

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155217	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/10/2015
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NAME OF PROVIDER OR SUPPLIER  WATERS OF HUNTINGBURG, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00185098.</p> <p>Complaint IN00185098: Substantiated, no deficiencies related to the allegation are cited.</p> <p>Survey dates: November 4, 5, 9, 10, 2015</p> <p>Facility number: 000122 Provider number: 155217 AIM number: 100290560</p> <p>Census bed type: SNF/NF: 68 Total: 68</p> <p>Census payor type: Medicare: 8 Medicaid: 43 Other: 17 Total: 68</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on</p>	F 0000		

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

TITLE

(X6) DATE

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

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F 0258 SS=D Bldg. 00	<p>11/17/15.</p> <p>483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. Based on observation, interview, and record review, the facility failed to ensure comfortable sound levels were maintained at the facility in regard to a resident observed talking loudly and counting out loud repeatedly for 3 of 4 survey days.(Resident #17)</p> <p>Findings include:</p> <p>On 11/4/15 at 11:59 A.M., Resident #17 was observed being brought into the main dining room where a large number of residents were present for the noon meal. Resident #17 was observed chanting loudly,"1, 2, 1, 2, right over there, go over there, right there, they don't have no g-- d--- business in there, 1, 2." Resident would briefly stop chanting and then repeat, "If you don't hurry up you ain't going to have no g-- d--- thing on. 1, 2, 1, 2, ... Resident #17 stopped chanting at 12:20 P.M.</p> <p>On 11/4/15 at 11:04 A.M., during</p>	F 0258	<p>Preparation and/or execution of this plan of correction ingeneral, or this corrective action in particular, does not constitute anadmission of agreement by this facility of the facts alleged or conclusions setforth in this statement of deficiencies. The plan of correction and specificcorrective actions are prepared and/or executed in compliance with state andfederal laws.</p> <p><b>The facility respectfully requests paper compliance for thiscitation.</b></p> <p>F-258</p> <p>It is the policy of thisfacility to provide a safe, comfortable homelike environment. This includes "noise control."</p>	12/10/2015

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	<p>interview with Resident #58, she indicated Resident #17 counts out loud 1, 2, 3, repeatedly in the dining room and it drives me crazy. Resident #58 indicated she wish the staff would feed Resident #17 somewhere else. Resident #58 indicated residents eating in the dining room don't want to hear counting out loud continually while eating. Resident #58 also indicated Resident #17 curses while at the dining room table. Resident #58 indicated Resident #17 takes her meals in the main dining room every day. Resident #58 indicated she knew of 1 female resident not eating in the facility dining room anymore but eats in her room due to Resident #17's loud talking and chanting.</p> <p>During interview with Resident #35 on 11/5/15 at 10:29 A.M., she indicated, Resident #17 was "very loud." Resident #35 indicated, Resident #17 talks very loudly to her doll. Resident #35 also indicated, Resident #17 talks loudly at meal times and the loud talking bothers other residents also.</p> <p>On 11/9/15 at 11:17 A.M., Resident #17 was observed in her room in her wheelchair with her room door open. Resident #17 was heard down the hall area counting loudly 1, 2, repeatedly.</p>		<p>Resident #17 does notchant repeatedly and/or swear loudly to the disturbance of other residents. Resident #17 has been reassessed as far as behaviors. Resident #17 has also had their meds reviewed. She has also had her care plan reviewed and updated. Non-pharmacological interventions are being used as much as possible to control/manage Resident #17's behaviors. Other residents as well as Resident #17 are currently enjoying a quiet, comfortable environment with a homelike atmosphere including acoustics.</p> <p>Residents who reside in the facility and who are able to hear have the potential to be affected by this finding. The DON/Designee/SSD will interview all interviewable residents to get a baseline of residents who have a concern with noise/loudness in the facility. These residents will be assured that any</p>	

