

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155483	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/17/2013
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NAME OF PROVIDER OR SUPPLIER  WATERS OF RISING SUN THE	STREET ADDRESS, CITY, STATE, ZIP CODE 405 RIO VISTA LN RISING SUN, IN 47040
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 13, 14, 15, 16, and 17, 2013</p> <p>Facility number: 000405 Provider number: 155483 Aim number: 100273800</p> <p>Survey team: Diana Sidell RN, TC Gordon Tyree RN (May 13, 14, 15, and 16, 2013) Nicole Wright RN Joan Laux RN</p> <p>Census bed type: SNF/NF: 48 Total: 48</p> <p>Census payor type: Medicare: 4 Medicaid: 33 Other: 11 Total: 48</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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	Quality Review completed 05/28/2013 W. Chris Greeney QIDP.				

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F000156 SS=C	<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 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:</p>						

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and 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,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on observation and interview the facility failed to ensure the Ombudsman's name and number was posted and failed to post the Residents' Rights poster where it was visible to residents seated in wheel chairs. This deficient practice had the potential to affect all 48 residents residing in the facility.</p> <p>Findings include:</p> <p>During the environmental tour, on 5/15/13 at 1:45 p.m., with the Administrator and Maintenance man, the Ombudsman's name and number was not observed posted with other advocacy groups. The Administrator indicated where the name and number had been posted on the bottom part of a paper with other numbers, and the name and number looked like it had been torn off the bottom of the page.</p> <p>On the left side of the door, to the entrance of the Mulberry dining room, a residents' rights poster was posted with the top edge of the poster approximately 6 feet from the floor, which was too high for residents in wheelchairs to read the top part of the</p>	F000156	<p>We are respectfully requesting a paper review. It is the intent of this Facility to ensure that the residents always have access to ombudsman's name and number and that the residents rights poster is at a height accessible to a resident in a wheelchair. A: ACTIONS TAKEN: The residents rights poster was lowered to approximately 23 inches from the floor making it easily read by a resident in a wheelchair. The ombudsman's name and number was posted on hallway bulletin board. B: OTHERS IDENTIFIED: No other issues were identified. C: MEASURES TAKEN: The resident's rights poster was moved down to approximately 23 inches from floor. The ombudsman's name and number were posted in a locked display board to ensure numbers will always be accessible to residents and family. D: HOW MONITORED: CEO/Designee will monitor area 2 X week X 4 weeks with no negative findings and as needed thereafter to ensure proper documentation is present. CEO/Designee will review during monthly quality assurance meetings and during quarterly quality assurance meetings with the medical director. E: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June</p>	06/14/2013

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	poster. The Administrator indicated residents in wheel chairs could not see the whole poster.  3.1-4(j)(3)(C)		14, 2013.		

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F000242 SS=E	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose 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 a residing smoking resident's right to smoke was honored when the facility was changed to a non-smoking facility for 2 of 3 residents interviewed related to smoking privileges in a sample of 4 known residents who had smoked prior to the change in the facility's policy. (Residents #9 &amp; #35)</p> <p>Findings include:</p>	F000242	<p>We are respectfully requesting a paper review. It is the intent of this Facility to ensure that the residents rights are respected.</p> <p>A: ACTIONS TAKEN: In regard to residents #9 and #35, they were interviewed by social service to ensure that they had no other concerns about residents rights..</p> <p>B: RESIDENTS IDENTIFIED: A 100% audit on all resident who were admitted prior to the February 22, 2013 tobacco free policy. C: MEASURES TAKEN:</p> <p>1- Any identified resident, who met the criteria (B), who wished to smoke will have a smoking assessment done to determine if they are safe to smoke independently or need to be supervised. 2- Those residents identified as needing supervision will have staff/designee assist resident with smoking during designated smoking times. 3- Social Service will hold resident council to inform residents of smoking policy. 4- Smoking policy will be updated to include new guidelines for residents who were admitted prior to February 22,</p>	06/14/2013			

