

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155217	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/30/2013
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NAME OF PROVIDER OR SUPPLIER  WATERS OF HUNTINGBURG THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542
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F000000	<p>This Visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 23, 24, 26, 29, and 30, 2013</p> <p>Facility number: 000122 Provider number: 155217 AIM number: 100290560</p> <p>Survey team: Terri Walters RN TC Martha Saull RN Dorothy Watts RN</p> <p>Census bed type: SNF/NF: 59 Total: 59</p> <p>Census payor type: Medicare: 10 Medicaid: 36 Other: 13 Total: 59</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 1, 2013, by Janelyn Kulik, RN.</p>	F000000		

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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F000317 SS=D	<p>483.25(e)(1) NO REDUCTION IN ROM UNLESS UNAVOIDABLE</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a range of motion program had been attempted and /or provided for 1 of 1 resident reviewed for restorative services in stage 2. Resident #5</p> <p>Findings include:</p> <p>On 7/23/13 at 1:46 P.M., during an interview with the Director of Nursing (DON), she indicated Resident #5 had contractures of the upper and lower extremities. She also indicated Resident #5 did not receive range of motion exercises.</p> <p>On 7/23/13 at 3:00 P. M, Resident #5's clinical record was reviewed. Diagnoses included but were not limited to: cerebral palsy, osteoporosis, dystmia, and anxiety. Her current Minimum Data Set</p>	F000317	<p>Preparation and/or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the facility of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p> <p>F317-SSD No reduction in ROM unless unavoidable It is the intent of this facility to ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.</p> <p><b>1. Actions Taken:</b> A) Resident # 5 was assessed to ensure no negative outcomes. B) Therapy did screen on Resident #5 to determine extent</p>	08/19/2013			

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	<p>Assessment (MDS) dated 7/9/13, indicated extensive assistance of 2 or more staff were needed for bed mobility and transfers. Total dependence of 2 or more staff was needed for dressing.</p> <p>On 7/29/13 at 9:55 A.M., Restorative CNA #1 was interviewed regarding restorative services for Resident #5. She indicated Resident # 5 was now receiving restorative services.</p> <p>On 7/29/13 at 10:12 A.M., the Restorative Nurse was interviewed regarding restorative services for Resident #5. She indicated the facility was now attempting passive range of motion exercises for Resident #5. She indicated a concern was that the resident might tighten up during exercises.</p> <p>On 7/29/13 at 11:32 A.M., during an interview with the Restorative Nurse she indicated Resident #5 had been admitted to the facility on 2/6/12. She indicated documentation was lacking range of motion exercises attempted or provided since her admission. She provided documentation of an Occupational Therapy (OT) screen dated 2/6/12 (admission date) regarding wheelchair positioning. The</p>		<p>of contractures/tone. C) Family reeducated on the positive outcomes of using splints and the possible negative outcomes of not using. Family still refuses the use of splints. D) Resident #5 has been on the restorative program and restorative aids will continue to do Range of Motion as tolerated by resident.</p> <p><b>2. How other residents have the potential to be affected:</b> A) All residents would have the potential to be affected.</p> <p><b>3. Measures Taken:</b> A) Therapy Manager in serviced therapy staff as well as DON and MDS/Restorative Nurse Manager on contracture versus tone. B) Nursing staff in-serviced on contractures versus tone also. C) 100% audit/assessment was completed on all residents to determine if they could benefit from therapy and/or restorative program relating to ROM.</p> <p><b>4. How Monitored:</b> <b>A)</b> ROM flow sheet has been implemented for therapist to ensure compliance in no reduction in ROM. <b>B)</b> This flow sheet will be triggered by the MDS process to notify when a resident needs to be assessed for possible contracture issues. <b>C)</b> Therapy Director/MDS Restorative Director/Designee will review at risk resident charts 5 times a week for 30 days, then</p>		