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	<p>On 11/9/15 at 1:55 A.M., Resident #17 was observed in bed with her room door open. Resident #17 at that time was chanting 1, 2, loudly repeatedly counting over and over.</p> <p>On 11/9/15 at 4:50 P.M., Resident #17 was observed in her wheelchair sitting in the 100 unit lounge area, counting 1, 2, out loud repeatedly. Two other residents were observed sitting in the lounge area. The counting was heard at the 100 unit nurses station and the lounge area hall way.</p> <p>On 11/10/15 at 8:39 A.M., Resident #17 was observed in her room with her room door open. Resident #17 was observed chanting 1, 2, repeatedly. The counting was heard down the hall area outside Resident #17's room and at the 100 unit nurse's station.</p> <p>On 11/10/15 at 12:00 P.M., during interview with Resident #88, Resident #88 indicated Resident #17's counting was "driving me crazy." Resident #88 indicated, she hadn't been sleeping well due to Resident #17's frequent loud counting. Resident #88 indicated Resident #17's loud talking bothered her roommate also.</p> <p>On 11/10/15 at 12:10 P.M., Resident #17</p>		<p>disturbing sound concerns willbe addressed. Of the residents who aretargeted as having concerns with "noise levels," 10 (various residents on the list) will beinterviewed 3 days weekly by the DON/Designee/SSD to see if they feel noiselevels are being controlled and are acceptable. Resident Council minutes will be reviewed monthly for any concerns withnoise. Any concerns will be investigatedand addressed as discovered. Thismonitoring will continue until 4 consecutive weeks of zero negative findingsare achieved. Afterwards, interviewswill be conducted weekly for a period of not less than 6 months to ensurecompliance. After that, monitoring willoccur randomly. At an inservice held forall staff on December 8th and 9th, the following was reviewed:</p> <p>A. Resident's Rights</p>	

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	<p>was observed sitting in the main facility dining room for the noon meal. Resident #17 was heard counting 1, 2, repeatedly thru out the dining room and into the hall way area leading into the dining room.</p> <p>On 11/10/15 at 3:10 P.M., the Administrator was made aware of residents at the facility voicing a problem with uncomfortable sound levels in regard to Resident #17's frequent chanting and loud talking. The Administrator at that time indicated he was aware of the problem.</p> <p>On 11/10/15 Resident #17's clinical record was reviewed. Resident #17's current admission date was 5/8/14. Her diagnoses included but were not limited to: dementia with behavior disturbance, psychosis, agitation, and anxiety. The most recent Quarterly MDS (Minimum Data Set) assessment dated 10/19/15, indicated Resident #17 experienced moderate cognitive impairment.</p> <p>Nursing progress notes dated, 11/5/15 at 11:13 A.M., 11/6/15 at 11:15 A.M., and 11/9/15 at 11:08 A.M., indicated, "... Late Entry: Note Text: [Resident #17's name] was yelling out..."</p> <p>3.1-19(f)</p>		<p>B. Homelike Environment</p> <p>C. Noise Sources</p> <p>D. What to do if a resident complains of noise</p> <p>E. CQI Agenda/Morning Meeting/Discussion of Concerns</p> <p>Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated.</p> <p>At the monthly QA meetings the results of the monitoring will be reviewed. Any patterns will be addressed via an Action Plan written by the committee. The Action Plan will be monitored weekly by the Administrator until resolution.</p>	

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F 0323 SS=E Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure, residents at risk to experience falls were provided with adequate supervision and effective interventions to prevent falls for 4 of 6 residents who met the criteria for review of accidents. (Resident #10, Resident #87, Resident #64, Resident #23)</p> <p>Findings include:</p> <p>1. On 11/4/15 at 12:20 P.M., Resident #10 was observed sitting in the dining room eating lunch. Resident #10 was then observed to rise from a stationary chair, travel through the dining room toward the hallway without a walker, without assistance or supervision.</p> <p>The clinical record of Resident #10 was</p>	F 0323	<p>Preparation and/or execution of this plan of correction ingeneral, or this corrective action in particular, does not constitute anadmission of agreement by this facility of the facts alleged or conclusions setforth in this statement of deficiencies. The plan of correction and specificcorrective actions are prepared and/or executed in compliance with state andfederal laws.</p> <p><b>The facility respectfully requests paper compliance for thiscitation.</b></p> <p>F-323</p> <p>It is the policy of thisfacility to provide adequate supervision and effective</p>	12/10/2015

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	<p>reviewed on 11/9/15 at 11:20 A.M. The record indicated the diagnoses of Resident #10 included, but were not limited to, heart failure, lack of coordination, difficulty with walking, anxiety disorder, dementia with behavioral disturbance, legal blindness, history of healed traumatic fracture, and muscle weakness. The record further indicated, Resident #10 was re-admitted to the facility on 10/6/15 after a hospitalization.</p> <p>The Re-Admission MDS (Minimum Data Set) assessment dated 10/06/15 indicated Resident #10 experienced cognitive impairment, behaviors which did not put the resident at significant risk for physical injury, and occasionally rejected care. The MDS further indicated, Resident #10 experienced unsteadiness during transitions/walking, required assistance to stabilize balance, had a history of falls, and had experienced two or more falls since admission.</p> <p>An undated Interim Care Plan for, "Risk for additional fall" included interventions of, "Call light in reach, orient to new surroundings and to staff, Reinforce [sic] safety awareness"</p> <p>A Historical Care Plan for History of Falls dated 9/22/15 indicated fall</p>		<p>intervention to prevent falls as much as possible. Residents #10, #87, #64 and #23 have been reassessed for falls. The IDT (Inter Disciplinary Team) has met and the care plans of these residents have been reviewed and updated with appropriate interventions to prevent falls. These residents have necessary supervision and needed assistance to prevent falls. The CNA instructions include any needed assistance which they are to provide.</p> <p>Any resident who resides in the facility has the potential to be affected by this finding. A "look back" audit has been completed at which time a comprehensive falls assessment was completed for all residents. The IDT has met and all care plans have been reviewed and updated based on the findings of the assessments. Further, CNA information as to their</p>	

