

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155275	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/29/2016
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NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00191951 and IN00195880.</p> <p>Complaint IN00191951- Substantiated. Federal/State deficiencies related to the allegations are cited at F353.</p> <p>Complaint IN00195880- Substantiated. Federal/State deficiencies related to the allegations are cited at F441 and F514.</p> <p>Survey Dates: March 28, 29, 2016.</p> <p>Facility number: 00175 Provider number: 155275 AIM number: 100274440</p> <p>Census bed type: SNF/NF: 78 Total: 78</p> <p>Census payor type: Medicare: 12 Medicaid: 57 Other: 2 Total: 78</p> <p>Sample: 5</p> <p>These deficiencies reflect State findings</p>	F 0000	We are officially requesting a Desk Review on all three of these tags.	

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

TITLE

(X6) DATE

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

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F 0353 SS=D Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on April 1, 2016 by #02748.</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview, and record review, the facility failed to ensure enough staff was available to meet the residents needs for 1 of 1 observations, 3</p>	F 0353	<p>Princeton POC Complaint Survey 3/29/16 F-353 It is the policy of the facility to see that there is always adequate staff available to meet the needs of all</p>	04/18/2016

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	<p>of 6 interviews, and 4 out of 6 months of resident council minutes reviewed. (Resident E)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 3/28/16 at 8:55 a.m., Staff #3 indicated on that day there were two nurses and one CNA on the unit. Staff #3 indicated the two nurses had split the hall and passed medications and completed treatments. Staff #3 indicated the CNA was completing all the care (toileting, showers, baths, answering call lights) and charting for the residents on the unit and the nurses would help. Staff #3 indicated there was usually one nurse and two CNA's. On 3/28/16 at 9:00 a.m., Resident E indicated she had to wait on her showers. Resident E was observed to still be in her night clothes. Resident E indicated she wanted to be dressed for the day prior to that time. On 3/29/16 at 5:30 a.m., Staff #4 indicated there was not enough staff. Staff #4 further indicated there had been a lot of call ins. On 3/29/16 at 9:45 a.m., Resident E indicated there were not enough nurse aides. Resident E further indicated this 		<p>residents as dictated per the orders of their doctors as well as their individual plans of care.</p> <p>Resident E gets her bed made and receives her showers and other ADLs timely and to her satisfaction. She feels there inadequate staff in place to accomplish this. The nursing staff themselves feel that they have adequate staff in place to allow them to meet the needs of the residents timely. Resident Council is satisfied with the facility's plan as far as hiring staff and allocating staff to areas in the facility based on acuity. The Resident Council feels their concerns have been adequately addressed and care needs including ADLs, call light response and bed making are being completed timely. This finding has the potential to affect all residents who reside in the facility. The Administrator and DON have met and discussed strategies to recruit and retain nursing staff. There has been a revised process for writing, posting and follow up of the nursing schedule. The nursing schedule will be reviewed daily for the following day by the Administrator and the DON to ensure that adequate staff is in place to meet the needs of the residents as per their care plans in a timely fashion. The DON/Designee will interview 10 interview-able residents weekly on various shifts to see if they feel</p>				

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	<p>mostly occurred during the day shift. Resident E indicated she had to wait to get assistance with her showers, getting dressed, and getting the bed made.</p> <p>5. On 3/29/16 at 11:07 a.m., the resident council minutes were reviewed. The 4 of 6 months of resident council minutes included, but were not limited to:</p> <p>October 14, 2015: Residents had complaints about sharing nurses. The suggested plan of action was to hire more nurses so this was no longer an issue.</p> <p>November 20, 2015: Residents had complaints about needing more nurse aids related to the number of call lights. The action taken section indicated CNA classes were currently taking place.</p> <p>December 28, 2015: Residents had complaints about not getting their beds made soon enough. Residents had further complaints that the nursing staff was so busy they were hard to find. The suggested plan of action was to hire more staff.</p> <p>March 21, 2016: Residents had complaints about not getting their showers earlier in the day. The action taken was to inservice the staff on resident requests.</p>		<p>their needs are being met timely. The emphasis will be placed on timeliness of: A.) Call Light Response B.) ADLs being completed including showers/personal care C.) Beds being made timely Further, 10 nursing staff members will be interviewed weekly on various shifts to see if they feel they have reasonable manpower to complete resident care tasks/needs timely. This monitoring as well as the interview-able resident monitoring as stated prior, will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, 3 interview able residents, and 3 staff members will be interviewed weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur. Note: Any concerns by either residents or staff will be addressed as discovered. The DON/Designee will request permission to attend the next 3 monthly Resident Council meetings in order to follow up and discuss nursing staff availability and satisfaction with needs being met from the perspective of the Resident Council. Any concerns will be immediately addressed. At an in service held for nursing staff on 4-15-2016, Resident Rights, ADLs and Accommodation of Needs was reviewed and discussed. In addition,the</p>				