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	<p>During an interview on 5-15-13 at 1:41 p.m., the Resident Council President indicated a couple residents had a problem with the changes in the smoking policy. He indicated the facility went smoke free in March 2012. He indicated it was Residents #9 and #35. He indicated he felt like it wasn't right how that was changed.</p> <p>During an interview on 5-15-13 at 1:55 p.m., with Resident #9, she indicated she didn't like the decision to go smoke-free but she didn't have a choice. She indicated she enjoys smoking. She indicated she refused</p>		<p>2013 and wish to smoke. 5- Ombudsman will be notified of new smoking guidelines. D:HOW MONITORED:1- Social Service/Designee will interview smoking residents 1 X week X 4 weeks to ensure residents rights are being respected. 2-Smoking assessments quarterly and PRN. 3- Resident council meetings monthly and PRN 4- CEO/Designee will review during monthly quality assurance meetings and during quarterly quality assurance meetings with the medical director. E: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 14, 2013.</p>		

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	<p>the quit-smoking aides that were offered to her and she currently smokes. Resident #9 indicated her family takes her out of the facility to smoke, either to a park or her sister's house.</p> <p>During an interview on 5-15-13 at 2:10 p.m., with the Social Services Director, he indicated the facility gave the residents a 30 day notice to the policy change for smoking. He indicated the facility sent letters to the families, had a specific meeting with the residents to inform them and get feedback from them, and the facility consulted the Ombudsmen regarding how long of a notice to give and decided on the 30 days. He indicated they offered alternatives for the residents who were interested in using them to quit.</p> <p>During an interview with the Administrator, on 5-15-13 at 4:04 p.m., when asked for the facility policy and procedure for the non-smoking policy, she indicated they don't have a policy due to being tobacco free. When asked what the procedure was for a resident that wants to smoke, she indicated their family can come and take them out to smoke. When asked if she has a policy stating this, she indicated she didn't know. She</p>				

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	<p>indicated she would find out and get back with us. She indicated when the facility went non-smoking, an inservice was done and the ombudsman was present. She indicated no residents chose the patches, the only option is if someone takes you out. The Administrator stated there were no provisions for residents who smoke at the time of the policy change to be "Grandfathered in". She indicated that it would be difficult to explain to new admissions who smoke, but are being told it is a smoke-free facility, and yet there are residents smoking on the grounds.</p> <p>During an interview with Resident #35, on 5-17-13 at 9:45 a.m., she stated the change in the facility smoking policy was "not right" but "you either did it or changed facilities". She indicated she felt like it went against her resident rights. She indicated they used to have a smoking building where they were allowed to go to and it was located eight feet away from the facility. She indicated they changed the smoking policy and that residents had 30 days to quit or to move out of the facility. She indicated the facility offered them patches and other smoking cessation tools, but she refused. She indicated</p>			

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	her sister had to come and take her out to smoke since the policy change.  3.1-3(u)(1) 3.1-3(u)(3)			

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F000253 SS=E	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation and interview, the facility failed to ensure carpets were clean in 1 of 27 resident rooms, and chairs in 2 of 2 dining rooms were sturdy and free of scuff marks.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 5/15/13 at 1:45 p.m., in the Pine dining room, 3 of 7 wooden chairs were observed to be wobbly and had multiple scuff marks on the wooden arms and legs.</li> <li>In the Mulberry dining room on 5/15/13, at 3:00 p.m., 6 of 7 wooden chairs had multiple scuff marks on the wooden arms and/or legs.</li> <li>In room 3, on 5/15/13 at 3:07 p.m., various dark gray stains were observed on the carpet in the center of the room.</li> </ol> <p>During an interview on 5/15/13 at 3:09 p.m., the Administrator said the stains were from food being spilled and other wetness on the floor.</p>	F000253	<p>We are respectfully requesting a paper review. It is the intent of this Facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. A: ACTIONS TAKEN: The 3 wobbly chairs were removed to ensure resident safety. The carpet was spot cleaned.</p> <p>B: OTHERS IDENTIFIED: 1- A 100% audit was performed by maintenance and CEO in facility for proper aesthetics and safety. 2- All rooms with carpet were inspected and a cleaning schedule was made.</p> <p>C: MEASURES TAKEN: 1- 8 tables and 32 chairs were ordered on 6-5-2013 2- Housekeeping/maintenance to list in order rooms in which carpet should be deep cleaned first and/or replaced. D: HOW MONITORED: 1- Housekeeping/maintenance/designee will do monthly checks on all chairs to ensure safety and proper aesthetics. 2- All rooms will be evaluated 1 X week for possible whole room carpet cleaning. This will be ongoing. 3- It is the intent of this facility to replace all carpet in rooms, 1, 2, 3, 4, 5, 6 and 8 and replace with tile within the year.</p>	06/14/2013	

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	3.1-19(f)(5)		CEO/Desginee will review during monthly quality assurance meetings and during quarterly quality assurance meeting with the medical director. E:This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 14, 2013.	