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	<p>interventions of, "...non-skid strips placed on sides of bed...call light in reach...encourage to ask for assist with transfer or ambulation prn [as needed]...keep paths free of clutter...therapy screen quarterly and prn..."</p> <p>A Physical Therapy Progress Note dated 9/30/15 indicated Resident #10 experienced, "...Impairments: Balance deficits, Cognitive decline, Decreased coordination...Decreased safety awareness, Deficits in judgment [sic] Strength impairments..." and was a high risk to experience falls,</p> <p>A Nursing note dated 10/3/15 at 8:00 A.M. indicated, "...Order received to transport to ER [Emergency Room] for eval [evaluation] and tx [treatment] of bx [behaviors]..."</p> <p>A Nursing note dated 10/3/15 at 2:00 P.M. indicated, "...Return from ER...no new orders..."</p> <p>A Nursing note dated 10/3/15 at 3:30 P.M. indicated, "...Order received for...tab alarm..."</p> <p>A Nursing note dated 10/5/15 at 10:01 A.M. indicated, "...Res. [resident] legally blind ...attempts to walk around with use</p>		<p>duties and expectations has also been reviewed and updated. The Administrator/DON have reviewed the assignments to ensure that adequate supervision is in place to see that all care planned interventions can be performed. All falls will be reviewed as they happen to identify the root cause. The falls will be reviewed by the IDT daily at the CQI morning meeting following the fall. The Falls Tracking Sheet will be used to track all pertinent circumstances surrounding the fall including :</p> <ol style="list-style-type: none"> <li>1) Res. name</li> <li>2) Date/Time of fall</li> <li>3) Assessment (include neuro checks as indicated)</li> <li>4) Notifications</li> <li>5) Incident Report</li> <li>6) Investigation</li> <li>7) Root Cause</li> <li>8)</li> </ol>	

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	<p>of hands to locate where she is...has to be cued [sic] to safety..."</p> <p>A Nursing note dated 10/5/15 at 6:46 P.M. indicated, "...noticed tab alarm was unhooked and sitting on empty in room. I asked her if I could put it back on, and she said, 'I don't need that thing. Don't put it back on'..." The note lacked any documentation to indicate a new intervention was implemented or supervision was provided to ensure the safety of Resident #10.</p> <p>A Nursing note dated 10/6/15 at 7:41 A.M. indicated, "resident refused to have personal alarm in place through [sic] noc [night] shift, stated she did not need it." The note lacked any documentation to indicate a new intervention was implemented to ensure the safety of Resident #10.</p> <p>A Nursing note dated 10/6/15 9:04 A.M. indicated, "...refused personal alarm again this morning." The note lacked any documentation to indicate a new intervention was implemented to ensure the safety of Resident #10.</p> <p>A Nursing note dated 10/8/15 at 4:8/15 at 4:55 A.M. indicated, "...resident attempted to get out of bed unassisted at times..." The note lacked any</p>		<p>Rule Out Abuse</p> <p>9)</p> <p>Referrals(Hosp./Therapy etc.)</p> <p>10)</p> <p>Care plan(New interventions)</p> <p>11)</p> <p>CNA (Info./Instructions update)</p> <p>The DON/Designee will ensure that all falls are reviewed and that interventions are added as appropriate. Also, the Administrator/DON/Designee will ensure that there is supervision in place to carry out the interventions. This plan will be ongoing. Additionally, falls and pain assessments will be completed upon admission, readmission, change of condition (as indicated), quarterly as well as post fall. This will be an ongoing practice. At an inservice held _____ for nursing staff the following was reviewed:</p> <p>A.</p> <p>Falls</p>	

