

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155183	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2015
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NAME OF PROVIDER OR SUPPLIER WATERS OF MARTINSVILLE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2055 HERITAGE DR MARTINSVILLE, IN 46151
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey</p> <p>Survey Dates: August 18,19, 20, 21, 24, and 25, 2015.</p> <p>Facility number: 000096 Provider number: 155183 AIM number: 100290890</p> <p>Census bed type: SNF/NF: 83 Total: 83</p> <p>Census payer type: Medicare: 9 Medicaid: 53 Other: 21 Total: 83</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws.</p> <p>The Waters of Martinsville respectfully requests paper/desk compliance for all stated deficiencies</p>	
F 0156 SS=D Bldg. 00	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the</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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	<p>resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and</p>			

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	<p>procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on interview and record review, the facility failed to ensure a resident was</p>	F 0156	Preparation and/or execution of this plan of correction in general, or this corrective action in	09/24/2015

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	<p>provided 48 hours notice for non-coverage of skilled services for 2 of 3 residents reviewed for advance beneficiary notice of Medicare non-coverage. (Resident #70 and Resident #97).</p> <p>Findings include:</p> <p>1. On 8/21/2015 at 2:42 p.m., the Business Office Manager (BOM) provided a "Notice of Medicare Non-Coverage" letter for Resident #70. The letter indicated Resident #70's skilled services would end on 4/23/2015. The letter included a photocopy of the envelope the letter was mailed in to Resident #70's representative however, no time stamp indicating the date the letter was mailed was observed. The letter was signed by Resident #70's representative on 5/18/2015.</p> <p>On 8/21/2015 at 2:50 p.m., the BOM provided a document titled "Collection Record." The document indicated on 4/19/2015, the BOM spoke by telephone with Resident #70's representative however, there was no mention of the Medicare Benefit ending on 4/23/2015.</p> <p>During an interview on 8/21/2015 at 3:00 p.m., the BOM indicated, "I know we are supposed to give the residents 3 days</p>		<p>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. The Waters of Martinsville respectfully requests paper/desk compliance for all stated deficiencies</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The NOMNC was provided to the legal representatives of each resident affected to advise them of Medicare Non-Coverage. The NOMNC was provided to resident #70's representative, as well as to resident #97's legal representative on 5/18/2015 and 7/29/2015 respectively.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>An audit of all residents with MCR coverage for the year and issuance of the required NOMNC was performed. All residents being covered by Medicare Part A has the potential to be affected. No other residents were affected by the alleged deficient practice.</p>	

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	<p>prior notice before the end of Medicare coverage. For some reason the envelope is not stamped and I cannot recall if I mentioned the benefit ending on 4/23/2015, when I spoke with Resident #70's representative on 4/19/2015."</p> <p>2. On 8/21/2015 at 2:42 p.m., the Business Office Manager (BOM) provided a "Notice of Medicare Non-Coverage" letter for Resident #97. The letter indicated Resident #97's skilled services would end on 7/28/2015. The letter included a photocopy of the envelope the letter was mailed in to Resident #97's representative. The stamped date indicated the letter was mailed on 7/27/2015. The letter was signed by Resident #97's representative on 7/29/2015.</p> <p>On 8/21/2015 at 2:50 p.m., the BOM provided a document titled "Collection Record." The document indicated the BOM mailed the Notice of Medicare Non-Coverage letter to Resident #97's representative on 7/27/2015, and spoke by telephone to the representative on 7/28/2015, to inform him the letter was on the way and it was important to sign and return.</p> <p>During an interview on 8/21/2015 at 3:00 p.m., the BOM indicated she realized</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Utilizing the daily census report, we will identify residents that are currently on MCR, in addition to their projected cut date. This data will be reviewed daily, and residents that are projected to be cut from MCR coverage within 7 days will be transferred to our white dry erase board to track until the NOMNC is issued, based on their actual cut date. Once the NOMNC is issued- a minimum of 48 hours prior to coverage ending- the resident will be removed from the dry erase board and their name will be recorded in the "Completion Log" with a dated copy of their signed NOMNC. This will be ongoing.</p> <p>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? The daily census review will be completed by the IDT team under the leadership of the administrator or his designee. MCR residents will be discussed daily, as will resident's projected cut date. Daily monitoring will occur with utilization of the white board. The "Completion Log" will be reviewed monthly by the administrator to ensure all</p>	

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F 0241 SS=D Bldg. 00	<p>Resident #97's Notice of Medicare Non-Coverage letter was mailed late.</p> <p>On 8/24/2015 at 11:05 a.m., the Administrator provided the policy "Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123, approved date of 12/31/2011, and indicated it was one currently being used by the facility. The policy indicated, " ...The NOMNC must be delivered at least two calendar days before Medicare covered services end ..."</p> <p>Medicare Advance Beneficiary Notice of Non-Coverage Second Edition dated April 2011 indicated, "A Medicare provider must give a completed copy of this notice to beneficiaries receiving services from a skilled nursing facilities ... not later than 2 days before termination of services..."</p> <p>3.1-4(a)</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>	F 0241	<p>notifications have been sent in the time framerequired. This will be ongoing. At the monthly QA meetings any patternsidentified as a result of this monitoring will be reviewed and discussed. However, any concerns will have beenaddressed as discovered.</p> <p>Preparation and/or execution of this</p>	09/24/2015