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure the dialysis center communicated dietary needs to the facility related to nutritional supplements for 1 of 1 resident reviewed for dialysis. (Resident #8)</p> <p>Findings include:</p> <p>Care Plan reviewed on 5-16-13 at 10:07a.m. and included a focus of: -Dx [diagnosis] of chronic renal failure, res[ident] receives dialysis 3 times a week, interventions include meds [medications] as ordered, arrange for transportation to and from dialysis for the resident, encourage resident to follow dialysis recommended diet, labs and tests as ordered, monitor bruit and thrill qshift [every shift] and prn [as needed]. -Resident very independent with her decision making especially regarding her healthcare, she may refuse medications or insulin at times, and she may be non-compliant with diet</p>	F000309	<p>We are respectfully requesting a paper review. It is the intent of this facility to provide care/services for highest well being. A: ACTIONS TAKEN: Nursing staff was inserviced on new guidelines for assessing dialysis residents upon return from dialysis and more thorough communication with the dialysis unit. .B: RESIDENTS IDENTIFIED: Only 1 dialysis resident currently in facility. C: MEASURES TAKEN: 1- Upon return from dialysis unit, all residents will have vitals taken and dialysis access sites assessed. These will be documented in resident charts. 2- The dialysis unit will fax a complete note that details the entire visit for that day. This includes vitals, all meds given, pre treatment and post treatment assessment. 3- Nursing will contact the dialysis unit that day if note is not sent. 4- All dialysis communication forms will be kept in a binder at the nurses station and thinned PRN. 5- All dietary recommendations will be discussed with resident to</p>	06/14/2013	

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	<p>recommended by dialysis, interventions include assess for s/s [signs and symptoms] of hyper/hypoglycemia prn [as needed], educate the resident on the importance of being compliant with her diet and the risks of being non-compliant, educate the resident on the importance of her medications and insulin and the risks of not taking them as ordered, notify MD [physician] of concerns, offer acceptable choices based from her likes for her diet so that she may be more compliant, respect resident rights.</p> <p>During an interview with the DON (Director of Nursing), on 5-16-13 at 11:00 a.m., she indicated Resident #8 goes to dialysis Monday, Wednesday, Friday to [local dialysis facility]. She indicated the dialysis center only sends back the transfer papers that were sent with the resident, they do not send any new documents with the resident when they are sent back. She indicated they will fax any new orders written and those are put on the resident's chart.</p> <p>During an interview with LPN #2 on 5-16-13 at 2:32 p.m., she indicated she usually has to call the dialysis center for an update on the resident</p>		<p>educate on importance of following recommendations. Physician will be notified of recommendations and will write appropriate order if He deems the recommendation as necessary. Dietary will be notified of recommendations and if applicable, family will be notified of recommendations. Residents rights will be respected on any of refusals of recommendations. Physician will be notified of any refusals. Care plan will be updated quarterly and PRN to reflect any recommendations, any education and any refusal that may occur. D:HOW MONITORED:1-DON/Designee will audit residents chart 3 X week X 4 weeks, and then1 X week to ensure proper documentation . This will be ongoing .2- Will discuss progress/problems PRN in morning meeting,CEO/Designee will review during monthly quality assurance meetings and during quarterly quality asurance meetings with the medical director. E: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 14, 2013.</p>		