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	<p>documentation to indicate a new intervention was implemented or supervision was provided to ensure the safety of Resident #10.</p> <p>Fall #1: A Nursing note dated 10/8/15 at 7:46 A.M. indicated, "resident found on floor beside her bed in her room this morning..." The note lacked any documentation to indicate a new intervention was implemented or supervision was provided to ensure the safety of Resident #10.</p> <p>A Nursing note dated 10/8/15 at 7:49 A.M. indicated, "incident happened at 530 [sic] [5:30] am [A.M.]"</p> <p>A Care Plan for Falls dated 10/8/15 indicated new interventions of, "low bed...scoop mattress" were implemented. The plan lacked any documentation to indicate supervision was provided to ensure the safety of Resident #10.</p> <p>Fall #2: A Nursing note dated 10/8/15 at 7:49 A.M. indicated, "resident found on her knees beside recliner in the HS [Hope Springs] [name of unit] lounge area....1:1 [one to one] not effective..." The note lacked any documentation to indicate a new intervention was implemented to ensure the safety of Resident #10.</p>		<p>Prevention/Assessment/Root Cause</p> <p>B. Falls—Care plan interventions/Supervision</p> <p>C. Incident Reports</p> <p>D. Falls Tracking Tool</p> <p>E. Discussion</p> <p>Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. All falls will be discussed/reviewed daily at the CQI meeting as previously stated. At the monthly QA meetings any trending will be addressed. If indicated, an Action Plan will be written by the committee. The Action Plan will be monitored weekly by the Administrator until resolution.</p>	

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	<p>A Nursing note dated 10/8/15 at 10:32 A.M. indicated, "...Non compliant [sic] with calling for assist..."</p> <p>The Re-Admission Physician's Orders dated 10/16/15 included, but were not limited to, orders for, "...up with walker, up with assist..." The orders lacked any documentation related to safety/fall precautions.</p> <p>The Nursing Admission Assessment dated 10/16/15 indicated Resident #10 was, "...alert and oriented to person and place...mobility...limited assistance...walker...gait disturbance/unsteady gait..."</p> <p>A Nursing note dated 10/18/15 at 1:57 A.M. indicated, "alert and disorient X 3 has been restless and agitated..." The note lacked any documentation to indicate a new intervention was implemented or supervision was provided to ensure the safety of Resident #10.</p> <p>A Physical Therapy Evaluation and Plan of Treatment dated 10/16/15 indicated Resident #10, "...exhibits...decrease in strength...reduced ability to safely ambulate, reduced balance...safety awareness = [equals] impaired...Fall Predictors: Impulsive ambulation...Reduced insight for unsafe</p>			

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	<p>situations, Reduced proactive balance...Reduced reactive balance...the patient is at risk for falls..."</p> <p>A Physical Therapy Treatment note dated 10/17/15 indicated, "...demo [demonstrates] unsteady gait..."</p> <p>Fall #3: A Nursing note dated 10/18/15 at 7:00 A.M. indicated, "While sitting in DR [dining room] at breakfast time, resident got out of w/c [wheel chair] to get herself coffee. Resident staggered and fell backwards onto floor...Placed personal tab alarm on w/c, which resident immediately took off and threw..." The note lacked any documentation to indicate a new intervention was implemented or supervision was provided to ensure the safety of Resident #10.</p> <p>Fall #4: A Nursing note dated 10/18/15 at 9:00 A.M. indicated, " Resident yelled out from her room. Was found sitting on floor..." The note lacked any documentation to indicate a new intervention was implemented or supervision was provided to ensure the safety of Resident #10.</p> <p>During an interview on 11/09/15 at 1:59 P.M., the DON [Director of Nursing] indicated no documentation would be</p>			

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	<p>provided to indicate immediate, effective interventions were implemented or supervision was provided after the 2 falls on 10/8/15, upon the resident's return from the hospital on 10/16/15, or after the 2 falls on 10/18/15.</p> <p>2. During an interview on 11/05/2015 9:14 A.M., LPN #5 indicated Resident #87 experienced 2 falls in the previous 30 days.</p> <p>During an interview on 11/5/15 at 10:09 A.M., Resident #87 was observed sitting in a recliner, removing a pair of white shoes, and attempting to apply a pair of brown shoes. The white shoes and the brown shoes were observed not to contain any type of secondary device.</p> <p>The clinical record of Resident #87 was reviewed on 11/9/15 at 12:00 P.M. The record indicated the diagnoses of Resident #87 included, but were not limited to, weakness, mild cognitive impairment, history of falling, lack of coordination, muscle weakness, and difficulty in walking.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 8/18/15 indicated Resident #87 experienced no cognitive impairment, no history of falls, and required the limited assist of one staff</p>			

