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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155275 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 06/08/2015 |
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| NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE | STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670 |
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| F 0000 Bldg. 00 | <p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00170040.</p> <p>Complaint IN00170040 - Substantiated. Federal/State deficiencies related to the allegations are cited at F312 and F364.</p> <p>Survey dates: May 27, 28, June 1, 2, 3, 4, & 8, 2015.</p> <p>Facility number: 000175 Provider number: 155275 AIM number: 100274440</p> <p>Census Bed Type: SNF/NF: 73 Total: 73</p> <p>Census Payor Type: Medicare: 12 Medicaid: 50 Other: 11 Total: 73</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> | F 0000 | | |
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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 0157 SS=D Bldg. 00 | <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure a family was notified of a resident's change in</p> | F 0157 | Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an | 07/08/2015 |

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| | <p>medications in 1 of 29 residents reviewed in the Stage 2 sample. (Resident B)</p> <p>Findings include:</p> <p>During an observation on 5/28/15 at 10:45 a.m., Resident B was observed to be sitting in a wheelchair in the dining room. Resident B was observed to be holding a toy. Resident B appeared to be confused.</p> <p>During an interview on 5/28/15 at 5:07 p.m., Resident B's daughter indicated Resident B had a medication dosage changed but the family was not notified for 3 (three) days.</p> <p>The clinical record for Resident B was reviewed on 6/1/15 at 12:19 p.m. The clinical record indicated Resident B had diagnoses including, but not limited to, dementia with behavioral disturbances, psychosis, anxiety state, and hypertension. An annual MDS (Minimum Data Set) assessment, dated 5/26/15, indicated Resident B had a BIMS (Brief Interview for Mental Status) assessment by the nursing staff of severe cognitive impairment.</p> <p>A care plan for agitation and/or anxiety, dated 5/21/15, indicated the family was to be notified of changes.</p> | | <p>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. Facility is requesting paper compliance for all deficiencies in this POC. F-157D Notify of Changes (injury/decline/room/etc.) As stated in the 2567, Resident B's family is now aware of the medication orders for Resident B from both 4/14/15 and /14/15. Residents who reside in the facility have the potential to be affected by this finding. Going forward, any resident who has a change in their condition as defined in Federal Guideline 157 including but not limited to a change in physical, mental or psychological status. In addition, if there is a new medication ordered or a change in a medication dose ordered, the family or responsible party will be notified of the change in a timely manner. The DON/Designee will monitor the 24 Hour Report as well as the shift to shift reports daily to identify any changes of condition. Those identified changes will be reviewed daily at the CQI meetings. Any needed notifications will be made at this time. This monitoring will be ongoing. At inservice's held</p> | | | | |

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| | <p>A physician's order, dated 4/14/15, indicated Resident B's physician had Ativan (an antianxiety medication) 0.5 mg (milligrams) 1 (one) tablet ordered for 8:00 a.m., 1:00 p.m., and 5:00 p.m.</p> <p>A nurse's note, dated 4/16/15, indicated Ativan had been started on 4/14/15. The note further indicated the family was not notified of the change of the Ativan order until 4/16/15.</p> <p>On 5/14/15, a physician's order indicated the Ativan had been decreased to 0.5 mg orally bid (twice a day) and Ativan 0.5 mg 1 tablet orally qd (everyday) prn (as needed). The nurses notes lacked documentation the family had been notified of the medication changes.</p> <p>During an interview with LPN #1 on 6/4/15 at 1:39 p.m., indicated the family should be notified immediately if there is a fall, a change in the resident's orders, and/or a change in the resident's condition.</p> <p>A policy titled, "Family/Responsible Party Notification of Change in Resident Condition," dated 2/28/12 and obtained from the DON (Director of Nursing) on 6/4/15 at 8:45 a.m., indicated a family member or responsible party would be</p> | | <p>between 6-25-15 and 7-7-15 for the nursing staff the definition of a "change of condition" as per the Federal Guidelines was reviewed including all required notifications. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. At the daily CQI meetings the results of the DON/Designee monitoring of the timely notification of "changes of condition" will be reviewed. Any patterns of concerns will be identified and reviewed. If necessary, an Action Plan will be written by the committee and reviewed weekly by the Administrator until resolved. As stated prior, this monitoring will be ongoing. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our DOC is 7/8/2015.</p> | | |