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	<p>when she returns from dialysis.</p> <p>During a review of Resident #8's dialysis records on 5-16-13 at 2:45 p.m., it showed the 'DIALYSIS/NURSING FACILITY COMMUNICATION FORM' for yesterday's packet that was sent to the dialysis center with the resident is filled out by nursing facility, but there is nothing filled out under the dialysis unit section. A review of the 'DIALYSIS/NURSING FACILITY COMMUNICATION FORM' for the last thirty days show nothing documented under the 'Dialysis unit' section.</p> <p>During an interview with DON (Director of Nursing) and the Administrator on 5-17-13 at 11:58 a.m. regarding the Dialysis/Nursing Facility Communication Form, the Administrator indicated that the only time the dialysis center fills out the communication form is when there are changes, the DON indicated they will also fax any new orders to the facility.</p> <p>During an interview with the DON on 5-17-13 at 1:00 p.m., when asked for a copy of the policy and procedure for dialysis, she indicated that the first page of the dialysis contract is the</p>			

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	<p>policy and procedure.</p> <p>During a review of treatment record on 5-16-13 at 2:10p., it indicated to palpate bruit/thrill (R) [right] upper arm every shift. Review of Nutritional Progress Record indicated on 3-27-13 communication from Dialysis indicates '...kitchen has been req (requested) to avoid cheese and resident now receiving 2xPhoslo with meals and snacks. No other labs communicated from Dialysis since last review'. Review of the physicians orders from 1-17-13 thru 4-19-13, no new orders were noted regarding diet restrictions or changes. Review of the residents food card shows nothing regarding cheese restrictions. During an interview with the DON, on 5-17-13 at 11:58 a.m., she indicated if the Dietician suggested a diet change, it should have been ordered but it wasn't.</p> <p>During a review of nurse's notes on 5-16-13 at 3:00 p.m. from 3-23-13 thru 4-23-13 does not indicate any charting regarding speaking to the dialysis center regarding resident. A Dietary Note is noted on 4-24-13 and indicates Labs from Dialysis this mo. [Month] indicate high K+ [potassium], Dialysis req. [requested] kitchen restrict high K+ foods. Check with</p>						

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	<p>Dialysis center re: [regarding] preferable pro. [protein] supplement to use BID. Review of the physicians orders from 1-17-13 thru 4-19-13, no new orders were noted regarding diet restrictions or changes. No new orders are noted after 4-19-13. Nurses Note dated 4-27-13 indicated "...Res[ident] is Verdi indep [independent] with her decision making especially regarding her healthcare. Res[ident] may refuse medications or insulin at times &amp; [and] she may be non-compliant with diet recommended by dialysis."</p> <p>During an interview with the DON on 5-17-13 at 1:30 p.m., she indicated that when Dialysis suggested no cheese, that the resident had her family bring her in cheese and she kept it in her refrigerator in her room. She indicated that the resident stated she is going to eat what she wants.</p> <p>3.1-37(a)</p>			

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review and interview, the facility failed to monitor the amount of supplements a resident received for 2 of 3 residents in a sample of 12. (Residents #41 and #8)</p> <p>Findings include:</p> <p>1. Resident #41's record was reviewed on 5/17/13 at 1:35 p.m. The diagnoses included, but were not limited to, morbid obesity, post surgical repair gastric band erosion (chronic), peritoneal adhesions, complications gastric band surgery, unspecified type vessel native/graft, and esophageal reflux.</p> <p>The Dietary consultation report, dated 3/1/13, "if available, suggest change "Mighty Shake" TID (three times a day) meals to "Resource Breeze) BID (twice a day) which will provide same</p>	F000325	<p>We are respectfully requesting a paper review. It is the intent of this Facility to maintain nutrition status unless unavoidable. A: ACTIONS TAKEN: In regard to residents #41 and #8, the physician was notified and appropriate documentation in place. B: OTHERS IDENTIFIED: 100% audit on all resident receiving supplements. C: MEASURES TAKEN: 1- Nursing staff inserviced on how to document nutritional supplements in computer. This had to be set up in the computer system. 2- Physician will be notified of any recommendations of nutritional supplements. D: HOW MONITORED: 1- DON/Designee will audit residents on supplements proper documentation 5 X week. This will be ongoing. 2- Will discuss any problems/concerns with supplement refusals in daily meetings. 3- Physician/family will be notified of any changes in residents condition or orders. 4-</p>	06/14/2013	