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	<p>member for locomotion off the unit and dressing.</p> <p>The most recent Quarterly MDS assessment dated 10/07/15 indicated Resident #87 experienced minimal cognitive impairment, no history of falls, and required supervision for locomotion off the unit and dressing.</p> <p>The Admission Physician's Order Recap dated 8/11/15 included, but was not limited to an order for, "...up ad lib [at liberty] w/1 [with one] assist..."</p> <p>The Admission Nursing Assessment dated 8/11/15 indicated Resident #87 experienced right leg weakness, pain, and was at risk to experience a fall.</p> <p>A Care Plan dated 8/30/15 for, "at risk for falls d/t [due/to] history of or recent fall" included interventions of, "attempt to keep areas free of clutter, keep call light in reach, notify and update MD [Physician] as needed, Therapy screen as indicated, quarterly and prn."</p> <p>A Physical Therapy Treatment Encounter Note dated 9/18/15 indicated, "...Pt [patient] dem [demonstrates] occ [occasional] episodes of tripping over RLE [Right lower extremity] toes during swing through phase due to...weakness..."</p>			

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	<p>A Fall Risk Assessment dated 10/2/15 indicated Resident #87 experienced no cognitive or gait impairment and was not at risk to experience a fall.</p> <p>A Physical Therapy Treatment Encounter Note dated 10/5/15 indicated, "...cues to increase step/stride length and foot clearance bilaterally to reduce shuffling gait and decrease fall risk. Pt [patient] with episodes of tripping over RLE foot during swing phase due to weak...pt not wishing to wear RLE AFO [ankle foot orthotic] at this time..."</p> <p>A Nursing Assist Pocket Worksheet provided by the DON (Director of Nursing) on 11/4/15 at 9:00 A.M. indicated Resident #87 required the assistance of one staff member for transfers and lacked any documentation related to fall risk interventions.</p> <p>Fall #1: A Fall Detail Report dated 10/11/15 at 12:20 P.M. indicated, "Resident in main dining, et [and] appeared to trip over own feet et did not hit head according to witness...appears to be a [sic] slightly embarrassed (sic) et a little shaky, w/c [wheel chair] provided for residents [sic] safety...description of action: alert and ambulatory without staff assistance...using walker proper footwear</p>			

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	<p>(sic)..." The detail report included a notation of, "...has an insert for...right foot...does not always wear this...has lack of coordination and loss of balance...staff will be instructed to put insert on while up and during the day..."</p> <p>A Nursing note dated 10/11/15 at 12:38 P.M. indicated, "...in main dining, et appeared to trip over own feet et did not hit head according to witness..." The note lacked any documentation to indicate a new intervention was implemented or supervision was provided to ensure the safety of Resident #87.</p> <p>A Physical Therapy Treatment Note dated 10/13/15 indicated, " Pt [patient] continues to demo [demonstrate] episodes of tripping over RLE, pt unwilling to don RLE AFO at this time..."</p> <p>A Care Plan for Falls dated 10/15/15 included an intervention of, "Make sure she has foot drop insert in shoe to help increase [sic] risk of tripping."</p> <p>The November 2015 Physician's Order Recap included, but was not limited to, an order for, "...up ad lib with 1 assist..."</p> <p>Fall #2: A Nursing Note dated 11/2/15 at</p>			

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	<p>5:34 P.M. indicated, "Resident LOA [leave of absence] with family this day. family reported to this nurse, resident fell..."</p> <p>An untimed Fall Detail report dated 11/2/15 indicated, "...fell with family..."</p> <p>During an interview on 11/9/15 at 2:30 P.M., LPN #5 indicated she was not aware Resident #87 required the use of an shoe insert or any type secondary shoe device and was not aware of any safety interventions for Resident #87.</p> <p>During an observation on 11/9/15 at 2:35 P.M. Resident #87 was observed ambulating independently with a walker from the bathroom to a personal recliner, wearing non-skid socks. During an interview, at that time, Resident #87 indicated he/she did not wear a shoe insert or any type of secondary device.</p> <p>During an interview on 11/9/15 at 3:00 P.M., LPN #5 indicated Therapy staff had tried a shoe insert in the past, but Resident #87 had refused and the insert had been discontinued at an unknown time.</p> <p>During an interview on 11/9/15 at 5:00 P.M., the DON indicated no documentation would be provided to</p>			