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	<p>record review, the facility failed to ensure a resident's dignity was maintained in that a clothing protector was placed after the resident indicated she did not want to wear a clothing protector for 1 of 1 randomly observed residents during dining observation. (Resident #3).</p> <p>Findings include:</p> <p>On 8/18/2015 at 12:05 p.m., The Administrator was observed to ask Resident #3 if she would like a clothing protector. Resident #3 indicated, "no." The Administrator was then observed to tell Resident #3 if that is your wish then you do not have to wear one.</p> <p>On 8/18/2015 at 12:10 p.m., Certified Nursing Assistant #1 (CNA) was observed to sit down next to Resident #3 and place a clothing protector on without asking if it was okay to do so. CNA #1 was then observed to assist Resident #3 with her lunch.</p> <p>During an interview on 8/18/2015 at 12:24 p.m., the Administrator indicated Resident #3 told him "no" when asked if she wanted a clothing protector on. The Administrator was observed to walk over to Resident #3 and ask if she had changed her mind about wearing the clothing protector. Resident #3 indicated, "no."</p>		<p>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 Martinsville respectfully requests paper/desk compliance for all stated deficiencies <i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>Resident #3 had her clothing protector removed per her stated preference for that meal. CNA #1 was educated on the rights of our residents and the importance of patience and waiting for a response from the resident when asking for their preference.</p> <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</i></p> <p>A "Preference Form" was developed to obtain the preferences of all our residents for their dining experience. Their stated preference on this form will be the default preference for their meal services moving forward. The resident always has the right to change their preference, thus during meal service</p>	

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	<p>The Administrator was observed to remove the clothing protector at that time.</p> <p>On 8/18/2015 at 2:20 p.m., CNA #1 indicated she usually assists Resident #3 with meals and is used to her likes and dislikes. CNA #1 indicated she asked Resident #3 if she wanted the clothing protector, but was ignored by the resident so she went ahead and put one on anyway. CNA #1 indicated she was aware Resident #3 had told the Administrator she didn't want a clothing protector on.</p> <p>On 8/24/2015 at 10:50 a.m., the Administrator provided the policy, "Your Rights As A Nursing Home Resident" dated November 2006, and indicated it was the one currently being used by the facility. The policy indicated, " You have the right to be treated with respect and dignity in recognition of your individuality and preferences ..."</p> <p>3.1-3(t)</p>		<p>any stated preference will supersedethe form. These preference sheets willbe maintained in a binder and accessible to staff. All interviewable residents had a preference formfilled out for them. Non-interviewable residentshad a family member or interested party familiar with their preferences fillout their form. New residents will havethis form completed as part of the admissions process. These forms will be reviewed and updated incare plan meetings moving forward.</p> <p><i>What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur?</i></p> <p>Since the survey, the entire staff has been educated onwhere to find resident preferences, and the dining service procedures to utilizeto ensure we are honoring our resident's preferences.</p> <p><i>How the correctiveaction(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>A dining services and resident preference audit will beperformed visually 3 times per week in areas where residents dine and atvarious meal times by department heads to ensure clothing protector preferenceand all dining preferences are honored. This audit will continue</p>	

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F 0244 SS=D Bldg. 00	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on interview and record review, the facility failed to ensure resident council grievances were acted upon and promptly resolved in that residents complained of being tired of eating sandwiches for entrees, sandwiches everyday as a substitute for all meals, and requesting more chicken.	F 0244	for 4 weeks. The audit will cease once 4 weeks of observation have been completed with at least 1 full week of zero preference contradictions noted. Any staff who fail to comply with the points of the in service will be further educated and/or progressively disciplined. Weekly audits will continue for a period of not less than 6 months to ensure ongoing compliance. Any concerns will be corrected as found. Random monitoring will take place ongoing. At the monthly QA meeting the results of the monitoring will be reviewed for patterns. If necessary, an Action Plan will be written by the committee. This plan will be monitored weekly by the administrator until resolved. 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	09/24/2015

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	<p>Findings include:</p> <p>1). On 8/25/15 at 5:36 p.m., the Administrator provided copies "RESIDENT COUNCIL MEETING MINUTES" and indicated the following:</p> <p>b. On 3/24/15, the resident council concerns were "Would like chicken breast." There was no plan of action noted.</p> <p>c. On 4/21/15, the resident council concerns were "would like more chicken breast." The plan of action form dated 4/21/15, indicated "Res. [resident] choice meal hot dogs grilled on grill outside, baked beans, chip, peach cobbler or [strawberry] pie ...Res. choice meal May 20th ..." The plan of action for the request for more chicken breast was on "4/22/15, served white & Dark chicken, will serve Breast on next chicken meal as well 5/4/15, ..will put blank papers out for all Res. Request. Are looking to move to select menus."</p> <p>d. On 5/20/15, the resident council concerns were "Would like more chicken breast." The solution indicated, "Not resolved."</p> <p>e. On 6/30/15, the resident council</p>		<p>Laws.</p> <p>The Waters of Martinsville respectfully requestspaper/desk compliance for all stated deficiencies</p> <p><i>What correctiveaction(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>A waffle iron and an 11 quart Round Kettle Cooker have beenpurchased in an effort to move away from the perception there are too many sandwiches in order to give more options to cook and to eat. In addition, we will introduce chicken breastas a regular alternative meal to be available minimally twice per week. The dietician has reviewed the menus andsubstitutes offered and has made recommendations for additions that are notsandwiches.</p> <p><i>How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action(s) will be taken?</i></p> <p>An audit of our current population will be completed toobtain the entire facility's food preferences, in addition to identifying anypatterns of displeasure or happiness with our current menus and alternativeoptions. Adverse reports of food qualityor options will be recorded and addressed in writing within 5 days, and therecords will note whether the request can or cannot be met. These responses will be provided to theresident or their</p>	