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	<p>amt (amount) pro (protein) as TID MS (Mighty Shake) but 100 less kcals (kilocalories)."</p> <p>The resident's weights were as follows: 3/9/13 200 pounds; 4/9/13 191 pounds; 4/24/13 189 pounds; 5/8/13 189 pounds.</p> <p>On 5/16/13 at 3:35 p.m., during an interview the Director of Nursing indicated Resident #41 refused supplemental shakes, and would hoard food in her room, which her family would bring to her frequently. No documentation in her care plan or nurses notes was indicated related to her refusal for supplemental shakes and hoarding food.</p> <p>On 5/17/13 at 3:20 p.m., during an interview the Director of Nursing indicated the resident's fluid intake was not specific to the amount of oral fluids or the amount of supplement taken.</p> <p>2. A review of Resident #8's orders on 5-17-13 at 1:31 p.m., indicated a regular diet was ordered. Care plans indicated a focus of resident very independent with her decision making</p>		<p>CEO/Designee will review during monthly quality assurance meetings and during quarterly quality assurance meetings with the medical director. E: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 14, 2014.</p>	

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	<p>especially regarding her healthcare, she may refuse medications or insulin at times, and she may be non-compliant with diet recommended by dialysis. Interventions include assess for s/s [signs and symptoms] of hyper/hypoglycemia prn [as needed], educate the resident on the importance of being compliant with her diet and the risks of being non-compliant, educate the resident on the importance of her medications and insulin and the risks of not taking them as ordered, notify MD [physician] of concerns, offer acceptable choices based from her likes for her diet so that she may be more compliant, respect resident rights. Review of a quarterly Minimum Data Set Assessment, dated 4-3-13, indicated Resident #8 was independent in cognitive skills for daily decision making.</p> <p>During an interview on 5-17-13 at 3:20 p.m. with the DON [Director of Nursing], she indicated resident refused any restrictions on her diet. The suggestion for a low K+ [potassium] diet is noted in the progress notes and the DON indicated that if there is any restriction that the resident notices, she will have her family bring in the food that</p>				

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	<p>is restricted and she will keep it in her fridge in her room.</p> <p>During a record review on 5-17-13 at 3:50p.m. for Resident #8, the dietary note indicated a recommendation for a supplement. Review of the dietary records does not indicate that she has received the supplement. No order for a supplement is noted in the physician's orders after a review.</p> <p>During an interview on 5-17-13 at 3:50p.m., the DON brought in a copy of Resident #8's diet card, there is no notation for a supplement noted on it. When asked if the order was ever written for a supplement she indicated that it had not been written but it should have been when that was suggested by the dietician.</p> <p>3.1-46(a)(1) 3.1-46(a)(2)</p>				

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F000371 SS=E	<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 a pantry refrigerator was clean and foods were stored under sanitary conditions for 1 of 1 pantry and failed to ensure food was covered during the distributing of hall trays for 3 of 3 observations on May 13, 14, and 17, 2013.</p> <p>Findings include:</p> <p>1. During the environmental tour on 5/15/13 at 1:45 p.m., in the nourishment room/pantry, the ice machine had a brown substance that was easily rubbed off onto a paper towel. The maintenance man stated it was "rust". The substance covered 1/4 of a metal plate on the lower edge, where the ice is expelled into the bin from the icemaker.</p> <p>In the nourishment room/pantry, in the small refrigerator, a thick layer of frosty ice covered the inside of the</p>	F000371	<p>We are respectfully requesting a paper review. It is the intent of this Facility to store, prepare, distribute and serve food under sanitary conditions. A: ACTIONS TAKEN: The ice machine was emptied and cleaned. The refrigerator was cleaned. The room trays will have some plastic wrap placed over food and drinks temporarily until a more efficient process can be initiated. B: OTHERS IDENTIFIED: No other cleaning issues. C: MEASURES TAKEN: 1- The ice machine had two rusty screws which were causing the problem. These screws were replaced. 2- The refrigerator was cleaned. 3- The dietary manager will order lids to sit on cups and bowls to keep them covered. The desserts will be covered with a plastic wrap. The type of plastic wrap may vary because of the type of desserts being served, but they will be appropriately covered. D: HOW MONITORED: 1- The ice machine was put on a weekly check with maintenance to check for any discolorations from faulty equipment. 2- The refrigerator will be cleaned by housekeeping daily</p>	06/14/2013			