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	<p>documentation indicated contractures of the shoulders, wrists, hands, knees, and toes. Documentation indicated, "... Family requested no PT/OT (Physical Therapy/Occupational Therapy) services @ this time, although pt (patient) may benefit from contracture mngt (management)."</p> <p>OT screens dated 1/4/13, 4/5/13, and 6/25/13, indicated contractures at all joints related to diagnosis of cerebral palsy.</p> <p>On 7/29/13 at 11:32 A.M., the Restorative Nurse was interviewed regarding a range of motion program for Resident #5. She indicated she guessed it was an oversight and a restorative program should have been attempted for this resident.</p> <p>On 7/29/13 at 2:55 P.M., a therapy screen dated 7/29/13 was received and reviewed. The documentation indicated, "...Contractures: none." "... Screen completed this date to re-assess ROM (Range of Motion). Pt (patient) holding BUE (Bilateral Upper Extremities)/ BLE (Bilateral Lower Extremities) in flexion synergy pattern and dem (demonstrates) (arrow pointing up) tone. PROM (Passive Range of Motion) of hands,</p>		<p>once a week for 30 days, then once a month thereafter or more often if needed per IDT and/or Persons at Risk (PAR) weekly meetings. A summary of these reviews will be discussed in the monthly QA meetings.</p> <p><b>5. This plan of Correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is, August 19, 2013.</b></p>				

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	<p>wrists, elbows, knees, is WFL (Within Functional Limits) while resisting tone. Shoulder flex to 90 (degrees) PROM. Pt and mother educated on use of hand splints to reduce risk of contracture or skin breakdown. Mother refusing splints for pt @ this time."</p> <p>A restorative therapy note dated 7/29/13 at 2:54 P.M., indicated, "Therapy did screen on Resident today to determine extent of contractures/tone. Screen today showed severe tone to all extremities, no contractures. Past screens have been documented as contractures and have been done by various therapists. Therapy had rec. (recommended) splints to hands to reduce risk of contracture. Family refused. Therapy manager has inserviced therapy staff as well as DON (Director of Nursing) and MDS (Minimum Data Summary Assessment/Restorative Nurse) on contracture vs. (versus) tone. Also working with staff to use those words in proper context."</p> <p>The first restorative progress note for Resident #5 dated 7/29/13 at 11:07 A.M., was received on 7/29/13 at 11:35 A.M., and reviewed. The documentation indicated,</p>			

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	<p>"Restorative aid has attempted to do PROM 5-10 reps (repetitions) to all extremities d/t (due to) cerebral palsy and Osteoarthritis, without success. Resident stiffens up making limbs rigid not allowing staff to do exercises. Will continue to attempt and will initiate program if resident participates."</p> <p>On 7/30/13 at 9:55 A.M., range of motion exercises were observed being provided by Restorative CNA #1 for Resident #5. Resident #5 was lying in bed in supine position with arms and legs flexed and her hands held in a closed fist position. Passive ROM exercises, approximately 3-5 repetitions of flexion and extension of upper arms were provided by Restorative CNA #1. The resident attempted to do active movements with her arms at times. Restorative CNA #1 encouraged and assisted resident to open her hands from a fist position to flex and extend the fingers of both hands. Both thumbs and 5th digits were more flexible than the other digits. Restorative CNA #1 indicated the fourth digit of the right hand was tighter. Resident # 5 was able to kick her right leg off the bed slightly approximately 3 or 4 times with instructions and encouragement.</p>			

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	<p>Restorative CNA #1 assisted the resident to kick the left leg off the bed but the leg remained in a more flexed position. Restorative CNA #1 was able to provide PROM to her feet and ankles. The resident did not verbalize or show non verbal signs of pain or distress. The Restorative CNA indicated at that time she had just started range of motion exercises last week. She indicated last week the resident was more resistive to exercises. She indicated today there was improvement with the range of motion exercises for this resident.</p> <p>3.1-42(a)(1)</p>			