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	<p>concerns were "Tired of sandwiches & fish." The plan of action was "Notified res. council and all res. that new Fall menu comes out in Sept. [September]."</p> <p>f. On 7/30/15, the resident council concerns were "...feel that dietary serving too many sandwiches. ...Solution: Sandwiches are frequent through summer/spring menu. facility will be switching to fall/winter menu next month. There a few on that menu. ..."</p> <p>g. On an undated, sheet indicating the resident council's concerns were "... fast food meals, ...food is getting lousy [too much sandwiches & fish, ...]."</p> <p>2). On 08/19/2015 2:25 p.m., Resident #4's grand daughter indicated, The food was not to the resident's liking. "It's food that most resident's don't like. Things like rice, fish, no seasoning. Substitutes are only peanut butter sandwiches, grilled cheese or a deli meat."</p> <p>3). On 08/24/2015 2:46 p.m., Resident #108's wife indicated, "Menus are horrible. Had pimento sandwiches and cole slaw for father's day. Substitutions are only grilled cheese and peanut butter sandwiches or left over 's from the night before." Resident #108's wife indicated she mentioned this concern to the</p>		<p>legal representative within 5 days of the request as well as being maintained by the Social Services Director or her designee. Food satisfaction will be addressed at the Resident Council meetings as part of the agenda going forward.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p> <p>An audit of our current population will be completed to obtain the entire facility's food preferences, in addition to identifying any patterns of displeasure or happiness with our current menus and alternative options. Reasonable requests will be submitted to the IDT team for implementation. Since the survey, all staff were inserviced as related to reporting any complaints with the food in writing to the Administrator, Dietary manager, or SSD. Concerns will be addressed at the next daily CQI Meeting. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated.</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 initial audit and subsequent audits will be reviewed by the IDT</p>	

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	<p>Administrator and was told he was working on it and corporate makes the decision.</p> <p>On 8/25/15 at 3:30 p.m., interview with the Director of Nursing indicated there was no tracking logs for resident's grievance.</p> <p>On 8/25/15 at 4:04 p.m., interview with the Administrator (ADM) indicated in April he implemented a tracking log "I disperse concerns to the appropriate department head." We have gotten new equipment to maintain the temperature of the food and tried to offer more alternatives. We have introduced salads. The ADM indicated he has proposed to bring various fast food vendor options into the facility, however, the residents are not giving him ideas of what they would like to eat as alternative to sandwiches. "We have changed vendors to get a higher quality of food and food choice options." The ADM indicated the vendor has a formulary and the facility could only make 8 changes at the beginning of the menu cycle. The Administrator projected time to implement choice meals would be by the end of the year and had concerns with how a menu change to accommodate 6 residents would be beneficial [indicating the Resident Council]. I have proposed a</p>		<p>team the following business day for review and potential implementation of any requests or preferences. Each request outside of normal practice will receive a written update addressing the request within 5 days, either detailing how we will accomplish the request within a specified time frame, or explaining why the request cannot be fulfilled. The results will be maintained and reviewed by the administrator as concerns arise, and/or after the completion of the bi-weekly audits. This audit will continue bi-weekly for a period of not less than 6 months to ensure ongoing compliance. Afterward, random monitoring will occur. At the monthly QA meeting the results of the monitoring will be reviewed for patterns. If necessary, an Action Plan will be written by the committee. This plan will be monitored weekly by the administrator until resolved.</p>	

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	<p>lot of things to incorporate and I need to put it into action. I will have a waffle bar and a omelette bar working in 30 days.</p> <p>On 8/25/15 at 4:50 p.m., the Director of Nursing (DON) provided policy, "Compliment/Grievance/Missing Property" dated 7/1/11, and indicated the policy was the one currently used by the facility. The policy indicated, "... 2. A grievance is to be filed in the office of the Section 504 Coordinator within 10 days after the person filing grievance becomes aware of the action alleged to be prohibited by the regulations. ...4. The Section 504 Coordinator shall issue a written decision determining the validity of the grievance no later than 30 days after filing. ...5. If grievance has not been resolved at this point, the Section 504 Chief Executive Officer will forward it to the Board of Managers' Representative who shall have an additional 30 days to resolve the grievance. ...7. The Grievance/Compliant ...Quality Assurance Tracking Report will be completed by Social Services/Designee. 8. The Tracking Log will be reviewed by the Quality Improvement Team. ..."</p> <p>On 8/24/15 at 10:50 a.m., the Administrator provided policy "YOUR RIGHTS AS A NURSING HOME RESIDENT" dated 11/2006, and</p>			

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F 0278 SS=D Bldg. 00	<p>indicated the policy was the one currently used by the facility. The policy indicated, "...You have a right to: ...Receive care in a manner which promotes and enhances your quality of life. This includes food of the quantity and quality to meet your needs and preferences. ..."</p> <p>3.1-7(b)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil</p>			

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	<p>money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the accuracy of the annual Minimum Data Set (MDS) assessment for 2 of 30 residents reviewed for accuracy of their MDS. (Resident #21, Resident #65)</p> <p>Findings include:</p> <p>1). On 8/19/15 at 10:14 a.m., Resident #65 indicated she does not have any teeth, but has dentures which she doesn't wear. "I wear them when I want to [indicating the dentures]."</p> <p>The admissions MDS dated 5/9/13, indicated, Resident #65 had no natural teeth and was edentulous [toothless]. The current annual Minimum Data Set (MDS) assessment dated 3/19/15, indicated Resident #65 was not edentulous.</p> <p>The Admission assessment dated 5/2/13, indicated Resident #65 wears dentures.</p> <p>The dental exam documentation dated 4/24/14, indicated, Resident #65 was edentulous.</p> <p>On 8/25/15 at 2:37 p.m., the Director of</p>	F 0278	<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 Martinsville respectfully requests paper/desk compliance for all stated deficiencies <i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>Residents #21 and #65 had their MDS amended to reflect their proper current functional status.</p> <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</i></p> <p>Any resident that has an MDS completed has the potential to be affected. An audit of our current population will be completed and reviewed by the clinical team to ensure accuracy of assessments for each resident. Any noted discrepancies will be addressed</p>	09/24/2015