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	<p>fridge freezer section. A yellow substance was observed on the bottom right of the fridge and the Administrator indicated it was orange juice. A brown substance was observed dried on the bottom right of the fridge.</p> <p>2. On 5/13/13 at 11:50 a.m., during the lunch meal, the hall room meal trays were observed being passed. The Activities Director, CNA #12 and CNA #13 were observed to pass the meal trays from the hall cart to the resident's rooms #'s 7, 8, 11, 12, 18, 20, and 21. These meal trays were observed carried into these resident's rooms without coverings on beverages (up to four glasses per tray) and desserts, and fruit cups.</p> <p>On 5/14/13 at 11:39 a.m., during the lunch meal the hall room meal trays were again observed being passed by</p>		<p>and deep cleaned 1 X week and PRN. 3-Kitchen staff and nursing staff inserviced on wiping up spills immediately when they happen or when they see them. 4-The Dietary Manager/Designee will audit food carts randomly during all three meals 5 X a week X 4 weeks, 3 X a week X 4 weeks, 2 X a week X 4 weeks, then 1 X week to ensure that all food and drinks are covered. This will be ongoing. 5- CEO/Designee will review during monthly quality assurance meetings and during quarterly quality assurance meetings with the medical director. E:This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 14, 2013.</p>		

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	<p>the Activities Director, CNA #13, and CNA #14. No coverings on the beverages or on the desserts were observed on the meal trays as they were distributed to the residents in Rooms #'s 3, 7, 8, 11,12, 20, and 21.</p> <p>On 5/17/13 at 11:48 a.m., during the lunch meal CNA #12, CNA #15, and CNA #16 were observed passing meal trays from hall cart to the residents in Room #'s 3, 7, 8, 18, and 22 without coverings on the beverages, fruit cups, and salads.</p> <p>On 5/17/13 at 4:10 p.m., the Administrator provided the information indicating the facility had served between 20 to 25 room trays each day this week.</p> <p>3.1-21(i)(1) 3.1-21(i)(2)</p>						

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F000441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to ensure</p>	F000441	We are respectfully requesting paper review. It is the intent of	06/14/2013			

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	<p>handwashing technique was followed for the prevention of infection control for 3 of 7 facility staff observed for handwashing.</p> <p>Findings include:</p> <p>During an observation, on 5-15-13 at 10:10 a.m., the DON (Director of Nursing) turned off the water with her bare hand, after washing her hands.</p> <p>During an observation, on 5-13-13 at 11:35 a.m., RN#1 washed her hands for less than 10 seconds after returning from the med cart.</p> <p>During an observation, on 5-15-13 at 13:30 p.m., the Social Services Director washed his hands, then turned the faucet off with his bare hand.</p> <p>During an observation, on 5-16-13 at 10:32 a.m., the Social Services Director was observed washing his hands, washed less than 10 seconds, and turned the water off with his hand.</p> <p>During an interview, on 5-17-13 at 5:35 p.m., with the DON, when asked what their policy and procedure was for handwashing, she indicated she washes her hands for the length of time it takes to sing the Happy Birthday song, she washes all surfaces and rinses all surfaces and she</p>		<p>this Facility that every employee will follow Facility policy for proper handwashing to prevent spread of infection. A: ACTIONS TAKEN: In regards to the 3 employees, they were immediately inserviced 1:1 for Facility handwashing policy with a return demonstration. B: OTHERS IDENTIFIED: No other's identified with potential for more than minimal harm. C: MEASURES TAKEN: All staff inserviced on facility handwashing policy with return demonstration. D: HOW MONITORED: CEO/Designee will do random audits 5 X week X 4 weeks, 3 X week X 4 weeks, 2 X week X 4 weeks, then 1 X week X 4 weeks on all departments. The CEO/Designee will watch employee demonstrate proper handwashing technique to ensure Facility policy and infection control is maintained. Handwashing inservices will be held on a quarterly basis with all staff to ensure continued compliance. CEO/Designee will review during monthly quality assurance meetings and during quarterly quality assurance meetings with the medical director. E: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 14, 2013.</p>		