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| F 0282 SS=D Bldg. 00 | <p>notified of any change in a resident's medications and/or dosages.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 observation, interview, and record review, the facility failed to follow the written plan of care, in that, a resident was not provided with interventions for insomnia for 1 of 29 residents reviewed in the Stage 2 sample. (Resident A)</p> <p>Findings include:</p> <p>During an observation on 5/28/15 at 10:35 a.m., Resident A was observed to be lying in bed with his clothes on. The resident was restless. No music was playing and a cup of water, which was on the overbed table, was not within reach of the resident.</p> <p>The clinical record of Resident A was reviewed on 6/1/15 at 2:56 p.m. Resident A had diagnoses including, but not</p> | F 0282 | <p>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> <p>Facility is requesting paper compliance for all deficiencies in this POC. F282D Services by Qualified Person/Care Plan</p> <p>The facility's intent is to provide qualified personnel to properly follow patient care plan to provide the highest quality level of care necessary for each resident.</p> <p>Resident A receives relaxation techniques offered to help induce sleep as per his care plan. These include calming music, encouragement of deep breathing</p> | 07/08/2015 |

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| | <p>limited to osteoarthritis, dementia with behavioral disturbances, insomnia, lack of coordination, depressive disorder anxiety state, difficulty in ambulation, and hypertension. The quarterly MDS (Minimum Data Set) assessment by the nursing staff indicated Resident A had severe cognitive impairment. The MDS indicated Resident A had physical behaviors which were directed towards others and also other behavioral symptoms not directed towards others.</p> <p>A care plan for insomnia, dated 3/25/15, indicated Resident A as to have relaxation techniques offered such as music, deep breathing, and a warm drink. The care plan indicated the resident was to be encouraged to do more activities in the day and a calm, quiet setting was to be provided at bedtime.</p> <p>During an interview on 6/2/15 at 10:40 a.m., LPN #2 indicated Resident A was awake most of the night and was sleepy most of the day. Upon query, LPN #2 indicated Resident A was placed in bed after each meal for a nap. LPN #2 indicated the interventions regarding a calm, quiet setting, music, deep breathing, or a warm drink were not offered to the resident at bedtime.</p> <p>A policy, provided by the DON (Director</p> | | <p>and a warm drink. Residents who reside in the facility have the potential to be affected by this finding. There was a "look back" audit done by the IDT team at which time all care plans were reviewed to ensure that they were current and appropriate. The DON/Designee along with other members of the IDT team will review 5 care plans weekly to see that the interventions are being implemented. These reviews will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, care plans will be reviewed quarterly as per policy and all interventions will be validated as being practiced. Any discrepancies will be addressed as found. This monitoring will be ongoing. At inservice's held 6/25/15 AND 7/7/15, for all staff, the policy, concept, relevance and development of the resident care plan was reviewed and discussed. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. At the daily CQI meetings the care plans reviewed since the previous CQI will be reported upon as far as accuracy and completeness. Any patterns of care plans not having interventions carried out as planned will be addressed. The committee will make</p> | |

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| F 0309 SS=D Bldg. 00 | <p>of Nursing) on 6/4/15 at 3:30 p.m., indicated each resident will have a plan of care that will identify how the interdisciplinary team would provide care.</p> <p>3.1-35(g)(2)</p> <p>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 ensure 1 of 1 resident in a sample of 1 reviewed for dialysis, received appropriate assessment of the dialysis shunt. (Resident #25)</p> <p>The clinical record of Resident #25 was reviewed on 06/01/15 at 2:40 p.m. The record indicated the diagnoses included, but were not limited to, acute renal failure, chronic airway obstruction, diabetes, depressive disorder, hypertension, anemia, difficulty in walking, muscle weakness, lack of coordination, obesity, edema, disorder of</p> | F 0309 | <p>recommendations and the IDT team will implement and report back to the QA committee weekly until resolution. As stated previously, the care plan monitoring will be ongoing. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our DOC is 7/08/15.</p> <p>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. Facility is requesting paper compliance for all deficiencies in this POC. F309D Provide care/services for highest well being Resident #25 receives all necessary and appropriate assessment of their dialysis shunt. These assessments are</p> | 07/08/2015 | |