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	<p>Nursing (DON) indicated Resident #65 admitted with no teeth. Resident #65 has dentures but won't wear them.</p> <p>On 8/25/15 at 3:13 p.m., Registered Nurse (RN) #1 indicated, Resident #65 had no teeth and didn't have any difficulty in eating.</p> <p>On 8/25/15 at 3:47 p.m., the Minimum Data Set (MDS) coordinator indicated the current annual MDS dated 3/19/15, oral/dental status was coded incorrectly. Resident #65 was edentulous.</p> <p>On 8/25/15 at 2:19 p.m., the Administrator indicated, there was no policy regarding accuracy of the MDS assessment. Resident #21's clinical record was reviewed on 8/24/15 at 11:32 a.m. Diagnoses included, but were not limited to: Alzheimer's disease and muscle weakness.</p> <p>The quarterly MDS assessment, dated 5/3/15, indicated Resident #21 needed extensive assistance with eating and personal hygiene, and the resident was totally dependent with bed mobility, transfers, dressing, toilet use, and locomotion(walking).</p> <p>The current quarterly Minimum Data Set (MDS) assessment, dated 8/2/15,</p>		<p>immediately and corrected within amendment to their MDS.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p> <p>The MDS coordinator and nursing staff were inserviced as to the requirement of timely and accurate documentation of the functional status of the residents. Once the initial audit and any necessary corrections have been completed, we will have weekly care plan meetings in which the DON, MDS Coordinator and Administrator will review the residents MDS to ensure accuracy in conjunction with the review of their plan of care. Any discrepancies will be immediately corrected to reflect the most current functional status, and the care plan will be updated accordingly.</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>At the completion of the weekly care plan/MDS meeting, any and all discrepancies, if they exist, will be placed in a log to track and trend so educational efforts can be directed accordingly. The results of these weekly audits will be maintained by the MDS Coordinator, and the audits will continue for a minimum of 4 weeks, and will be complete when 2 additional consecutive weeks with</p>	

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F 0329 SS=D Bldg. 00	<p>indicated Resident #21 needed extensive assistance with bed mobility, transfers, dressing, eating, toilet use, and personal hygiene, and the resident was totally dependent with locomotion.</p> <p>On 8/24/15 at 9:25 a.m., the Director of Nursing indicated Resident #21 has been totally dependent since admission and the MDS was probably coded wrong.</p> <p>On 8/25/15 at 1:17 p.m., the MDS coordinator indicated the May 3, 2015 quarterly assessment was coded wrong and she needed to make an amendment.</p> <p>On 8/25/15 at 2:19 p.m., the Administrator indicated the facility did not have a policy regarding the accuracy of the MDS assessments.</p> <p>3.1-31(i)</p> <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</p>		<p>zerocorrections have been accomplished.</p> <p>Afterward, 10 MDSs will be reviewed monthly for a period of no less than 6 months to ensure ongoing compliance. Then, the MDS consultant will review routinely on their visits monthly moving forward. At the monthly QA meetings, any patterns will be discussed and an action plan developed if necessary. The plan will be reviewed by the Administrator weekly until resolution.</p>	

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	<p>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 a resident who received a psychotropic medication was monitored for targeted behaviors and for effectiveness of medications for 1 of 5 residents reviewed for unnecessary medication use. (Resident #119)</p> <p>Findings include:</p> <p>Resident #119's clinical record was reviewed on 8/24/15 at 9:32 a.m. The resident was admitted on 8/13/15. Diagnoses included but were not limited to: anxiety and depression.</p> <p>The physician's August 2015, orders for Resident #119 indicated the following:</p> <p>On 8/13/15, the resident was ordered Prozac (antidepressant medication) 20 mg (milligrams) daily.</p>	F 0329	<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 Martinsville respectfully requests paper/desk compliance for all stated deficiencies <i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>Resident # 119 had a behavioral management flow sheet started immediately upon identification one was lacking. All nurses have been inserviced/re-educated on the importance of side effect monitoring as it pertains to anti-psychotic medications, and</p>	09/24/2015

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	<p>The Wolters Kluwer Nursing 2014 Drug Handbook, 34th edition, copyright 2015, Black Box Warning for Prozac included: " ... Monitor patient closely for worsening of depression or suicidal behavior..."</p> <p>The clinical record lacked documentation which indicated side effects nor targeted behaviors for which the medication was prescribed were monitored for Resident #119's Prozac. The record lacked behavior flow records.</p> <p>On 8/21/15 at 10:55 a.m., RN #1 indicated the nurses should chart everyday for behaviors and side effects.</p> <p>On 8/25/15 at 12:23 p.m., the Assistant Director of Nursing indicated Resident #119 did not have any behavior flow record, however, the Social Service Director would immediately start a new behavior flow record.</p> <p>On 8/24/15 at 11:25 a.m., the Administrator provided the facility's policy, "Behavior Management/Psychotropic Medication Protocol," undated, and indicated it was the policy currently being used by the facility. The policy indicated, " c) The SSD [Social Service Director] will fill</p>		<p>further educated on the proper documentation procedures.</p> <p>Resident #119 was interviewed to ensure the black box warnings associated with her medication were heeded and zero adverse side effects were noted.</p> <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</i></p> <p>Any resident receiving psychotropic or antipsychotic medications has the potential to be affected by the alleged deficient practice. An audit of our current population on anti-psychotic or psychotropic medications will be reviewed by the SSD, DON, ADON and Administrator to ensure that all those receiving these medications are being monitored for adverse side effects. Identification of a lack of monitoring will be addressed immediately and the resident will be assessed to ensure safety, and documentation updated. The nurse in charge of the resident at the time will receive education regarding the proper procedures and requirements. All nurses have been in service/re-educated on the importance of side effect monitoring as it pertains to anti-psychotic medications, and further educated on the proper documentation procedures.</p>	

