No further information was available.</p>		<p>hours of annual dementia training.</p> <p>The orientation process for new employees has been altered to encompass the initial requirement of dementia training, and an annual dementia class has been posted and will be conducted to ensure all employees receive the required training.</p>				