

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155183	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2012
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NAME OF PROVIDER OR SUPPLIER WATERS OF MARTINSVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2055 HERITAGE DR MARTINSVILLE, IN 46151
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F0000	<p>This visit was for Recertification and State Licensure survey.</p> <p>Survey dates: February 19, 20, 21, 22, and 23, 2012</p> <p>Facility number: 000096 Provider number: 155183 AIM number: 100290890</p> <p>Survey team: Leia Alley, RN, TC Dinah Jones, RN, Marcy Smith, RN Patty Allen, BSW</p> <p>Census bed type: SN/NF: 92 Total: 92</p> <p>Census payor type: Medicare: 21 Medicaid: 58 Other: 13 Total: 92</p> <p>Sample:19</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 2/26/12 Cathy Emswiller RN</p>	F0000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or 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. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/09/2012.</p>	

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

TITLE

(X6) DATE

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

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure accuchecks (a fingerstick blood test to measure blood sugar) were obtained according to the physician order for 1 of 19 residents reviewed for physician's orders in a sample of 19. (Resident #101)</p> <p>Findings included:</p> <p>The record of Resident #101 was reviewed on 2/20/12 at 9:30 a.m.</p> <p>Diagnoses for Resident #101 included, but were not limited to, diabetes mellitus and high blood pressure.</p> <p>A care plan for Resident #101, dated 9/13/10 and updated 12/7/11, indicated a problem of "Alteration in glucose tolerance due to dx [diagnosis] DM. [diabetes mellitus]" An intervention was "...3. Accuchecks prn [as needed] report abnormal to MD..."</p> <p>A physician's order dated 1/17/12 indicated Resident #101 was to have a fasting accucheck every day for 7 days</p>	F0282	<p>F-282 COMPREHENSIVE CARE PLANS</p> <p>It is the intent of this facility to provide or arrange services to ensure an accucheck (a fingerstick blood test to measure blood sugar) is obtained per the physician's orders by qualified persons in accordance with each resident's written plan of care.</p> <p>A. ACTIONS TAKEN:</p> <p>1. In regards to Resident # 101, the physician was notified the accucheck was not completed.</p> <p>B. OTHERS IDENTIFIED:</p> <p>1. 100% audit/review was completed to ensure all physicians' orders had been completed per MD</p>	03/09/2012

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	<p>and the physician was to be notified of the results.</p> <p>Results of these accuchecks were not found in Resident #101's record. Further information was requested from the Director of Nursing (DoN) on 2/20/12 at 4:00 p.m. regarding the accuchecks ordered on 1/17/12.</p> <p>On 2/21/12 at 9:10 a.m. the DoN indicated the accuchecks ordered on 1/17/12 had not been done. She indicated the nurse who took the order had gone home sick and the order had not been processed. She indicated the physician had been notified on 2/21/12 the accuchecks had not been done.</p> <p>3.1-35(g)(2)</p>		<p>instructions as required.</p> <p>Clarification orders were obtained as needed.</p> <p>C. MEASURES TAKEN:</p> <p>1. All Nurses' was educated/in-serviced to facility policy in regards to completing orders from receiving the order, transcribing the order, follow up and completion of orders. The importance of accuracy with all MD orders, and the importance of follow-up with the MD's orders.</p> <p>D. HOW MONITORED:</p> <p>1. The DON/Designee will audit/review all new physician orders in the daily QA stand-up meeting for accuracy of completion. This will be an on-going process.</p> <p>2. The Adm. /Designee will review all audits as completed in the</p>		

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			<p>monthly QA meeting with the IDT; and quarterly in the QA meeting with the Medical Director.</p> <p>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 03/09/2012</p>		

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F0329 SS=A	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure non-pharmacological interventions were attempted prior to administering an anti-anxiety medication for 1 of 8 residents reviewed for receiving antipsychotic medications in a sample of 19. (Resident #16)</p> <p>Findings included:</p> <p>The clinical record for Resident #16 was reviewed on 2/21/12 at 9:50 a.m.</p>	F0329	<p>Since this is an "A" tag, no POC is required. Addendum to add a POC per ISDH requirements F-329 UNNECESSARY DRUGS</p> <p>The facility's intent is to provide appropriate non-pharmacological interventions prior to administering an anti-anxiety medication.</p> <p>A. ACTIONS TAKEN:</p>	04/06/2012