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	<p>out a Target Behavior Monitoring form on any newly admitted resident who ... receives psychoactive/psychotropic medication..."</p> <p>3.1-48(a)(3)</p>		<p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p> <p>Daily, all new orders will be reviewed during clinical standup meeting to ensure that any new psychotropic or antipsychotic medication orders are followed and side effects or lack thereof noted appropriately. Any resident receiving orders for either type of these medications will be placed on the white board for daily monitoring by the IDT team. The documentation for these residents will be reviewed and updated accordingly daily by IDT team to ensure staff is tracking any potential side effects of a new antipsychotic or psychotropic medication.</p> <p>Since the survey, all nurses have been inserviced and re-educated on the importance of behavior as well as side effects of medication monitoring. Any staff that fail to comply with the points of the inservice will be further reeducated and/or progressively disciplined as indicated.</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>Daily, all new orders will be reviewed during clinical standup meeting to ensure that any new psychotropic or antipsychotic</p>	

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F 0371 SS=F Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was cooked to the proper temperature prior to removing from the oven and placed in the steam table on the serving line as indicated by the facility policy and 410 IAC 7-24 Retail Food Establishment Sanitation Requirements in that barbecue chicken breasts had not</p>	F 0371	<p>medication orders are followed and side effects or lack there-of are noted appropriately. Any resident receiving orders for either type of these medications will be placed on the white board for daily monitoring by the IDT team. The documentation for these residents will be reviewed and updated daily by IDT team to ensure staff is tracking any potential side effects of a new anti-psychotic or psychotropic medication.</p> <p>At the monthly QA meetings, any patterns will be discussed and an action plan developed if necessary. The plan will be reviewed by the Administrator weekly until resolution. The monthly audit will be maintained by the Social Services Director.</p> <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</p>	09/24/2015

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	<p>reached a safe temperature.</p> <p>Findings include:</p> <p>On 8/24/15 at 11:30 a.m., Cook #1 was observed to obtain temperatures of cooked lunch items. Cook #1 was observed to document temperatures of the food before the thermometer had completely stopped calculating the temperature. Cook #1 indicated she was not aware of how long to allow the temperature to hold once the thermometer numbers had stopped calculating.</p> <p>The temperature of the barbecue chicken breast was observed to measure 157.3 degrees Fahrenheit when taken out of the oven. Cook #1 indicated the temperature should measure 155 degrees Fahrenheit or greater.</p> <p>On 8/24/15 at 12:19 p.m., the Dietary Manager provided "Food Temperature Log" forms and indicated that was the suggested temperatures from their corporate office. The form indicated, "House Meat, Substitute Meat, Ground Meat, Pureed Meat" should be 155 degrees or greater. This form lack documentation of what types of meats fall in those categories. The Dietary Manager agreed the forms should be</p>		<p>compliance with State and Federal Laws. The Waters of Martinsville respectfully request paper/desk compliance for all stated deficiencies</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The poultry was immediately placed back into the oven to reach the proper temperature prior to serving to the residents. Cooks and dietary staff were immediately inserviced on the proper cooking temperature for poultry and all meats. Our temperature logs and policies were updated to detail the proper cooking temperature of each specific meat. The meal for this day was measured at 172 degrees when removed from the oven prior to serving to our residents. Cooks and dietary staff were inserviced on the holding time on the thermometers once the numbers stop moving.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>Cooks and dietary staff were immediately inserviced on the proper cooking temperature for all meats focusing on poultry temperatures specifically. Our temperature logs and policies were updated to detail the proper cooking temperature of each specific meat.</p>	

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	<p>specific to the type of meat cook.</p> <p>On 8/24/15 at 12:06 p.m., the Administrator provided policy "Serving Food and Beverages" undated, and indicated the policy was the one currently used by the facility. The policy indicated,</p> <p>1. Foods shall be served at the following temperatures to ensure a safe ... dining experience. The policy lacked documentation of what the temperature should be for various types of meat coming out of the oven. The policy only addressed meat casseroles temperature should be 155-170 degrees Fahrenheit.</p> <p>On 8/26/15 at 8:34 a.m., review of the "RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENTS" dated November 13, 2004, indicated, " COOKING FOOD Sections 182 through 185 ... Cooking of raw animal foods Sec. 182. (a) Except as specified under subsections (b) through (d), raw animal foods, such as ... meat, poultry, and foods containing these raw animal foods, shall be cooked to heat all parts of the food to a temperature and for a time that complies with one (1) of the following methods based on the food that is being cooked: ...(3) One hundred sixty-five (165) degrees Fahrenheit or above for fifteen (15) seconds for the following: (A) Poultry ..."</p>		<p>The meal for this day was measured at 172 degrees when removed from the oven prior to serving to our residents. Cooks and dietary staff were inserviced on the holding time on the thermometers once the numbers stop moving.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Cooks and dietary staff were immediately inserviced on the proper cooking temperature for all foods focusing on poultry temperatures specifically. Our temperature logs and policies were updated to detail the proper cooking temperature of each specific meat. Cooks and dietary staff were inserviced on the holding time on the thermometers once the numbers stop moving. Prior to serving any meal, the cooking temperature will be verified and initialed by another member of the dietary staff in coordination with the cook. The dietary manager will review all temperature logs daily. Any discrepancies will be immediately addressed with staff re-education and/or progressive discipline as indicated.</p> <p>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?</p>	

