

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	<p>This visit was for Recertification and State Licensure Survey. This visit included Investigation of Complaint IN00145320.</p> <p>Complaint IN00145320 - Substantiated. Federal/state deficiencies related to the allegation are cited at F159.</p> <p>Survey Dates: May 27, 28, 29, 30 and June 2, 3, and 4, 2014.</p> <p>Facility number: 000178 Provider number: 155280 AIM number: 100273840</p> <p>Survey team: Jennifer Carr, RN, TC Julie Dover, RN Angela Halcomb, RN Brenda Buroker, RN (May 28 and June 2, 2014)</p> <p>Census bed type: SNF/NF: 90 Total: 90</p> <p>Census payor type: Medicare: 12 Medicaid: 67 Other: 11 Total: 90</p>	F000000	<p>Please see enclosed plan of correction for The Waters of Dillsboro/Ross Manor for Recertification, State Licensure Survey and Complaint IN00145320. We respectfully request a desk review for all deficiencies in this POC. 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>	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000159 SS=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1</p> <p>Quality Review completed on June 11, 2014, by Brenda Meredith, R.N.</p> <p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview and record review, the facility failed to provide accounting services according to generally accepted accounting principles, for 1 resident's personal funds entrusted to the facility on the resident's behalf in that monies due the resident were not credited to the resident's respective bank account in a timely manner, for 1 of 3 residents reviewed for personal funds review (Resident A).</p> <p>Findings include:</p>	F000159	<p>It is the intent of this facility to provide accounting services according to generally accepted accounting principles. A: Actions Taken: 1. Residents invoice was immediately paid by company credit card. B: Others Identified: 1. 100% audit back to July 2013, on all residents checks and deposit slips. No others were identified. C: Measures Taken: 1. BOM/Designee will make copies of all checks and review with Administrator/Designee , immediately upon opening of all checks. D: How Monitored: 1. BOM and Administrator/Designee</p>	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>During a phone interview with Resident A's son on 6/4/2014 at 11:25 a.m., he indicated that he was his mother's Power of Attorney. The facility cashed a check, dated 7/31/2013 and made out to Resident A in the amount of \$323.75, without her consent and deposited the money into the facility account. He indicated that he talked to the Business Office Manager (BOM) several times and stated, "I haven't heard back from the nursing home. She [BOM] said that she saw where the nursing home cashed it [the check] and put it in their account. She told me that they would try to get a hold of somebody higher up....they never got back to me." He further indicated that the check was made out to Resident A from her insurance company as payment to an ambulance service. He indicated, "They [the ambulance company] didn't get paid. They've been calling me for a year for payment." He further indicated that he attempted to file police report, indicating, "They [police] told me they couldn't pursue it because no one person committed it...it's more of a civil crime."</p> <p>During an interview with the BOM on 6/5/2014 at 12:11 p.m., she indicated, "That was right around the time the old Business Manager got hurt and I took over." When asked if the facility cashed</p>		<p>will review all checks and deposit slips before being deposited into bank for accuracy. 2. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring. E: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 30, 2014.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>checks made out specifically to residents for deposit into the facility account, she indicated, "Yes." She further indicated, "I thought it was an insurance payment." When queried as to whether she required residents to endorse checks made out to them (residents), she indicated, "Sometimes." Regarding Resident A not receiving an update from the facility since he last contacted them in February, she indicated, "I told him I would look into it and it's still on my desk."</p> <p>During an interview with the Administrator and the BOM on 6/4/2014 at 2:05 p.m., the BOM provided a copy of a check, dated 7/31/2013 and made out to Resident A in the amount of \$323.75, a 7/31/2014 Explanation of Benefits from Resident A's insurance company, and a deposit slip, dated 8/8/2013, which indicated, "Pay to the order of [bank name]. For Deposit Only. Waters of Dillsboro."</p> <p>The BOM confirmed that the check was deposited on 8/8/2014 into the corporate bank account. She indicated, "Then the family called because they were trying to find the check. I saw that the check had been deposited to the facility. We started researching it and saw that it said 'For [ambulance service]' instead of to us." Both the BOM and Administrator</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>confirmed that the check was deposited to the facility account in error. The BOM indicated, "Usually if a check is made out to a resident, we have them sign it and deposit it."