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	<p>Diagnoses for Resident #16 included, but were not limited to, Alzheimer's disease, dementia and agitation.</p> <p>A care plan for Resident #16, updated on 1/11/12, indicated a problem of "Anxiety...takes Lorazepam." (An anti-anxiety medication) A goal was "Res. (Resident) will be free of signs or symptoms of anxiety ..." Interventions included "1) Validate feelings...5) Encourage relaxation techniques 6) Encourage activities of interest."</p> <p>A recapitulated physician's order for February, 2012, with an original date of 11/13/11, indicated Resident #16 could receive Lorazepam 0.25 milligrams every 6 hours as needed for restlessness or anxiety.</p> <p>Review of a Medication Administration Record for January, 2012, indicated Resident #16 was given 0.25 milligrams of Lorazepam on 1/8/12 at 3:30 p.m. for anxiety. The record did not indicate any non-pharmacological interventions were attempted to alleviate the resident's anxiety prior to giving her the Lorazepam.</p> <p>Further information was requested from the Director of Nursing (DoN) on 2/21/12 at 6:00 p.m. regarding</p>		<p>1. In regards to Resident #16: a tracking form was put into place to monitor for a minimum of three non-pharmacological interventions prior to administration of an anti-anxiety medication.</p> <p>B. OTHERS IDENTIFIED:</p> <p>1. 100% audit of all residents with orders for anti-anxiety medications will be completed to initiate tracking for non-pharmacological interventions prior to administration of anti-anxiety medications. A tracking form was put into place for all identified residents with orders for anti-anxiety medications.</p> <p>C. MEASURES TAKEN:</p> <p>1. The Licensed Nursing staff will be in-serviced on anti-anxiety medications and appropriate non-pharmacological interventions to be attempted and documented prior to administering an anti-anxiety medication.</p>		

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	<p>non-pharmacological interventions attempted prior to administering Lorazepam to Resident #16 on 1/8/12.</p> <p>On 2/22/12 at 10:00 a.m. the DoN indicated she was not able to find any information regarding non-pharmacological interventions attempted on Resident #16 prior to giving her the Lorazepam on 1/8/12. She indicated the facility used to use a behavioral sheet to document interventions on but a new process had been started and they weren't using this sheet anymore. She indicated it was harder for the nurses to remember to try to use and document non-pharmacological interventions.</p> <p>3.1-48(b)(1)</p>		<p>D. HOW MONITORED:</p> <p>1. The SSD/Designee will audit/monitor the behavior management program for appropriate non-pharmacological interventions, and documentation of these interventions prior to administration of an anti-anxiety medication for all residents on anti-anxiety medications. This will be an on-going process.</p> <p>2. A quarterly review of all residents with orders for anti-anxiety medications will be completed with the care plan review by the IDT. This will be an on-going process.</p> <p>3. These audits will be reviewed as completed in the weekly QA stand-up meeting with the IDT; in the monthly QA meeting with the IDT; and quarterly in the QA meeting with the Medical Director.</p> <p>E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is: 04/06/2012</p>	

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F0371 SS=F	<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 and interview, the facility failed to prepare, distribute and serve food under sanitary conditions and equipment used to prepare food was maintained in a sanitary condition during 1 of 2 kitchen observations. This had the potential to affect 90 of 93 residents who received meals from the kitchen.</p> <p>Findings Include:</p> <p>During the dietary walk through on 2/19/12 at 10:00 a.m., with Dietary Staff # 1 the following were observed:</p> <ol style="list-style-type: none"> 1. The hood over the stove and double door oven had loose, chipped, and missing paint. 2. There were black/greasy streak running down the wall from under the hood. 3. A hole in the wall approximately 3" by 4" beside the stove. 4. Only one of two burners would ignite the other burner had to be ignited by staff. 5. The only skillet in the kitchen had 	F0371	<p>F-371 Food Procure, store/Prepare/Serve - SANITARY CONDITIONS</p> <p>The facility's intent is the trash can lids will be clean; the oven will be clean, the walk-in refrigerator will be clean; the storage rack will be clean; and the fans will be clean.</p> <p>A. ACTIONS TAKEN:</p> <ol style="list-style-type: none"> 1. The cleaning of the kitchen was immediately initiated; the kitchen was deep cleaned on 2/20/2012; including but not limited to: the hood over the stove and double oven was cleaned and repainted; the wall under the hood was cleaned; the hole in the wall was repaired; the stove was inspected and serviced by an outside consultant and cleared for use on a temporary basis and a new stove was ordered on 2/27/2012; the skillet was replaced on 2/20/2012; the large 	03/09/2012