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F 0514 SS=D Bldg. 00	<p>3.1-21(i)(2) 3.1-21(i)(3)</p> <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>Based on interview and record review, the facility failed to ensure staff were accurately documenting for behaviors and side effects of psychotropic medications for 5 of 5 residents reviewed for</p>	F 0514	<p>The dietary manager will review all temperature logs daily. Any discrepancies will be addressed with staff re-education and/or progressive discipline as indicated. Any discrepancies in proper temperature will also immediately be reported to the administrator. The administrator will also review the temperature logs weekly until 4 weeks with zero discrepancies has been achieved. Once this result is achieved, the administrator will continue to review the temperature logs monthly for a minimum of 6 months to ensure ongoing compliance.</p> <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</p>	09/24/2015

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	<p>unnecessary medication use. (Resident #24, Resident # 39, Resident #119, Resident #4, Resident #97)</p> <p>Findings include:</p> <p>1. Resident #24's clinical record was reviewed on 8/24/15 at 10:05 a.m. Diagnoses included but were not limited to: anxiety and depression.</p> <p>The physician's August 2015, orders for Resident #24 indicated the following:</p> <p>On 5/29/15, the resident was ordered Celexa (antidepressant medication) 20 mg (milligrams) every morning for depression and perphenazine (antipsychotic medication) 2 mg twice a day for generalized anxiety disorder.</p> <p>A review of Resident #24's August Behavior/Intervention Monthly Flow Records indicated the following:</p> <p>On 8/1/15, one shift did not accurately document assessment for behaviors nor side effects in regard to the resident's psychotropic medications, Celexa and perphenazine.</p> <p>On 8/2/15, two shifts did not accurately document assessment for behaviors nor side effects in regard to the resident's</p>		<p>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 Martinsville respectfully requests paper/desk compliance for all stated deficiencies <i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>Blank behavioral tracking forms have been stocked at each nurses station, and the nurses have been inserviced/re-educated on the proper procedure to filling out the behavioral flow sheets and how to document behaviors as it relates to rationale to continue or discontinue antipsychotic or psychotropic medications. Affected residents were reviewed by their physicians for appropriate medications with zero changes made to any resident. Resident #24, #39, #119, #4 and #97 each had behavioral flow sheets implemented immediately. These resident's behavioral flow sheets will be reviewed daily by the clinical team to ensure accuracy. Any discrepancies will immediately be corrected, and the staff member educated.</p> <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</i></p> <p>All residents that receive</p>	

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	<p>psychotropic medications, Celexa and perphenazine.</p> <p>On 8/5/15, two shifts did not accurately document assessment for behaviors nor side effects in regard to the resident's psychotropic medications, Celexa and perphenazine.</p> <p>On 8/9/15, one shift did not accurately document assessment for behaviors nor side effects in regard to the resident's psychotropic medications, Celexa and perphenazine.</p> <p>On 8/14/15, two shifts did not accurately document assessment for behaviors nor side effects in regard to the resident's psychotropic medications, Celexa and perphenazine.</p> <p>On 8/18/15, one shift did not accurately document assessment for behaviors nor side effects in regard to the resident's psychotropic medications, Celexa and perphenazine.</p> <p>On 8/19/15, one shift did not accurately document assessment for behaviors nor side effects in regard to the resident's psychotropic medications, Celexa and perphenazine.</p> <p>On 8/21/15 at 10:55 a.m., RN #1</p>		<p>antipsychotic or psychotropic medications have the potential to be affected. An audit of our current population on anti-psychotic or psychotropic medications will be reviewed by the SSD, DON, ADON and Administrator to ensure that all those receiving these medications are being monitored for adverse side effects. This audit will also ensure anyone receiving these types of medications will have an associated behavioral flow/tracking sheet. Identification of a lack of monitoring will be addressed immediately and the resident will be assessed to ensure safety, staff re-educated and their documentation updated. The behavioral flow/tracking sheets will be reviewed daily by the SSD director, and any holes in the documentation will be communicated to the DON and Administrator at morning meeting. Any unfilled areas will be taken to the staff member responsible by the DON or her designee for re-education and to ensure accuracy of the flow sheet when it is completed. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Then, monitoring will occur weekly for a period of not less than 6 months to ensure ongoing compliance. Any discrepancies will be addressed as found.</p>	

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	<p>indicated the holes in the Behavior/Intervention Monthly Flow Record meant the nurses did not chart for that day, however, they should chart everyday for behaviors and side effects.</p> <p>On 8/25/15 at 12:03 p.m., the Director of Nursing indicated the nurses are expected to chart on the residents' Behavior/Intervention Monthly Flow Record for each shift and there should not be any holes on the sheet.</p> <p>2. Resident #39's clinical record was reviewed on 8/25/15 at 9:03 a.m. Diagnoses included but were not limited to: psychosis, anxiety, depression, and dementia with behavioral disturbance.</p> <p>The physician's August 2015, orders for Resident #39 indicated the following:</p> <p>On 02/01/15, the resident was ordered excitalopram (antidepressant medication) 10 mg (milligrams) daily and quetiapine fumarate (antipsychotic medication) 50 mg at bedtime.</p> <p>A review of Resident #39's August Behavior/Intervention Monthly Flow Records indicated the following:</p> <p>On 8/1/15, two shifts did not accurately document assessment for behaviors nor</p>		<p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p> <p>All nurses have been inserviced/re-educated on the importance of side effect monitoring as it pertains to anti-psychotic and psychotropic medications, and further educated on where to document. Any staff who fail to comply with the points of the service will be further re-educated and/or progressively disciplined as indicated.</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 behavioral flow/tracking sheets will be reviewed daily by the SSD director, and any holes in the documentation will be communicated to the DON and Administrator at morning meeting. Any unfilled areas will be taken to the staff member responsible by the DON or her designee for re-education and to ensure accuracy of the flow sheet when it is completed. The DON will maintain records of discrepancies and coaching associated with corrections to the documentation. These will be reviewed weekly with the administrator.</p> <p>At the monthly QA meetings, any</p>	