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F 0441 SS=D Bldg. 00	<p>6. On 3/29/16 at 1:05 p.m., Staff #3 indicated sometimes there was enough staff and sometimes there was not. Staff #3 further indicated they had a lot of call ins.</p> <p>On 3/29/16 at 3:00 p.m., the DON indicated there was not a facility policy in regards to staffing.</p> <p>This Federal tag relates to Complaint IN00191951.</p> <p>3.1-17(a)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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</p>		necessity of being timely when meeting all care needs was discussed. Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings, any concerns will be reviewed. Any patterns identified will have an Action Plan written by the committee to address them. Any Action Plan will be monitored weekly by the Administrator until resolution.		

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	<p>infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to maintain a safe and sanitary environment, in that, hand hygiene was not completed and resident equipment was not cleaned, for 1 of 4 resident care observations. (Resident A, Staff #1)</p> <p>Findings include:</p> <p>On 3/29/16 at 10:30 a.m., Staff #1 was observed to change a dressing for Resident A. Staff #1 entered the</p>	F 0441	F-441 It is the policy of the facility to ensure and maintain a safe and sanitary environment for the residents at all times including proper hand hygiene and the use of clean equipment during dressing changes. Resident A has their dressing changed using proper infection control practices as per the facility's policy and procedure. This includes proper hand hygiene, cleaning of equipment such as scissors, use of any pens or markers to date the dressing and use of a disposal bag to collect soiled or	04/18/2016

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	<p>residents room and applied gloves. No hand hygiene was observed. Staff #1 prepared the supplies and removed the tubigrip from Resident A's left leg. Staff #1 obtained bandage scissors from her pocket and cut the kerlix bandage away from Resident A's leg. The bandage scissors were not observed to be cleansed prior to use. Staff #1 placed the bandage scissors back in her pocket. The bandage scissors were not observed to be cleansed after use. Staff #1 removed the remaining dressing from the resident's leg. Staff #1 discarded the soiled dressing and cleansed the resident's wound. Staff #1 began to open the new dressing supplies, obtained the bandage scissors from her pocket, and cut the new dressing to fit the wound. The bandage scissors were not observed to be cleansed prior to cutting the dressing. Staff #1 placed the bandage scissors on the resident's bed. Staff #1 continued to apply the new dressings to the resident's leg. Staff #1 removed the left glove and obtained a marker from her pocket. Staff #1 wrote on the new dressing using the right gloved hand and placed the marker back in her pocket. Staff #1 placed the trash in the bag, placed the bandage scissors back her pocket, removed the glove on the right hand, and exited the room. No hand hygiene was observed and the bandage scissors were not</p>		<p>contaminated items produced during the dressing change. Any resident who has addressing change performed in the facility has the potential to be affected by this finding. The DON/Designee will monitor 5 dressing changes weekly on various shifts to see that proper technique is practiced before, during and after the dressing change and that infection control is not breached. Any concerns observed will be halted prior to a breach taking place. Appropriate education and discipline will follow as indicated. This monitoring will continue until 4 consecutive weeks of zero negative findings. Afterwards, 3 dressing changes will be monitored weekly on various shifts for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur. At an inservice held for all nurses on 4-15-2016, the following was reviewed. A.) Clean Dressing Change Policy/Procedure B.) Hand hygiene before/during/after dressing changes C.) Equipment/scissors associated with dressing changes D.) Proper way to date/initial a dressing E.) Disposal of a soiled dressing Note: All nurses will be "checked off" as to completing a mock dressing change using proper hand hygiene as well as</p>	