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F000329 SS=D	<p>483.25(I) 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 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 interview and record review, the facility failed to ensure alternative interventions were attempted prior to administration of a prn (as needed) antianxiety medication for 1 of 10 residents reviewed for psychoactive medication administration. Resident #38</p> <p>Findings include:  The clinical record of Resident #38</p>	F000329	<p>Preparation and/or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the facility of facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. F329-SSD Drug Regimen is Free from Unnecessary Drugs It is the intent of this facility to</p>	08/19/2013			

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	<p>was reviewed on 7/29/13 at 10 A.M. Diagnoses included, but were not limited to, depressive disorder. The most recent MDS (Minimum Data Set Assessment) dated 5/24/13 indicated the resident had a cognitive status of severely impaired.</p> <p>A care plan, dated 3/21/13, addressed the problem of "At risk for increase in anxiousness R/T (related to) DX (diagnosis) and tearfulness r/t not remembering spouse had recently expired in November of 2012. RX (treatment) Ativan." Approaches included, but were not limited to, the following: "Encourage resident to voice feelings...monitor for effectiveness of meds (medications) and interventions."</p> <p>On 7/30/13 at 2:50 P.M., the Director of Nursing (DON) was interviewed. She indicated in March of 2013, the resident had an increase in anxiety and had frequently received prn Ativan. She indicated the facility had requested a physician order for a routine order for Ativan 1 mg bid and this order had been received on 3/28/13.</p> <p>On 7/30/13 at 2:55 P.M., the "Behavior/Intervention Monthly Flow</p>		<p>ensure that all resident's drug regiment is free from unnecessary drugs.</p> <p><b>1. Actions Taken:</b></p> <p>A) Resident #38 was assessed to ensure no negative outcomes.</p> <p>B) All nursing staff was in-serviced concerning Behavior Management Policy &amp; Procedure.</p> <p>C) All nursing staff was instructed to contact the DON and/or on-call nurse before administering a psychotropic medication.</p> <p><b>2. How other residents have the potential to be affected:</b></p> <p>A) All residents would have the potential to be affected.</p> <p><b>3. Measures Taken:</b></p> <p>A) A 100% audit was taken to determine all residents who are currently on a PRN psychotropic medication.</p> <p>B) All nursing staff was in-serviced on the proper use of the Behavior Intervention flow record and the communication protocol relating to the administration of psychotropic medications.</p> <p><b>4. How Monitored:</b></p> <p>A) Social Service Director will print off daily behavior sheet and bring to morning meeting to be reviewed by IDT to identify any possible issues.</p> <p>B) DON/Designee will discuss any behavior/medication/orders from the 24 hour report in morning meeting with IDT to identify any possible issues.</p> <p>C) At risk residents will be discussed in the weekly (PAR) person</p>				

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	<p>Record" was reviewed for March 2013. The form indicated for the entire month, the "behavior" of "anxiety" was documented on 4 days. The form indicated the intervention attempted was "medication (should not be first intervention)." Documentation was lacking on the form of the resident experiencing anxiety on 3/8/13.</p> <p>On 7/30/13 at 3:30 P.M. a copy of the March 2013 MAR (medication administration record) was reviewed. The form indicated the following order: "Ativan 1 mg, take 1 tablet...three times daily as needed for anxiety." The MAR indicated the resident had received prn Ativan 1 mg a total of 18 times during the month.</p> <p>The March MAR indicated on 3/8/13, the resident had received the Ativan 3 times, 9 A.M., 2:45 P.M. and 8:30 P.M. Documentation was lacking on the MAR as to the reason why and/or the response of the Ativan. Documentation was lacking in the nurses notes for 3/8/13 of alternative interventions attempted and/or response to the resident's receipt of the medication.</p> <p>The March 2013 MAR indicated the</p>		<p>at risk meetings. Any new admits at risk will be added to the PAR review.</p> <p><b>D) SSD/DON/Designee will review at risk resident charts 5 times a week for 30 days, then once a week for 30 days, then once a month thereafter or more often if needed per IDT. A summary of these reviews will be discussed in the monthly QA meetings.</b></p> <p><b>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is, August 19, 2013.</b></p>				