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	<p>side effects in regard to the resident's psychotropic medications, excitalopram and quaetiapine fumarate.</p> <p>On 8/2/15, three shifts did not accurately document assessment for behaviors nor side effects in regard to the resident's psychotropic medications, excitalopram and quaetiapine fumarate.</p> <p>On 8/3/15, two shifts did not accurately document assessment for behaviors nor side effects in regard to the resident's psychotropic medications, excitalopram and quaetiapine fumarate.</p> <p>On 8/5/15, two shifts did not accurately document assessment for behaviors nor side effects in regard to the resident's psychotropic medications, excitalopram and quaetiapine fumarate.</p> <p>On 8/6/15, one shift did not accurately document assessment for behaviors nor side effects in regard to the resident's psychotropic medications, excitalopram and quaetiapine fumarate.</p> <p>On 8/7/15, one shift did not accurately document assessment for behaviors nor side effects in regard to the resident's psychotropic medications, excitalopram and quaetiapine fumarate.</p>		<p>patterns will be discussed and an action plan developed if necessary. This plan will be monitored weekly by the administrator or his designee until resolved.</p>	

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	<p>On 8/8/15, one shift did not accurately document assessment for behaviors nor side effects in regard to the resident's psychotropic medications, excitalopram and quaetiapine fumarate.</p> <p>On 8/9/15, two shifts did not accurately document assessment for behaviors nor side effects in regard to the resident's psychotropic medications, excitalopram and quaetiapine fumarate.</p> <p>On 8/10/15, one shift did not accurately document assessment for behaviors nor side effects in regard to the resident's psychotropic medications, excitalopram and quaetiapine fumarate.</p> <p>On 8/11/15, one shift did not accurately document assessment for behaviors nor side effects in regard to the resident's psychotropic medications, excitalopram and quaetiapine fumarate.</p> <p>On 8/14/15, one shift did not accurately document assessment for behaviors nor side effects in regard to the resident's psychotropic medications, excitalopram and quaetiapine fumarate.</p> <p>On 8/15/15, one shift did not accurately document assessment for behaviors nor side effects in regard to the resident's psychotropic medications, excitalopram</p>			

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	<p>and quaetiapine fumarate.</p> <p>On 8/16/15, one shift did not accurately document assessment for behaviors nor side effects in regard to the resident's psychotropic medications, excitalopram and quaetiapine fumarate.</p> <p>On 8/19/15, one shift did not accurately document assessment for behaviors nor side effects in regard to the resident's psychotropic medications, excitalopram and quaetiapine fumarate.</p> <p>On 8/20/15, one shift did not accurately document assessment for behaviors nor side effects in regard to the resident's psychotropic medications, excitalopram and quaetiapine fumarate.</p> <p>On 8/21/15 at 10:55 a.m., RN #1 indicated the holes in the Behavior/Intervention Monthly Flow Record meant the nurses did not chart for that day, however, they should chart everyday for behaviors and side effects.</p> <p>On 8/25/15 at 12:03 p.m., the Director of Nursing indicated the nurses are expected to chart on the residents' Behavior/Intervention Monthly Flow Record for each shift and there should not be any holes on the sheet.</p>			

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	<p>3. Resident #119's clinical record was reviewed on 8/24/15 at 9:32 a.m. Diagnoses included but were not limited to: anxiety and depression.</p> <p>The physician's August 2015, orders for Resident #119 indicated the following:</p> <p>On 8/13/15, the resident was ordered Prozac (antidepressant medication) 20 mg (milligrams) daily.</p> <p>The clinical record lacked documentation which indicated targeted behaviors for which the medications were prescribed were monitored for Resident #119's Prozac. The record lacked behavior flow records.</p> <p>On 8/21/15 at 10:55 a.m., RN #1 indicated the holes in the Behavior/Intervention Monthly Flow Record meant the nurses did not chart for that day, however, they should chart everyday for behaviors and side effects.</p> <p>On 8/25/15 at 12:23 p.m., the Assistant Director of Nursing indicated Resident #119 did not have any behavior monitoring flow records, however, the Social Service Director would immediately start a new behavior monitoring flow record.</p>			

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	<p>On 8/24/15 at 11:25 a.m., the Administrator provided the facility's policy, "Behavior Management/Psychotropic Medication Protocol," undated, and indicated it was the policy currently being used by the facility. The policy did not address daily monitoring for targeted behaviors and side effects related to psychotropic medication use.</p> <p>4. Resident #4's clinical record was reviewed on 8/24/2015 at 11:25 a.m. Diagnoses included but were not limited to: dementia with behavioral disturbances, anxiety, and depression.</p> <p>The physician's August 2015, orders for Resident #4 indicated the following:</p> <p>On 5/26/2015, the resident was ordered sertraline tablet (anti-depressant medication) 50 mg (milligrams) in the evening for delusions related to dementia. On 3/31/2015, the resident was ordered sertraline tablet 100 mg one time a day related to depressive disorder.</p> <p>On 6/16/2015, the resident was ordered Seroquel tablet (anti-psychotic medication) 50 mg two times a day for dementia with behavioral disturbances.</p>			