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	<p>cooked on black greasy substance on 2/3 of the skillet's interior.</p> <p>6. There was a large pan with water in it under the three compartment.</p> <p>During interview at that time with dietary staff # 2 indicated the sink had a leak.</p> <p>7. The sink attach to the food prep table located behind the steam table had a leak.</p> <p>8. The walk in freezer door was hard to close, it had a build up of ice on the interior side of the door and the aluminum strip along the bottom of the door was bent and separated from the door.</p> <p>During an interview with the Dietary Manager, on 2/21/12 at 4: 00 p.m., she at that time verified the above mentioned observations were correct and had the potential to affect 90 of 93 residents who received meals from the kitchen.</p> <p>3.1-21(i)(3)</p>		<p>pan under the sink was removed from under the three compartment sink and the sink was repaired; the food prep table with attached sink was repaired; the walk-in freezer was cleaned with built up ice removed and the aluminum strip at the bottom of the door was replaced.</p> <p>B. OTHERS IDENTIFIED:</p> <p>1. All residents would have the potential to be affected.</p> <p>C. MEASURES IN TAKEN:</p> <p>1. All dietary staff were re-in-serviced on 3/6/2012 by the Dietary Manager on proper kitchen sanitation and completion of the posted cleaning schedules.</p>		

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			<p>2. The Dietary Manager/Designee will audit sanitation of kitchen daily and monitor all logs cleaning logs daily for completion. This will be an on-going process.</p> <p>3. The Adm. /Designee will audit/monitor the kitchen weekly for sanitation issues and completion of the sanitation logs. This will be an on-going process.</p> <p>D. HOW MONITORED:</p> <p>1. The Adm. /Designee will review all audits at daily QA stand-up meeting; monthly at QA meeting with the IDT; and Quarterly at the QA meeting with the Medical Director.</p> <p>E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, out date of completion is:</p> <p>3-9-12.</p>		

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F0502 SS=D	<p>483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on record review and interview, the facility failed to ensure accuchecks (a fingerstick blood test to measure blood sugar) were obtained according to the physician order for 1 of 19 residents reviewed for labs completed as ordered by the physician. (Resident #101)</p> <p>Findings included:</p> <p>The record of Resident #101 was reviewed on 2/20/12 at 9:30 a.m.</p> <p>Diagnoses for Resident #101 included, but were not limited to, diabetes mellitus and high blood pressure.</p> <p>A care plan for Resident #101, dated 9/13/10 and updated 12/7/11, indicated a problem of "Alteration in glucose tolerance due to dx [diagnosis] DM. [diabetes mellitus]" An intervention was "...3. Accuchecks prn [as needed] report abnormal to MD..."</p> <p>A physician's order dated 1/17/12 indicated Resident #101 was to have a fasting accucheck every day for 7 days</p>	F0502	<p>F-502 PROVIDE/OBTAIN LABORATORY SVC QUALITY/TIMELY It is the intent of this facility to provide or arrange services to ensure an accucheck (a fingerstick blood test to measure blood sugar) is obtained per the physician's orders by qualified persons in accordance with each resident's written plan of care. A. ACTIONS TAKEN: 1. In regards to Resident # 101, the physician was notified the accucheck was not completed. B. OTHERS IDENTIFIED: 1. 100% audit/review was completed to ensure all physicians' orders had been completed per MD instructions as required. Clarification orders were obtained as needed. C. MEASURES TAKEN: 1. All Nurses' was educated/in-serviced to facility policy in regards to completing orders from receiving the order, transcribing the order, follow up and completion of orders. The importance of accuracy with all MD orders, and the importance of follow-up with the MD's orders. D. HOW MONITORED: 1. The DON/Designee will audit/review all new physician orders in the</p>	03/09/2012			

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NAME OF PROVIDER OR SUPPLIER WATERS OF MARTINSVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 2055 HERITAGE DR MARTINSVILLE, IN 46151		
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	<p>and the physician was to be notified of the results.</p> <p>Results of these accuchecks were not found in Resident #101's record. Further information was requested from the Director of Nursing (DoN) on 2/20/12 at 4:00 p.m. regarding the accuchecks ordered on 1/17/12.</p> <p>On 2/21/12 at 9:10 a.m. the DoN indicated the accuchecks ordered on 1/17/12 had not been done. She indicated the nurse who took the order had gone home sick and the order had not been processed. She indicated the physician had been notified on 2/21/12 the accuchecks had not been done.</p> <p>3.1-35(g)(2)</p>		<p>daily QA stand-up meeting for accuracy of completion. This will be an on-going process. 2. The Adm. /Designee will review all audits as completed in the monthly QA meeting with the IDT; and quarterly in the QA 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: 3-9-12</p>		