</p> <p>The BOM indicated that she was aware of the error in February, but did not correct the error or follow up with the family. The Administrator indicated, "I think it was a dropped ball."</p> <p>On 6/4/2014 at 2:14 p.m., the Administrator provided a copy of Resident A's Delegation of Responsibility for the Management of Personal Funds, dated 7/28/2019, which indicated by Resident A's initial and signature, "I hereby authorize the facility manage the resident's personal funds." The Administrator additionally provided a copy of the administrative policy "Resident Trust", which indicated, "Purpose: To manage resident's personal monies deposited into an interest bearing bank account set up by the Facility and the Finance Department. This allows all residents to safely keep their personal money accessible for their use. Responsibility: Facility CEO. Procedure: 1. Prior to accepting trust funds for a resident, the Facility must have the resident or responsible party sign a Resident Trust Fund Authorization</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/04/2014	
NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE				STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000248 SS=D	<p>Form. 2. Upon receiving written authorization from a resident or responsible party, the Facility must hold, safeguard and manage an account for the personal funds of a resident. These funds must be reasonably accessible to the resident." No signed Resident Trust Fund Authorization Form was provided for Resident A.</p> <p>This Federal tag relates to Complaint IN00145320.</p> <p>3.1-6(b) 3.1-6(c)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review and interview, the facility failed to provide activities according to the best interest of the resident for 1 of 3 residents reviewed for activities (Residents #101).</p>	F000248	It is the intent of this facility to provide activities according to the best interest of the resident. A: Actions Taken: 1. All activities are to be held as written on monthly calender. Substitutions may be used as needed. B: Others	06/30/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/04/2014
NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE			STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Findings include:</p> <p>During an interview with Resident #101's wife on 5/27/2014 at 2:40 p.m., she indicated, "They don't provide enough activities in this section [Dementia Unit]."</p> <p>Resident #101's clinical record was reviewed on 5/30/2014 at 9:48 a.m. Diagnoses included, but were not limited to, vascular dementia, congestive heart failure, and osteoporosis. The 3/12/2014 Admission Minimum Data Set (MDS) assessment indicated that Resident #101's cognitive skills for daily decision making were "Severely Impaired." The same MDS assessment indicated, "Should Interview for Daily and Activity Preferences be Conducted? No. If resident is unable to complete, attempt to complete interview with family member or significant other." MDS Staff Assessment of Daily and Activity Preferences indicated "Yes" to the following activities: "listening to music, being around animals such as pets, do things with groups of people, participating in favorite activities, spending time outdoors, and participating in religious activities or practices."</p> <p>A Care Plan, dated 3/12/2014, indicated,</p>		<p>Affected: 1. Potential for other residents residing on the dementia unit to be affected C: Measures Taken: 1. Staff inserviced on importance of residents attending scheduled activities. D: How Monitored: 1. Any activity change will be reported to Administrator/Designee. 2. Administrator/Designee will make daily checks for scheduled activities, 5x wk x 2 wks, 3x wk x 2 wks, 1x wk x 1 wk and ongoing to ensure posted activities are being held. 3. Any resident that does not attend scheduled activities will be offered 1:1 activities per their care plan. 4. IDT will observe for scheduled activities during daily rounds. 5. Facility will continue to review individual activity care plans during quarterly care plans and PRN. 6. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring. E: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 30, 2014.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>"Focus: Res [Resident] can make decisions in regards to activities. Res will benefit from sensory stimulation. Res can pursue leisure activities with set up help. Goal: Res will participate in 3 group activities a week. Res will have assist in pursuing leisure activities. Res will engage in sensory stim [stimulation] 3 times a week. Interventions: Provide res with monthly activity calendar. Invite and encourage res to attend. Provide supplies and assist res as needed to pursue leisure activities. Provide sensory stimulation 3 times a week and document outcome. Res will exercise his right to accept or decline invitation to all activities."</p> <p>Recapitulated May 2014, Physician's Orders indicated, "May participate in activities per individual plan."</p> <p>Activity Progress Notes indicated, "No Progress Notes Found."