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	<p>resident had received prn Ativan a total of 18 times. The clinical record was lacking documentation of alternative interventions attempted prior to administration of the Ativan and/or a response to the medication for 15 of the Ativan administrations.</p> <p>On 7/30/13 at 3:50 P.M., the DON was interviewed. She indicated the resident was given prn Ativan frequently in March 2013. At this time, the nurses notes were reviewed. The DON indicated documentation was lacking of alternative interventions attempted prior to administration of the prn Ativan. The DON indicated staff was to attempt 3 alternative interventions and notify a supervisor prior to administering a prn medication.</p> <p>On 7/30/13 at 4:30 P.M. a current copy of the facility policy and procedure for "Behavior Management Psychotropic Medication Protocol" was received from the DON. The policy was dated 9/2012. The policy included, but was not limited to, the following: "...the planned interventions for each individual resident's behavior will be communicated to the appropriate staff members. Interventions and</p>			

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	response will be documented.  3.1-48(a)(4)			

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F000465 SS=D	<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 maintain sanitary bathrooms and /or bathrooms in good repair for 12 of 22 bathrooms observed. This had the potential to impact 20 residents residing on the 100 unit and 200 unit. Rooms: 102, 103, 119, 120, 123, 124, 133, 132, 215, 220, 221, 224, 225.</p> <p>Findings include:  On 7/23/12, the bathrooms in Rooms 123, 124, 132, 133, 220, 221, had parts of the caulking missing and or pulling away from the commode leaving gaps around the commode. The remaining caulking was black/brown. There was a strong smell of urine. The floor was</p>	F000465	<p>Preparation and/or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission or agreement by the facility of 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>F465-SSD Safe/Functional/Sanitary/Comfortable/Environment It is the intent of this facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p><b>1. Actions Taken:</b> A) The Housekeeping Director and her staff deep cleaned all bathroom floors. B) The Plant Operations Director</p>	08/19/2013

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NAME OF PROVIDER OR SUPPLIER  WATERS OF HUNTINGBURG THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542		
(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>sticky and tacky. There were dark stains and debris noted in front of the commode and debris noted in the corners and along the baseboards.</p> <p>On 7/23/13, bathrooms were observed to have areas above the sink where a soap dispenser had been mounted on the wall. The dispenser had been removed leaving 6 unfilled nail holes with bare ripped drywall exposed in the following rooms : 102, 103,119,120, 215, 224, 225.</p> <p>On 7/30/13 at 3:30 P.M., during an interview and tour of the 100 and 200 Units with the Health Care Administrator (HCA), he indicated the bathrooms needed repair and/or cleaning. The HCA indicated he would have maintenance and housekeeping start working on the bathrooms right away.</p> <p>3.1-19(f)</p>		<p>removed old calking and replaced with new calking around commodes and/or sinks.</p> <p>C) The Plant Operations Director repaired walls identified.</p> <p>2. <b>How other residents have the potential to be affected:</b> All residents would have the potential to be affected.</p> <p>3. <b>Measures Taken:</b> A) 100% audit of all bathrooms was completed to identify and rectify any issues.</p> <p>4. <b>How Monitored:</b> A) Monthly bathroom checks were placed on Plant Operations Director Preventative Maintenance program. B) Bathroom cleaning was placed on all housekeepers daily check-off sheets. C) Administrator/Designee will complete audits three times a week for four weeks, then as needed thereafter. A summary of these audits will be discussed in the Monthly QA meetings.</p> <p>5. <b>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. We are hereby requesting a desk review. Our date of compliance is, August 19, 2013.</b></p>		