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	<p>uses a paper towel to turn off the faucet and then dries her hands thoroughly.</p> <p>Review of the facilities handwashing policy and procedure, indicated: "Wash hands well for approximately 15 seconds to aid in the mechanical removal of bacteria. Grasp paper towel and blot or pat hands dry. Use paper towel to turn off water." The Centers for Disease Control Guidelines for handwashing (<a href="http://www.cdc.gov/handwashing/">http://www.cdc.gov/handwashing/</a>) indicate proper handwashing includes "rubbing your hands together under running water with soap to make a lather and scrub them well...for at least 20 seconds."</p> <p>3.1-18(l)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155483		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/17/2013	
NAME OF PROVIDER OR SUPPLIER  WATERS OF RISING SUN THE				STREET ADDRESS, CITY, STATE, ZIP CODE 405 RIO VISTA LN RISING SUN, IN 47040			
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F000458 SS=E	<p>483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.</p> <p>Based on observation and interview, the facility failed to provide at least 80 square feet per resident for 2 of 27 resident rooms. (rooms 5 and 7) This deficient practice affected 4 of 48 residents residing in the facility.</p> <p>Findings include:</p> <p>During the environmental tour, on 5/15/13 at 1:45 p.m., with the Administrator and Maintenance man, the following rooms were observed to have less than 80 square feet per resident:</p> <ul style="list-style-type: none"> <li>* Room 5 had 3 resident beds and was 217 square feet equaling 72.33 square feet per resident.</li> <li>* Room 7 had 3 resident beds and was 224 square feet, equaling 74.66 square feet per resident.</li> </ul> <p>The Administrator indicated they would use the beds if they got an admission</p>	F000458	A letter requesting a room waiver for rooms 5 and 7 was sent to Miriam Buffington, Enforcement Manager, Division of Long Term Care, in Indianapolis, Indiana on Friday June 7, 2013.	06/14/2013			

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	3.1-19(1)(2)(3)(4)(8)			

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F000516 SS=E	<p>483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public.</p> <p>The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>The facility must safeguard clinical record information against loss, destruction, or unauthorized use.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medical records were stored to prevent destruction for 1 of 1 storage room.</p> <p>Findings include:</p> <p>During the environmental tour, which began on 5/15/13 at 1:45 p.m., the storage closet beside the laundry room was observed to have multiple boxes of resident information, stored under one sprinkler head that was observed on the right side of the ceiling. The Administrator indicated at that time, that is where they were always stored.</p> <p>A Policy and Procedure for "Health Records" indicated, but was not</p>	F000516	<p>We are respectfully requesting paper review. It is the intent of this Facility to safeguard clinical record information against loss, destruction, or unauthorized use. A: ACTIONS TAKEN: The medical records are currently in boxes in a locked closet with a sprinkler system. A plastic tarp was placed temporarily over top of boxes and secured to prevent damage from water in case the sprinkler system went off. B: OTHERS IDENTIFIED: No other medical records were identified. C: MEASURES TAKEN: On May 24, 2013, 4 lockable filing cabinets were ordered to secure medical records. On June 4th, 2013 1 lockable filing cabinet was ordered to secure medical records. We will continue to order filing cabinets until we no longer have space. When file cabinets can no longer be used due to space, the records will be placed</p>	06/14/2013			

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	<p>limited to, "Guideline: It is the intent of the facility to have a health record system that facilitates the retrieval of information regarding individual residents. Responsibility: All Licensed Nursing Personnel. Procedure...7. Health records of discharged/expired residents will be kept for a minimum of six (6) years. The Health Record clerk and CEO (or designee) are responsible for the destruction of the records. All records are to be destroyed by shredding or incineration...."</p> <p>3.1-50(d)</p>		<p>in plastic totes to prevent any destruction and placed in a locked room .D:HOW MONITORED: 1-CEO/Designee will inspect medical record 5 X week to ensure no further issues from any overflow of records or need for more file cabinets and/or plastic totes.This will be ongoing 2- CEO/Designee will review during monthly quality assurance meetings and during quarterly quality assurance meetings with the medical director.. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 14, 2013.</p>		