</p> <p>The Director of Nursing (DoN) was interviewed on 5/30/2014 at 10:48 a.m. She indicated that the Dementia Unit Activities Director was also the Dementia Unit Social Services Director and was doing specific, unit-based activities. She indicated, "Normally [previously] they would go off the unit for activities, but it increased their behaviors and confusion."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The posted activities calendar indicated the following activities for 6/2/2014:</p> <p>"9:30 a.m.: Get Up &amp; Move 10:00 a.m.: Coffee Chat 11:00 a.m.: Lunch 2:00 p.m.: Craft Making Summer Flowers...for doors 3:00 p.m.: Glam Time 4:00 p.m.: Cards/Connect Four 5:00 p.m.: Dinner"</p> <p>During a continuous observation on the Dementia Unit on 6/2/2014 from 9:20 a.m. through 10:28 a.m., neither of the scheduled activities, "Get Up &amp; Move" or "Coffee Chat," were observed to take place.</p> <p>On 6/2/2014 at 9:38 a.m., Resident #101 was observed sitting in his room in a recliner with the television on but barely audible. His head was resting on the rolling bedside table to the left of his recliner.</p> <p>On 6/2/2014 at 9:44 a.m., Resident #127 was observed sitting at an empty table in an otherwise empty dining room. The resident requested to know the time and was alert to person and place. The resident indicated, "I've been here one to two months and I ain't seen no activities</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>here....That church thing went on last Sunday I know....Once in a while we do [go outside]...we go outside and sit down. I don't think we go out as often as we should." He further indicated that there was no morning stretching ["Get up and Move"], as indicated on the activities schedule.</p> <p>On 6/2/2014 at 9:47 a.m., 5 residents were observed sitting in the common area with a centrally located television on, but barely audible. None of residents were observed to be looking at the television.</p> <p>On 6/2/2014 at 10:02 a.m., Resident #127 was observed sitting at the same table in an otherwise empty dining room with country music playing softly on a small boom box until Physical Therapist #1 announced that it was time for therapy at 10:17 a.m.</p> <p>On 6/2/2014 at 10:28 a.m., the Dementia Unit Activities Director began offering the residents in the common area coffee and assisting them to the dining room, indicating, "It's almost time for lunch." She then indicated to the three residents sitting in the dining room, "I have some flower cut-outs for your door since we didn't get to that...." No flower cut-outs were observed on any resident doors in the Dementia Unit on 6/2, 6/3, or 6/4,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>2014.</p> <p>On 6/2/1014 at 11:25 a.m., an interview was conducted with the Resident Council President (Resident #15), who resides on Station 2. Resident #15 indicated, "I feel like they just put that list [Activities Calendar] up there for show. They don't do the activities."</p> <p>On 6/2/2014 at 2:05 p.m., Resident #101 was observed in his room, asleep in his recliner.</p> <p>The Dementia Unit Activities Director was interviewed on 6/2/2014 at 3:35 p.m.. She indicated, "Ideally, I'm supposed to do the Dementia Unit, but I'm also helping Social Services do other tasks. What I'm going to do is take over Social Services for Station 2 and The [Dementia] Unit." The scheduled 3:00 p.m. "Glam Time" activity did not take place.</p> <p>The posted activities calendar indicated the following activities for 6/3/2014:</p> <p>"9:30 a.m.: Get Up &amp; Move 10:00 a.m.: Coffee &amp; Doughnuts 11:00 a.m.: Lunch 2:00 p.m.: Outside...weather permitting 3:00 p.m.: Sensory 4:00 p.m.: Puzzles/Cards</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>5:00 p.m.: Dinner"</p> <p>During a continuous observation, on 6/3/2014 from 9:10 a.m. through 10:18 a.m., neither of the scheduled activities, "Get Up &amp; Move" or "Coffee &amp; Doughnuts," were observed to take place.</p> <p>On 6/3/2014 at 9:30 a.m., 6 residents were observed sitting in front of a television in the common area of the Dementia Unit with a country music station playing at a barely audible volume. Four of the 6 residents were observed to be sleeping.</p> <p>On 6/3/2014 at 9:40 a.m., Resident #101 was observed in his room, sleeping in his recliner.</p> <p>During an interview with the Dementia Unit Social Services Director on 6/3/2014 at 11:10 a.m., she provided copies of the May and June, 2014 activity calendars for the Dementia Unit, Station 1, Station 2, and Ross Manor. She also provided Resident #101's documentation of participation in activities for May and June, 2014. She indicated that she is the only Activities staff person on the Dementia Unit and that she is also the Social Services Director for the Dementia Unit and Station 2. When queried as to whether or not she is able to direct all of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the scheduled activities on the calendar, she indicated, "I try." Regarding repeated observations of no 9:30 a.m. scheduled activities, she indicated, "Well that's the thing we need to work out. I have morning meetings at that time."