STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG THE	1350 N TODD DR SCOTTSBURG, IN 47170

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F000000	This visit was for the Investigation of Complaint IN00162067 and Complaint IN00163164. Complaint IN00162067 - Unsubstantiated due to lack of evidence. Complaint IN00163164 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309. Survey dates: January 21, 22 and 23, 2015 Facility number: 000478 Provider number: 155494 AIM number: 100290430 Survey team: Gloria J. Reisert, MSW/TC Jennifer Sartell, RN Census bed type: SNF/NF: 81 Total: 81 Census payor type: Medicare: 14 Medicaid: 61 Other: 6 Total: 81 Sample: 8	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	This deficiency also reflects State findings in accordance with 410 IAC 16.2-3.1. Quality review completed on January 30, 2015, by Brenda Meredith, R.N.			
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview and record review, the facility failed to initiate neurological assessments on 1 of 6 residents reviewed for resident to resident altercations and 1 of 2 residents reviewed for falls. (Resident #D and #B) Findings include: 1. The Clinical Record for Resident #D was reviewed on 1/22/15 at 9:00 a.m. The diagnoses included, but were not limited to dementia with behavior	F000309	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. - F309 – Provide Care/Services for highest well being	02/10/2015

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	disturbances, depression, anxiety and insomnia. The Minimum Data Set assessment, dated 11/6/14, indicated Resident #D was extensive assist of 2 with transfers, dressing and bed mobility. The Nurses Note, dated 1/9/15 at 01:30 (1:30 a.m.), included, but was not limited to the following: "QMA [Qualified Medical Assistant] entered resident room, upon approaching resident, resident was noted to have a laceration above right eye and bruising to right eye and nose. This nurse asked resident what happened, and resident state ? [sic] the man kept hitting me.? [sic] This nurse asked resident what man? And resident state ? [sic] the black man.? [sic]...Resident injuries cleaned...." Resident #D was sent to the emergency room for evaluation. The Nurses Note, dated 1/10/2015 at 04:31 (4:31 a.m.), included the following: "Resident has returned EMS [Emergency Medical Services] stretcher 2 attendants. New orders of hydrocodone 7.5 q6h [every 6 hours] prn [as needed] for moderate pain and Ceftin 250mg [milligrams] BID [twice daily]. Noted		*Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.* *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* Head to toe assessment, including neuro checks completed on Resident #D with no negative outcomes related to this deficiency. Resident #B was d/c'd before this survey was completed and resides in an assisted living facility. Resident #B's condition at time of transfer was stable with no negative outcomes from the fall. *How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?* 100% audit of all residents with a fall and/or head injury, in the last 30 days, was completed with no others identified.	

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	transcribed and faxed to pharmacy...." The Nursed Note, dated 1/10/2015 at 04:35 (4:36 a.m.), indicated the following: "Report from ER [emergency room] nurse noted Right Sinus Fx [fracture]." The hospital records for Resident #D, dated 1/10/15, indicated the following: "...Impression: 1...Fractures of the bilateral frontal processes of the maxilla are noted with slight leftward deviation. 2. Questionable nondisplaced small fracture of the medial wall of the right maxillary sinus...." During an interview with the Director of Nursing, on 1/22/15 at 11:30 a.m., she indicated a neurological assessment was not initiated for Resident #D because he was was sent to the hospital and a CT [computed tomography] was done. She also indicated Resident #D did not come back from the hospital with orders for neuro (neurological) checks. On 1/22/15 at 1:15 p.m., Resident #D was observed resting in bed with deep		*What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?* The IDT team will perform a review with each fall/head injury to ensure neuro checks were started, during the IDT/Clinical meetings following the fall/head injury as they occur and as warranted. All nurses to be educated on the guidelines of neuro assessments per policy, to include all unwitnessed falls to automatically have neuro checks started. *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?* The DON or designee will audit all falls/head injuries for 6 months or until 100% compliance achieved for 30 consecutive days. These measures will be reviewed and addressed accordingly based on daily and quarterly QA meetings.	

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	purple bruising around his eyes, right side of nose, forehead and right outer cheek. The Policy and Procedure for Head Injuries/Neurological Assessment, dated 7/1/11, was provided on 1/22/15 at 9:25 a.m. by the Director of Nursing. It included, but was not limited to the following: "Guideline: Assessments are to be done when it is suspected or known that a resident has had a blow to the head. Responsibility: All Licensed Nursing Personnel Procedure: Monitor the resident for 24 hours as indicated below: 1...2...Neurological signs as indicated below: BP [blood pressure] & P [pulse] q [every] 15 minutes x [times] 4; check pupils; BP [blood pressure] & P [pulse] q [every] 30 minutes x [times] 2; check pupils; Complete vital signs and neurological signs q [every] 4h [4 hours] x 24hrs [24 hours]...4. Utilize Neurological Assessment form to document findings...." 2. The Clinical Record for Resident #B was reviewed on 1/21/15 at 11:00 a.m. The diagnoses included, but were not limited to, psychosis, anxiety and			

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	dementia with behavior disturbances. The Minimum Data Set assessment, dated 12/5/14, indicated Resident #B was supervision with assist of 1 with transfers and ambulation. The Nurses Note, dated 12/24/14 at 11:46 a.m., included, but was not limited to the following: "Therapy found resident lying on back with legs bent and feet flat on floor in another res [resident] room. Res [resident] was lying by the bathroom door. The other res [resident] in the room reported that the res [resident] entered the room and attempted to hit himself and roommate. Res [resident] was redirected to room by staff. Res [resident] in room stated that this res [resident] did not hit either one of them...New order received [sic] to send res [resident] out to [facility name] d/t [due to] behaviors." The document titled "Fall" included, but was not limited to the following: "...Incident Description Nursing Description: Therapy found resident lying on back with legs bent and feet flat on floor in another res [resident] room. Res [resident] was lying by the bathroom			

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	door. The other res [resident] in the room reported that the res [resident] entered the room and attempted to hit himself and roommate. Res [resident] was redirected by staff. Immediate Action Taken Description: Resident was assessed head to toe...Dr [Doctor] made aware and psyc [psychiatric] called new orders to send res [resident] out d/t [due to] behaviors. Res [resident] was redirected several times...." The IDT (Interdisciplinary Team) note, dated 12/26/14 at 09:39 (9:39 a.m.), included, but was not limited to the following: "...IDT met and reviewed res [resident] fall and altercation from 12/23 [sic]...Res [resident] #F attempted to assist res [resident] to doorway and show her the way out of room, as residents approached doorway, Resident #F stated res [resident] eyes rolled back into residents head and then fell backwards to floor. Staff assessed res [resident] and found no injuries, and assisted res [resident] to her room to bed...." During an interview with the Director of Nursing on 1/21/15 1 p.m., she indicated when a resident has an unwitnessed fall,			

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	neurological assessments are started because it is unknown if the resident hit their head. During an interview with LPN #2, on 1/21/15 at 2 p.m., she indicated when a resident has an unwitnessed fall, neurological assessments are initiated. Resident #B's clinical record lacked documentation of neurological assessments being initiated after her fall on 12/24/14. During an interview with the Director of Nursing on 1/23/15 at 11:00 a.m., she indicated Resident #B's fall was not witnessed by staff. This Federal tag relates to Complaint IN00163164. 3.1-37(a)			