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	<p>On 5/14/2015, the resident was ordered Ativan tablet (anti-anxiety medication) 0.5 mg two times a day for anxiety and on 4/8/2015, Ativan tablet 0.5 mg every 6 hours as needed for anxiety.</p> <p>The August 2015, Behavior/Intervention Monthly Flow Record for Seroquel and Ativan indicated no documentation for monitoring of targeted behaviors and monitoring of potential medication side effects on the day shift for 22 days out of 31, 19 out of 31 days on the evening shift and 23 out of 31 days for the night shift.</p> <p>The August 2015, Behavior/Intervention Monthly Flow Record for sertraline indicated no documentation for monitoring of targeted behaviors and monitoring of potential medication side effects on the day shift for 21 out of 31 days, 19 out of 31 days on the evening shift and 24 out of 31 days for the night shift.</p> <p>On 8/21/2015 at 10:44 a.m., Registered Nurse #1 (RN), indicated the blanks in the Behavior/Intervention Monthly Flow Record meant the nurses did not chart for that day, however, they should chart everyday for behaviors and side effects.</p> <p>On 8/21/15 at 10:57 a.m., the Director of Nursing indicated the nurses are not</p>			

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	<p>charting on the days where there are blanks on the Behavior/Intervention Monthly Flow Record.</p> <p>On 8/24/2015 at 11:25 a.m., the Administrator provided the policy "Behavior Management/Psychotropic Medication Committee Agenda dated 9/12 and indicated it was the one currently being used by the facility. The policy did not address daily documentation for the monitoring of side effects and targeted behaviors related to psychotropic medication use.</p> <p>5). Resident #97's clinical record was reviewed on 8/24/15 at 11:22 a.m. Diagnoses included but were not limited to: depressive disorder, anxiety and dementia with behavioral disturbance</p> <p>The current physician's order dated August 2015, indicated the following:</p> <p>Resident #97 received 50 mg (milligram) trazadone three times a day for anxiety, and 500 mg of Depakote in the evening and 250 mg in the a.m. for dementia with behavioral disturbances.</p> <p>Review of the the current "BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD" dated August 2015, indicated the following:</p>			

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	<p>On 8/1 and 8/2/15, no shift accurately documented assessment for behaviors nor side effects in regard to the resident's psychotropic medications, Depakote and trazodone.</p> <p>On 8/3/15, two shifts did not accurately document assessment for behaviors, and no shift accurately documented assessment for side effects in regard to the resident's psychotropic medications, Depakote and trazodone.</p> <p>On 8/4/15, no shift accurately documented assessment for behaviors and no shift accurately documented assessment for side effects in regard to the resident's psychotropic medications, Depakote and trazodone.</p> <p>On 8/5 and 8/6/15, one shift accurately documented assessment for behaviors and no shift accurately documented assessment for side effects in regard to the resident's psychotropic medications, Depakote and trazodone.</p> <p>On 8/7 and 8/8/15, two shifts accurately documented assessment for behaviors and no shift accurately documented assessment for side effects in regard to the resident's psychotropic medications, Depakote and trazodone.</p>			

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	<p>On 8/9/15, two shifts did not accurately document assessment for behaviors, and no shift accurately documented assessment for side effects in regard to the resident's psychotropic medications, Depakote and trazodone.</p> <p>On 8/10/15, two shifts accurately documented assessment for behaviors, and no shift accurately documented assessment for, side effects in regard to the resident's psychotropic medications, Depakote and trazodone.</p> <p>On 8/11/15, one shift did not accurately document assessment for behaviors, and no shift accurately documented assessment for, side effects in regard to the resident's psychotropic medications, Depakote and trazodone.</p> <p>On 8/12 and 8/13/15, no shift accurately documented assessment for side effects in regard to the resident's psychotropic medications, Depakote and trazodone.</p> <p>On 8/14/15, one shift did not accurately document assessment for behaviors, and no shift accurately documented assessment for, side effects in regard to the resident's psychotropic medications, Depakote and trazodone.</p> <p>On 8/15/15, one shift did not accurately</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155183	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2015
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NAME OF PROVIDER OR SUPPLIER WATERS OF MARTINSVILLE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2055 HERITAGE DR MARTINSVILLE, IN 46151
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	<p>document assessment for behaviors, and no shift accurately documented assessment for side effects in regard to the resident's psychotropic medications, Depakote and trazodone.</p> <p>On 8/16/15, one shift did not accurately document assessment for behaviors, and no shift accurately documented assessment for, side effects in regard to the resident's psychotropic medications, Depakote and trazodone.</p> <p>On 8/17 and 8/18/15, no shift accurately documented assessment for side effects in regard to the resident's psychotropic medications, Depakote and trazodone.</p> <p>On 8/19 and 8/20/15, one shift did not accurately document assessment for behaviors, and no shift accurately documented assessment for, side effects in regard to the resident's psychotropic medications, Depakote and trazodone.</p> <p>On 8/21 through 8/24/15, no shift accurately documented assessment for, side effects in regard to the resident's psychotropic medications, Depakote and trazodone.</p> <p>On 08/21/2015 10:55:a.m., interview with RN #1 indicated the holes in the charting means the nurses are not</p>			

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	<p>charting that day and they should be charting everyday for behaviors and side effects.</p> <p>08/21/2015 10:57 a.m., interview with the Director of Nursing (DON) indicated staff is not charting on the days where there are blanks and they should be. She has a lot of prn [as needed] staff and they just forget to do it. They are trying to get everything on the MAR so it is easier to chart.</p> <p>On 8/25/15 at 9:30 a.m., interview with LPN #4 and the Minimum Data Set (MDS) coordinator indicated, there were no side effects being monitored for Resident #97's Depakote. LPN #4 indicated, since Resident #97 was not taking Depakote for seizure they would not monitor for side effects. The MDS coordinator indicated there should have been side effects listed on the care plan to monitor for the Depakote. "Normally there would be a careplan to monitor side effects, but I don't see one [indicating side effects on the care plan]."</p> <p>The behavior monitoring sheet indicated side effects but lacked documentation of side effects being monitored.</p> <p>3.1-50(a)(2)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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