</p> <p>Resident #101's documentation of participation in activities for May and June, 2014 included, but was not limited to, the following: Resident #101 "passively participated" on 5/27/2014 for 9:30 a.m. "Sit N' Fit", 10:00 a.m. "Coffee Time", 2:00 p.m. "Outside Stretch", and 2:30 p.m. "Watering Plants." Resident #101 was observed in his room during an interview with his wife on 5/27/2014, as indicated above, from 2:40 p.m. through 2:54 p.m. The weather was observed to be warm and dry. Resident #101 was indicated as "passively participated" on 5/28/2014 for 9:30 a.m. "Shake N Fit", 10:00 a.m. and "Coffee Time." Resident #101 was indicated as "passively participated" on 5/29/2014 for 9:30 a.m. "Morning Stretch" and 10:00 a.m. "Coffee/Tea." On 5/30/2014, Resident #101 was indicated as not participating in any activities except "Dinner." On 6/2/2014, Resident #101 was indicated as "Unavailable" for all 5 scheduled activities.</p> <p>On 6/3/2014 at 2:00 p.m., the activity</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>"Outside/Patio Chat" was scheduled for the Dementia Unit, Station 1, and Station 2. During observations on all three units from 2:05 p.m. through 2:20 p.m., no residents were observed on the main porch in front of the building. 1 staff member was sitting with 2 ambulatory residents on a porch off of the Dementia Unit Dining Room. No other residents were observed to be outside anywhere around the building, despite the weather being warm, dry, and slightly overcast.</p> <p>On 6/3/2014 at 2:18 p.m., Resident #101 was observed in his room, asleep in his recliner.</p> <p>A copy of the Activity Director Job Description was provided by the Administrator on 6/3/2014 at 2:20 p.m. and reviewed at that time. The Position Summary indicated, "Responsible for planning and directing a program of diversified activities for residents of the health care facility. The goal of the activity program is to provide mental and physical stimulation as well as to create an invigorating social atmosphere for the residents."</p> <p>During multiple random observations throughout the survey dates of May 27, 28, 29, 30, and June 2, 3 and 4, 2014, Resident #101 was not observed in any</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/04/2014	
NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE				STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000250 SS=D	<p>activities and was never observed outside of his room except for meals.</p> <p>3.1-33(a) 3.1-33(b)(1) 3.1-33(b)(2) 3.1-33(b)(9) 3.1-33(c) .</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to ensure that dental and audiology services were provided for 1 of 3 residents reviewed for dental services (Resident #101).</p> <p>Findings include:  During an interview with Resident #101's wife on 5/27/2014 at 2:43 p.m., she indicated that Resident #101 lost his lower dentures approximately 2 weeks prior. She indicated that staff was aware and indicated, "They [facility staff] just haven't found them yet is what they tell me....They [facility] also lost one of his</p>	F000250	<p>It is the intent of this facility to ensure that dental and audiology services are provided. A: Action Taken: 1. Family signed agreement to allow resident to be seen by our audiologist and dentist. Dentist appointment made for June 18,2014 and audiologist appointment scheduled for July 11, 2014. B: Others Identified: 1. 100% audit on all residents to ensure they have dental and audiology services offered or provided. All residents have been offered services or facility provides services. C: Measures Taken: 1. 100% audit on all residents care plans to determine if they were admitted with or later acquired</p>	06/30/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>hearing aids about a month ago. They keep telling me they have everyone on the look-out and haven't found it yet. He still has one [hearing aid] left."</p> <p>Resident #101's clinical record was reviewed on 5/30/2014 at 9:48 a.m. Diagnoses included, but were not limited to, vascular dementia, congestive heart failure, and osteoporosis. His most recent Minimum Data Set (MDS) assessment, dated 3/11/2014, indicated that his cognitive skills for daily decision making were "severely impaired." No documentation related to Resident #101's missing dentures or hearing aid was located in Nursing Progress Notes, Assessments, Social Services Notes, care plans, or anywhere else in the clinical record.</p> <p>Recapitulated May, 2014 Physician's Orders indicated, "May see dentist, optometrist or podiatrist of choice as needed."</p> <p>On 5/30/2014 at 10:48 a.m., the Director of Nursing (DoN) indicated, "He frequently takes them out on his own. They [staff] would find them in his recliner.....He's set up to see the audiologist and dental consults [named the contract company]." Regarding the length of time Resident #101 had gone</p>		<p>dentures or hearing aides.</p> <p>2. 100% audit on all residents to determine if they still have those dentures or hearing aides if appropriate. 3. Any resident that is found to be missing dentures or hearing aides, staff will search for missing items and if unable to find, families will be notified. D: How Monitored: 1. Staff will notify Social Services/Activities/Administrator immediately for any missing dentures or hearing aides. 