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	<p>indicate an immediate intervention had been implemented or supervision had been provided to prevent further falls after the fall on 10/11/15.</p> <p>3. During a continuous observation on 11/04/2015 from 9:10 A.M. through 9:35 A.M., Resident #64 was observed sitting by himself/herself in a common lounge, in front of a television with eyes closed.</p> <p>During an interview on 11/05/2015 09 A.M. , LPN #5 indicated Resident #64 had experienced one fall in the previous 30 days.</p> <p>The clinical record of Resident #64 was reviewed on 11/9/15 at 8:50 A.M. The record indicated the diagnoses of Resident #64 included, but were not limited to, Alzheimer's disease, muscle weakness, difficulty in walking, lack of coordination, hemiplegia [paralysis], hemiparesis [weakness], and gait/mobility abnormality.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 8/11/15 indicated Resident #64 experienced severe cognitive impairment, required the extensive assistance of two staff for transfers, and had no history of falls.</p> <p>The most recent Quarterly MDS dated</p>			

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	<p>9/30/15 indicated Resident #64 experienced moderate cognitive impairment required to total assistance of two staff for transfers and had no history of falls.</p> <p>A Nursing Admission Assessment dated 8/4/15 indicated Resident #64 was oriented to person and place.</p> <p>A Fall Risk Assessment dated 8/4/15 indicated Resident #64 was at risk to experience a fall.</p> <p>A Care Plan for "at risk for fall d/t history or recent fall" dated 8/6/15 included the following interventions: "attempt to keep areas free of clutter, keep call light in reach, move bed with right side against the wall, therapy screen as indicated quarterly and prn [as needed], and notify and update MD [physician] as needed."</p> <p>Fall #1: A Fall Detail Report dated 8/6/15 at 3:00 A.M. indicated, "Heard resident yelling...CNA entered room to see resident off edge of bed on the right side legs wedged into air conditioner, I moved bed away from him while CNA lowered resident to the floor...resident description: 'The cleaning woman told me she'd turn the light on for him!'...immediate action taken assesed (sic) ROM [range of motion]...WNL</p>			

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	<p>[within normal limits]...got resident up with [brand name of mechanical lift]...noted a small puncture area on right leg below knee...impaired memory ...confused...gait imbalance...decrease [sic] safety awareness...admitted within the last 72 hours...incident during unassisted self transfer from bed... improper footwear (sic)..." The note lacked any documentation to indicate an immediate new intervention was implemented or supervision was provided to prevent further falls.</p> <p>A Nursing note dated 8/6/15 at 9:57 A.M. indicated, "Resident started to slide off right side of bed and legs were wedged between side of bed and air conditioner, small puncture area just below right knee..." The note lacked any documentation to indicate an immediate new intervention was implemented or supervision was provided to prevent further falls.</p> <p>An untimed Nursing Fall note dated 8/6/15 indicated Resident was calling out. CNA went to check on resident and he was between air conditioner and bed...Root cause-Resident exited bed wrong side... Intervention bed moved with right side against wall. Bed alarm placed MD and family notified. The note lacked any documentation to indicate an</p>				

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	<p>immediate effective intervention was implemented or supervision was provided to prevent further falls.</p> <p>A Care Plan for "at risk for fall d/t history or recent fall" dated 8/12/15 included the following interventions: "bed placed up against wall, education provided per therapy on importance of using call light"</p> <p>A Quarterly Fall Risk Assessment dated 9/1/15 indicated Resident #64 experienced no falls in the previous 3 months and balance problems.</p> <p>Fall #2: A Fall Detail Report dated 10/14/15 at 12:59 A.M. indicated, "...found on floor kneeling on floor by bed by CNA who summoned nurse and 2 other CNA's no obvious sign of injury resident assisted to bed with 4 assist...no injuries...impaired memory...confused...decreased safety awareness...incident during unassisted self transfer from bed...bed in lowest position..." The note lacked any documentation to indicate an immediate new intervention was implemented or supervision was provided to prevent further falls.</p> <p>A Nursing note dated 10/14/15 at 1:24 A.M. indicated, "...Resident found kneeling on floor by CNA nurse and 2</p>			

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	<p>other CNA's summoned to room..." The note lacked any documentation to indicate an immediate new intervention was implemented or supervision was provided to prevent further falls.</p> <p>An untimed Fall note dated 10/14/15 indicated, "A bruise noted on the top of his head. Neuro checks started... will move nightstand away from bed and place a mat beside bed. He had been more condused (sic) lately. Recently had a u/a [urinalysis] and labs and all was noted within normal ranges...does have a dx [diagnosis] of renal failure."</p> <p>A Care Plan for "at risk for fall d/t history or recent fall" dated 10/14/15 included the following interventions: "move night side table away from bed, put mat of floor beside bed"</p> <p>During an interview on 11/10/15 at 2:00 P.M., the DON indicated no documentation could be provided to indicate immediate interventions to prevent further falls were immediately implemented or supervision was provided after the fall on 8/6/15 and 10/14/15.</p> <p>During an interview on 11/10/15 at 4:30 P.M., The DON (Director of Nursing) indicated the untimed Fall notes were</p>			