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F 0514 SS=D Bldg. 00	<p>observed to be cleansed at any time. Staff #1 entered the soiled utility and discarded the trash. Staff #1 then entered a different residents room close to the soiled utility room, and performed hand hygiene.</p> <p>On 3/29/16 at 2:00 p.m., Staff #2 indicated hands should be washed before performing resident care and after completing resident care prior to exiting the resident's room.</p> <p>On 3/29/16 at 3:00 p.m., the DON provided the "Hand Hygiene" policy, undated. The policy included, but was not limited to, decontaminate hands after removing gloves.</p> <p>This Federal tag relates to Complaint IN00195880.</p> <p>3.1-18(b)(1) 3.1-18(l)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on</p>		<p>properinfection control practices. Any staff who fail to comply with the points of the inservice will be further educated and or progressively disciplined as indicated. At the monthly QA meetings the results of the monitoring will be reviewed. Any patterns will be identified, however any concerns will have been corrected as observed prior to a breach being committed.</p>	

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	<p>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 documentation for wound measurements, treatments, and weekly skin assessments were in the clinical records for 3 of 3 residents reviewed for wounds. (Resident A, Resident B, Resident C)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 3/29/16 at 10:45 a.m., a review of wound records were completed for Resident A, B, and C. A review of resident records dated 1/22/16 to 3/24/16, indicated that no measurements or weekly skin assessments were charted in the clinical record for Resident A, B, or C. On 3/29/16 at 2:15 p.m., the Director of Nursing indicated that the treatment administration record had not been signed by the nurse completing treatments for Resident C on 3/6/16, 	F 0514	<p>F-514 It is the policy of the facility to ensure that that documentation for wound measurements, treatments and weekly skin assessments are contained within the clinical record for all residents. Residents A, B and C have their weekly skin assessments including measurements of any wounds contained in their clinical records on a weekly basis. Resident C's treatment administration record is signed routinely following treatment administration. All residents are to receive a skin assessment weekly, so all residents have the potential to be affected by this finding. Further, residents who have a wound and require a weekly measurement of the wound also have the potential to be affected by this finding. The DON/Designee will monitor weekly to see that all residents have had a weekly skin assessment completed. This monitoring will be ongoing. Further, the DON/Designee will</p>	04/18/2016

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	<p>3/9/16, 3/15/16, and 3/18/16. The physicians order indicated Resident C's wound was to be cleansed with wound cleanser and covered with a hydrocollord dressing every three days. She further indicated that wound measurements and weekly skin assessments were not in the clinical records for Resident A, B, and C.</p> <p>3. On 3/29/16 at 3:00 p.m., the Director of Nursing indicated that the facility did not have a policy on documentation.</p> <p>This Federal tag relates to Complaint IN00195880.</p> <p>3.1-50(a)(1) 3.1-50(f)(2)</p>		<p>monitor to see that all wounds are measured weekly and that all treatments are documented as performed. The weekly measurements of wounds will be monitored at the weekly Skin Weight Assessment Team meetings. The monitoring of treatments being done and documented will occur 3 times weekly by the DON/Designee. This monitoring of treatments will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, the monitoring will occur weekly at the SWAT meetings ongoing. Any concerns will be addressed and corrected (obtained) as discovered to be missing. At an in service held for nurses on 4-15-2016, the following was reviewed: A.) Documentation Med's/Treatments B.) SWAT Meeting-Documentation required for weekly meeting C.) Monitoring of Treatment/Wound documentation D.) When is a notification appropriate based on wound documentation? Who is notified? E.) Discussion Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be discussed, however any concerns will have been corrected (obtained) upon discovery of being missing.</p>		

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

PRINTED: 04/21/2016

FORM APPROVED

OMB NO. 0938-0391

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