2. Social Services/Activities will review care plan quarterly and PRN to ensure appropriate appointments are being made for dentist and audiologist if needed. 3. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting E: This plan of correcton constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 30, 2014.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>without his lower dentures and one hearing aids, she indicated, "We searched for them for a long time...several places in his room....laundry, dietary...two weeks does seem like a long time." When queried regarding an acceptable length of time to wait before following up to replace lost items such as dentures and/or hearing aids, she indicated, "Maybe a day or two to make sure we covered laundry, etc...maybe two at most."</p> <p>On 6/3/2014 at 9:50 a.m., CNA #3 indicated, "He's [Resident #101] usually always leaving them [dentures] in his recliner. Usually when he gets up, I check the sides to see if they're there. I know he's missing his bottom ones, but I don't know for how long."</p> <p>On 6/3/2014 at 10:05 a.m., the Dementia Unit Social Services Director indicated, "We were just waiting to see if we could find them [dentures]. I thought I saw his wife here yesterday signing a thing so he could see [contract services]." She further indicated that Medical Records contacted the contract company that day to make a dental appointment. When queried regarding Resident #101's missing hearing aid, she indicated, "I guess I don't recall hearing about his hearing aid....I wouldn't want to wait that</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/04/2014
NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE			STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>long [to follow up]." She further indicated that she had not documented any Social Services Progress Notes related to Resident #101's missing dentures or hearing aid.</p> <p>During an interview with the Medical Records Director on 6/3/2014 at 10:12 a.m., she indicated that Resident #101's wife signed a new consent to include the dentist and audiologist the day before and that she learned that Resident #101 required a dental appointment "yesterday." She indicated that she was not aware that Resident #101 required an audiology appointment. She indicated, "When the dentist calls, I will get them to have audiology call me too."</p> <p>The administrator was interviewed on 6/3/2014 at 11:32 a.m. She indicated that Social Services is responsible for ensuring that medically-related social services, specifically dental and audiology services, are provided. Regarding the length of time Resident #101 had gone without lower dentures or one of his hearing aides, she indicated, "Yes, it's a concern."</p> <p>3.1-34(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F000272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:                      Identification and demographic information;                      Customary routine;                      Cognitive patterns;                      Communication;                      Vision;                      Mood and behavior patterns;                      Psychosocial well-being;                      Physical functioning and structural problems;                      Continence;                      Disease diagnosis and health conditions;                      Dental and nutritional status;                      Skin conditions;                      Activity pursuit;                      Medications;                      Special treatments and procedures;                      Discharge potential;                      Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set</p>			
-----------------	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>(MDS); and Documentation of participation in assessment. Based on observation, record review and interview, the facility failed to conduct a comprehensive dental assessment as part of the Minimum Data Set (MDS) assessment for 2 of 3 residents reviewed for Dental Status and Services (Residents #15 and #18).</p> <p>Findings include:</p> <p>1. During an interview on 05/27/2014 at 3:00 p.m., Resident #18 indicated she had chewing and eating problems related to having no natural teeth and no dentures. Resident #18 also indicated she had sore gums. During this interview Resident #18 was observed to have no natural teeth and no dentures in her mouth.</p> <p>A record review was conducted on 05/30/2014 at 10:28 a.m. The 12/20/2013 Minimum Data Set (MDS) annual assessment indicated Resident #18 did not have any broken or missing teeth or dentures, no mouth or facial pain, and no discomfort or difficulty chewing. The 3/31/2014 quarterly MDS assessment also indicated no loose or broken teeth or dentures, no mouth or facial pain, and no difficulty or painful chewing.</p>	F000272	<p>It is the intent of this facility to conduct a comprehensive dental assessment as part of the MDS assessment. A: Action Taken: 1. Dental assessments were modified. B: Others Identified: 1. No other residents were identified. C: Measures Taken: 1. 100% audit of all residents to ensure dental assessments were completed. 