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	<p>written after an interdisciplinary team meeting was held, usually the following morning after the fall. The DON then indicated, interventions were implemented after the meeting. The DON further indicated immediate, effective interventions or supervision should be provided after a resident experiences a fall.</p> <p>4. Resident #23 was observed on 11/9/15 at 9:03 A.M. sitting alone in his/her room in the wheelchair. Resident #23 had the right side of the wheelchair pulled up against the bedside. On 11/9/15 at 9:46 A.M., Resident #23's chair alarm started sounding. CNA #12 responded to Resident #23's alarm. During the first attempt to transfer Resident #23, CNA #12 locked the left wheel of the wheelchair and attempted to assist Resident #23, lifting the resident with the gait belt, to a partial standing position, and instructed the resident to grasp the walker. Resident #23 was unable to grasp the walker handles or achieve a standing position and, in an uncontrolled manner, started to sit back in the wheelchair. The brake on the right side of the chair was not locked and the wheelchair started to push away from him as he lowered to the seat. On the second attempt to transfer Resident #23 by herself, CNA #12 removed the walker</p>			

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	<p>and was observed to pull the resident from the seat surface of the chair using the gait belt. With no assistance from the resident, CNA #12 pivoted the resident with his feet twisted and placed Resident #23 on the edge of the bed and attempted to scoot him back. Resident #23 yelled out several curse words as he landed on the bed. CNA #12 then lifted Resident #23's legs onto the bed and scooted him into position. During an interview at that time, CNA #12 indicated Resident #23 was supposed to be transferred with the assistance of 1 or 2 staff. CNA #12 said, "Today he probably needed 2."</p> <p>The clinical record of Resident #23 was reviewed on 11/9/15 at 10:00 A.M. The record indicated Resident #23 was admitted on 8/5/15 with diagnoses including, but not limited to, Alzheimer's disease, CVA (Cerebral Vascular Accident).</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 8/3/15 and 9/13/15 indicated Resident #23 experienced severe cognitive impairment, required the assistance of 2 staff with transfers, was always incontinent and required the assistance of 2 staff for toileting.</p> <p>A Care Plan for falls initiated on 8/12/15 read as follows:</p>			

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	<p>"...Interventions/Tasks...do not leave resident in room unattended, unless asleep and check frequently. Date initiated: 8/12/15..."</p> <p>An undated "Nursing Assistant Pocket Worksheet" (CNA assignment sheet) provided by the Director of Nursing on 11/4/15 at 11:00 A.M., documented that Resident #23 needed the assistance of 2 staff for transfers, but it lacked documentation that Resident #23 was not to be left in room unattended.</p> <p>A second undated "Nursing Assistant Pocket Worksheet" (CNA assignment sheet) was provided by the Director of Nursing on 11/9/15 at 9:00 A.M., which documented that Resident #23 needed the assistance of 2 staff for transfers, but it also lacked documentation that Resident #23 was not to be left in room unattended.</p> <p>Fall #1 The Progress Notes dated 8/7/15 at 6:15 P.M. indicated that Resident #23 experienced an unwitnessed fall and the notes read as follows: "...Res (resident) found sitting on floor with back leaning against wall. Skin tear right elbow and right wrist..." The Falls Care Plan and the nurses' notes lacked documentation that Resident #23 had an immediate intervention to ensure his safety.</p>			

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	<p>Fall #2 The Progress Notes dated 8/9/15 at 9:00 A.M. indicated, Resident #23 experienced an unwitnessed fall and the notes read as follows: "...Resident found on floor of room...injury only noted that skin tear area from previous fall was bleeding..." The Falls Care Plan and the nurses' notes lacked documentation that Resident #23 had an immediate intervention to ensure his safety.</p> <p>Fall #3 The Progress Notes dated 8/11/15 at 10:00 P.M. indicated Resident #23 experienced an unwitnessed fall and the notes read as follows: "...Called to unit per CNA. Res (resident) sitting on buttocks on floor in front of w/c. When asked what happened res stated "I wanted to get up..."no injuries noted..." The Falls Care Plan and the nurses' notes lacked documentation that Resident #23 had an immediate intervention to ensure his safety.</p> <p>Fall #4 The Progress Notes dated 8/18/15 at 7:25 A.M., indicated Resident #23 experienced an unwitnessed fall and the notes read as follows: "...Resident yelling out. Entered room and resident found lying on floor on right side...No injuries noted...Resident was incontinent of urine...Resident not to be in room unattended unless asleep..." The Falls</p>			