2. All nuring staff to attend mandatory inservice to ensure accurate dental assessment and proper documentation. D: How Monitored: 1. 1 X WK X 4 WKS and ongoing, MDS/Designee will audit all new admissions comprehensve assessments to ensure dental assessments have been completed. 3. Quarterly and PRN, charts will be reviewed during care plans to ensure all dental assessment have been completed. 4. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be moniotred adn reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring. E: This plan of correction constitutes our credible allegation of compliance with all regulatory requirement. Our date of compliance is June 30, 2014.</p>	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Resident #18's 4/8/2014 Dietary Care Plan indicated the resident had "oral/dental health problems." The goal for this care plan indicated the resident would be free of infection, pain, or bleeding in the oral cavity.</p> <p>The medical record indicated 11 teeth were extracted on 5/16/2013.</p> <p>During an interview on 06/02/2014 at 12:35 p.m., Resident #18 indicated she did not want a mechanical soft diet all the time. Resident #18 indicated she could ask the staff to cut her food when she needed help. Resident #18 indicated she has tuff gums and can chew most of her food without any problem.</p> <p>During an interview on 06/02/2014 at 2:56 p.m., the Social Worker indicated Resident #18 had a set of dentures but refused to wear them.</p> <p>2. During an interview on 05/28/2014 at 1:44 p.m., Resident #15 indicated she had gum problems because her dentures were too big. Resident #15 also indicated the staff were aware of this problem and she has seen the dentist three different times.</p> <p>During an interview on 06/03/2014 at 9:27 a.m., the Social Worker indicated the dentist had charted that the resident</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/04/2014
NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE			STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000314 SS=D	<p>was not a candidate for dentures. The Social Worker also indicated Resident #15 had wanted dentures anyway and had been to the dentist three times for adjustments and the dentures continued to be uncomfortable.</p> <p>Resident #15's chart was reviewed on 06/03/2014 at 11:19 a.m., the section labeled oral/dental status on the quarterly MDS assessments, dated 11/12/2013 and 2/12/2014, were blank with nothing indicated. The annual MDS assessment, dated 2/21/2014, indicated Resident #15 had no problems with teeth or dentures. No care plans related to the residents dental status were in her chart.</p> <p>3.1-31(c)(9)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to ensure staff completed a dressing change per protocol during wound care and the physician was not notified of a worsening pressure ulcer for 1 of 1 residents (Resident #40).</p> <p>Finding includes:</p> <p>During a stage one staff interview on 5/28/14 at 10:45 a.m., LPN #1 stated Resident #40 has a stage three pressure ulcer (full thickness tissue loss) on the coccyx.</p> <p>A medical record review during stage one on 5/29/14 at 9:00 a.m., of the Annual MDS (Minimum Data Set) assessment, dated 3/24/14, indicated Resident #40 had one stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle) on the coccyx.</p> <p>During an interview with the (Assistant Director of Nursing) ADON on 5/30/14 at 9:35 a.m., the ADON indicated that</p>	F000314	<p>It is the intent of this facility to ensure staff complete a dressing change per protocol during wound care and notify MD of any worsening pressure ulcer. A: Action Taken: 1. Resident no longer in facility. B: Others Identified: 1. 100% audit on all residents with dressing changes and worsening pressure areas for MD notification. No others identified. C: Measures Taken: 1. All nurses inserviced on how to complete a dressing change per protocol during wound care and to notify MD of any worsening pressure ulcers. D: How Monitored: 1. DON/Designee will observe dressing changes(as available) 3 x wk x 3x wks, 2x wk x 2wks, 1x wk x 2 wks and ongoing to ensure dressing changes are per protocol. 2. DON/Designee will review nurses notes and orders during morning meeting to ensure that MD notification has occurred for any worsening pressure ulcers. 3.Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly</p>	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/04/2014	
NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE				STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Resident #40 has a stage III pressure area on coccyx.</p> <p>Resident #40's clinical record was reviewed on 5/30/14 at 10:14 a.m. This resident has diagnoses which included, but were not limited to DMII (diabetes mellitus 2), CVA (cerebral vascular accident) with right sided weakness, dementia and anemia.</p> <p>A quarterly MDS (minimum data set) assessment, dated 12/24/13, indicated Resident #40's cognitive status was severely impaired, the resident required extensive assistance of staff for bed mobility, was at risk for pressure ulcers and had a stage 3 pressure ulcer during the time of the MDS assessment.