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NAME OF PROVIDER OR SUPPLIER  WATERS OF HUNTINGBURG, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542
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(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>Care Plan documented Resident #23 was not to be left in room unattended unless asleep.</p> <p>Fall #5 The Progress Notes dated 8/29/15 at 9:42 A.M., indicated Resident #23 experienced an unwitnessed fall and the notes read as follows: "...At 6:20 this am. resident seen sitting on the floor in front of the couch, in the lounge of Hope Springs...no injuries noted..." The Falls Care Plan and the nurses' notes lacked documentation that Resident #23 had an immediate intervention to ensure his safety.</p> <p>Fall #6 The Progress Notes dated 9/23/15 at 6:20 A.M., indicated Resident #23 experienced an unwitnessed fall and the notes read as follows: "...resident yelling out at aprox (approximately) 0330, this nurse went into...room and resident sitting on floor beside bed on buttocks...skin tear on right outer palm of hand measuring 1.7 X 1.0 cm (centimeters) ...right knee abrasion measuring 2 X 2.4 cm...purple bruising noted to right first digit measuring 3.7 X 1.4 cm right foot 2nd toenail loose and bleeding...pt was unable to tell this nurse why...was getting up..." The Falls Care Plan and the nurses' notes lacked documentation that Resident #23 had an immediate intervention to ensure</p>			

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	<p>his safety.</p> <p>Fall #7 The Progress Notes dated 10/25/15 at 5:53 A.M. indicated Resident #23 was being transferred by staff and the notes read as follows: "...resident lowered to floor d/t resident unable to assist with staff assisted pivot transfer to w/c from bed d/t resident's increased weakness during bed check..." The Falls Care Plan and the nurses' notes lacked documentation that Resident #23 had an immediate intervention to ensure his safety.</p> <p>A Progress Note dated 10/25/15 at 8:15 P.M. read as follows: "...Transfers becoming more difficult, as resident does not appear to comprehend the process of standing up. Most support now depends on the person (s) assisting the resident with movement from bed to chair, or from any one sitting location to another..."</p> <p>Fall #8 The Progress Notes dated 11/1/15 at 10:12 A.M. indicated Resident #23 experienced an unwitnessed fall and the notes read as follows: "...RESIDENT FOUND ON FLOOR WITH CHAIR ALARM SOUNDING AND NEXT TO HIS WHEELCHAIR. HE WAS FOUND TO BE INCONTINENT OF URINE AT THE TIME OF FALL. ASSESSED FOR</p>			
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	<p>INJURIES AND NONE FOUND..." The Falls Care Plan and the nurses' notes lacked documentation that Resident #23 had an immediate intervention to ensure his safety.</p> <p>Fall #9 The Progress Notes dated 11/1/15 at 10:12 A.M. indicated Resident #23 experienced an unwitnessed fall and the notes read as follows: "...He needs constant (sic) supervision from staff as is unsafe and will try to transsfer (sic) himself...he fell to floor in dining room while trying to leave area. He struck his head on right side causing a small abrasion and bump and discoloration to that area. He reopened old tear to right elbow area and has ffour (sic) new ones to his fingers and right hand as well as index finger left hand. Order received to send to (name of hospital) E-room for evaluation and treatment..."</p> <p>The "Fall Program Guidelines" dated 5/2013 were provided on 11/10/15 at 11:42 A.M., and read as follows: "...6. Resident's identified as a fall risk will have an individual care plan to address the contributing factors that place them at risk, goals to prevent falls/injuries, and interventions/ approaches to promote safety of the resident."</p> <p>During an interview on 11/10/15 at 3:01</p>			

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	<p>P.M., CNA #13 indicated she did not have a CNA assignment sheet, but CNA #13 indicated that all residents on the 200 hall were to be transferred with 1 or 2 staff. CNA #13 further indicated that on some days residents needed one staff member and other days residents needed 2 staff members for transfer. CNA #13 said, "You would know how many it takes to transfer them after you've tried to stand them up." At that time, CNA #13 referred to Resident #23 (who was sitting in the hall near CNA #13) and said, "Like Resident #23, on somedays it takes one to transfer him and on other days it takes two to transfer him."</p> <p>During an interview on 11/10/15 at 10:38 A.M., the Director of Nursing indicated that Resident #23 should be transferred with the assistance of 2 staff members and should not be left unattended in his room.</p> <p>3.1-45(a)(2)</p>			