</p> <p>An annual MDS assessment dated 3/24/14, indicated Resident #40's cognitive status was severely impaired, the resident was a risk for pressure ulcer and had a stage 4 pressure ulcer during the time of the MDS assessment.</p> <p>In an interview on 6/2/14 at 2:14 a.m., the ADON indicated Resident #40's wound started in the facility has been there for "several years." She indicated, Resident #40's area is a stage IV has always been a stage IV, it has healed and opened, healed and opened again.</p>		<p>QA Meeting for determination of ongoing monitoring. E: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Ourdate of compliance is June 30, 2014.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>During a dressing change observation on 6/3/14 at 9:52 a.m., for Resident #40, LPN #2 was observed to place wound supplies on the overbed table. LPN #2 washed hands and placed disposable gloves on. LPN #2 removed old dressing from coccyx and placed old dressing in Resident #40 trash can. LPN #2 removed disposable gloves and put in Resident #40 trash can did not wash hands. LPN#2 put on new gloves. LPN #2 sprayed wound cleaner directly on wound and cleansed area with a 4x4 gauze. LPN #2 removed gloves and put a new pair of gloves on. LPN #2 placed Santyl ointment (a sterile enzymatic debriding ointment) in wound bed. LPN #2 removed gloves and said i need to go outside to get more 4x4 gauze. LPN #2 come back into Resident #40 room did not wash hands. LPN #2 placed on new pair of gloves, opened two 4x4 gauze packages and poured normal saline in the opened 4x4 gauze. LPN #2 then removed the wet 4x4's and squeezed the excess water into Resident #40's trash can and placed in wound. LPN #2 covered the wound with two dry 4x4 gauze. LPN #2 removed gloves and placed tape over gauze. LPN #2 washed hands after the procedure. Resident #40's wound was observed to be pink around the edges with several black areas on the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>bottom of the wound.</p> <p>Review of the Resident weekly skin assessment sheets on 6/3/14 at 10:00 a.m., indicated this resident has a "stage II pressure ulcer on coccyx." Wound measurements for this same assessment, dated 5/17/14, are as follows: 6 cm (centimeters) x 5 cm with a 4 cm x 1 cm dark area. Healing process section for the same sheet are as followed, the worsening box is checked, the physician notified box is not checked. Weekly skin assessment sheet dated 5/25/14, indicated wound on coccyx is now a stage IV. Wound measurements for this assessment are as follows: 7 cm x 5 cm x 0.3 cm. Healing process section for this sheet, improving box is checked.</p> <p>In an interview on 6/4/14 at 10:55 a.m., the ADON indicated that there was no documentation stating that the MD (physician) was notified about the worsening of the pressure ulcer on 5/17/14.</p> <p>The policy "Pressure Ulcer Assessment and Staging," provided by the Administrator on 5/30/2014 at 10:53 a.m., included, but was not limited to, "GUIDELINE: When a pressure area is identified, an accurate assessment will be completed; a treatment program will be</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>initiated and monitored....The physician is to be notified when a pressure ulcer develops and skin conditions do not show improvement within 2 weeks...."</p> <p>Review of the care plan for Resident #40: OPEN AREA CARE PLAN, GOALS included but were not limited to: area will resolve without complications, area will show improvement weekly. INTERVENTIONS included but were not limited to: Tx. (treatment) per order, F/U (follow-up) with WCC (Wound Care Center) per order, F/C (foley catheter) to aid in wound healing, Dietary supplement per order, RD (registered dietician) visit PRN, T&amp;R (turn and reposition) q2hrs (every 2 hours) and prn (as needed), Pressure relieving devices per order, LAL (low air loss) mattress per order, Notify MD/family for change in condition, Weekly and prn skin checks and measurements.</p> <p>3.1-40(a)(2) 3.1-40(a)(3)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with 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</p>			
-----------------	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>transport linens so as to prevent the spread of infection.</p> <p>Based on observation and record review, the facility failed to ensure proper hand washing during a clean dressing change for 1 of 1 residents reviewed. (Resident #40)</p> <p>Findings include:</p> <p>During a dressing change observation on 6/3/14 at 9:52 a.m., for Resident #40. LPN #2 was observed to place wound supplies on the overbed table. LPN #2 washed hands and placed disposable gloves on. LPN #2 removed old dressing from coccyx and placed old dressing in Resident #40 trash can. LPN #2 removed disposable gloves and put in Resident #40 trash can did not wash hands. LPN#2 put on new gloves. LPN #2 sprayed wound cleaner directly on wound and cleansed area with a 4x4 gauze. LPN #2 removed gloves and put a new pair of gloves on. LPN #2 placed Santyl ointment (a sterile enzymatic debriding ointment) in wound bed. LPN #2 removed gloves and said i need to go outside to get more 4x4 gauze. LPN #2 come back into Resident #40 room did not wash hands. LPN #2 placed on new pair of gloves, opened two 4x4 gauze packages and poured normal saline in the opened 4x4 gauze. LPN #2 then</p>	F000441	<p>It is the intent of this facility to ensure proper hand washing during a clean dressing change.</p> <p>A: Action Taken: 1. Resident no longer in this facility. B:Others Identified: 1. 100% audit on residents with clean dressing changes to ensure proper hand washing technique. No others were identified. C: Measures Taken: 1.ALL nurses will be inserviced on policy and procedure of hand washing during a clean dressing change. D: How Monitored: 1. The Don/Designee will observe hand washing during a clean dressing change 5 x wk X 4wks, 3 x wk X 3wks, 2x wk x 2wks, 1x wk x 1 wk ( as available) and ongoing to ensure proper hand washing technique. 2. The Administrator will review all monitoring results 1x wk x 8wks, then in monthly and quarterly QA Meetings. 3. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring. E: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 30, 2014.</p>	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>removed the wet 4x4's and squeezed the excess water into Resident #40's trash can and placed in wound. LPN #2 covered the wound with two dry 4x4 gauze. LPN #2 removed gloves and placed tape over gauze. LPN #2 washed hands after the procedure.</p> <p>On 6/3/14 at 10:45 a.m., the Administrator presented a copy of the facility's current policy on "Dressing Change, Clean." Review of this policy at this time included, but was not limited to: "EQUIPMENT: Appropriate container for soiled dressing, Clean gloves (two pair). PROCEDURE: 1. Wash hands. 2. Place plastic bag near foot of bed to receive soiled dressing. 3. Create clean field. 5. Put on first pair of disposable gloves. 6. Remove soiled dressing and discard in plastic bag. 7. Dispose of gloves in plastic bag. 8. Wash hands. 9. Put on second pair of disposable gloves. 10. Pour prescribed solution onto gauze to be used for cleaning, if required. 14. Remove gloves and discard with all unused supplies in plastic bag."</p> <p>3.1-18(l)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F009999	<p>3.1-14 PERSONNEL</p> <p>(j) Medication shall be administered by licensed nursing personnel or qualified medication aides. If medication aides handle or administer drugs or perform treatments requiring medications, the facility shall ensure that personnel have been properly qualified in medication administration by a state-approved course. Injectable medications shall be given only by licensed personnel.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure that 1 Qualified Medication Aide (QMA) had a current license for 1 of 10 QMAs reviewed for employee records (QMA #4).</p> <p>Findings include:</p> <p>Employee Records were reviewed for</p>	F009999	<p>It is the intent of this facility to ensure that QMA's have a current license if they are working as a QMA. A: Action Taken: 1. QMA was informed of expired license and did not work as a QMA until license was renewed. B:Others Identified: 1. 100% audit of all QMA licenses. One other license was identified but the employee does not work as a QMA. C: Measures Taken: 1. Affected staff was not permitted to work as a QMA until license had been renewed. D: How Monitored: 1. All potential hires with licences will be verified by BOM/Designee and reviewed by Administrator/Designee before hire. 2.BOM/Designee will audit all employee with licenses 1 X month and ongoing to ensure all licenses are current. 3. BOM/Designee will give Administrator/Designee monthly audit to review to ensure compliance. 4. No staff will be permitted to work as licensed until license is renewed. 5 Any inconsistent results will be immediately clarified and corrected appropriately. Results</p>	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/04/2014	
NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE				STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>current licensure on 5/28/2014 at 10:00 a.m. QMA #4's Indiana Online Licensing page indicated, "Expiration Date: 3/31/2014. License Status: Expired."</p> <p>Facility staffing schedule for the dates May 18, 2014 - May 31, 2014 indicated that QMA #4 was scheduled to work as a QMA in the facility on May 19, 20, 21, 22, 24, 25, 27, 28, 29, and 30, 2014.</p> <p>A review of the daily as-worked schedules and Medication Administration Records (MARs) for May, 2014 indicated that QMA #4 worked as a QMA in the facility on May 5, 6, 7, 10, 11, 14, 19, 21, 24, and 25, 2014.</p> <p>During an interview with QMA #4 on 5/30/2014 at 12:05 p.m., she indicated that she became aware that her license had expired when facility administration informed her on 5/27/2014. She further indicated that the last day she worked as a QMA was 5/25/2014 and that she has worked as a Certified Nursing Assistant (CNA) since that time.</p> <p>3.1-14(j)</p>		<p>will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring E: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 30,2014.</p>				

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

PRINTED: 07/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2014
NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE			STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	