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| | <p>kidney/ureter, atrial fibrillation, esophageal reflux, and talipes.</p> <p>A care plan for end stage renal disease with need for dialysis 3 days a week identified interventions including, but not limited to, the following: Notify doctor and family of noted problems such as bleeding after removal of dressing, absence of bruit/thrill, decrease in physical/mental function and observe shunt site after return from dialysis.</p> <p>No consistent documentation for the assessment of the AV (arteriovenous) fistula was recorded in the treatment record or in the nurses notes.</p> <p>An observation of Resident #25 on 6/1/15 at 4:30 p.m., indicated the AV (arteriovenous) fistula for dialysis was patent to the right upper arm.</p> <p>An interview with LPN (Licensed Practical Nurse) #3 on 6/1/15 at 3:22 p.m., indicated the resident had dialysis 3 days per week.</p> <p>An interview with the DON (Director of Nursing) on 6/2/15 at 11:30 a.m., indicated that there was no assessment of the AV fistula documented.</p> <p>A policy titled "Shunt (Arteriovenous) -</p> | | <p>documented Any resident with an arteriovenous shunt has the potential to be affected by this finding. The DON/Designee will monitor 3 days weekly post dialysis to see that any resident with an arteriovenous shunt has proper assessment and the assessment is documented. Any concerns will be addressed as discovered. This will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, the monitoring will occur at least monthly ongoing. Nursing staff was inserviced between 6/25/15 and 7/7/15 on the Arteriovenous shunt policy and procedure. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. The results of the monitoring by the DON/Designee of the arteriovenous shunt assessments and the related documentation will be reviewed at the daily CQI meeting following the monitoring. Any concerns will have been addressed as found. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our DOC is 7/8/15.</p> | |

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| F 0312 SS=D Bldg. 00 | <p>Observation Of" was provided by the DON on 6/4/15 at 3:30 p.m. The procedure included, but was not limited to, the following: "Assess insertion sites for redness, swelling and drainage. Assess shunt for patency."</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review, and interview, the facility failed to provide services to maintain personal care for 2 of 3 residents reviewed for ADL (activities of daily living) care in a sample of 35 who met the criteria for cleanliness, grooming, and oral hygiene, in that, showers, grooming, and oral care were not provided. (Resident A, Resident B)</p> <p>Findings include:</p> <p>1. During an observation on 5/28/15 at 11:32 a.m., Resident A was observed lying in bed with their clothes on. The</p> | F 0312 | <p>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. Facility is requesting paper compliance for all deficiencies in this POC. F312D ADL Care Provided for Dependent Residents Residents A and B receive personal care and are kept clean, dry and comfortable. This Includes cleanliness, grooming and oral hygiene needs</p> | 07/08/2015 |

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| | <p>resident's mouth appeared to have food particles in it.</p> <p>During an observation on 5/28/15 at 1:45 p.m., Resident A was observed sitting in a wheelchair in the dining room. Resident A's hair was disheveled and the resident had facial hair present. Resident A had a dried yellow substance on the side of their chin.</p> <p>The clinical record of Resident A was reviewed on 6/1/15 at 2:52 p.m. Resident A had diagnoses including, but not limited to, osteoarthritis, dementia with behavioral disturbances, difficulty in walking, depressive disorder, anxiety state, hypertension, and insomnia. The quarterly MDS (Minimum Data Set) assessment, dated 4/14/15, indicated Resident A had a nursing assessment which indicated severe cognitive impairment. The MDS further indicated Resident A required the extensive assist of 2 (two) persons for bathing and personal hygiene.</p> <p>A CNA assignment sheet, obtained from CNA #2 on 6/2/15 at 8:19 a.m., indicated Resident A was to receive a shower 2 (two) times per week on Monday and Thursday during the day.</p> <p>A review of the bathing log, dated 5/2/15</p> | | <p>being met. Residents who are not able to carry out their own ADLs (Activities of Daily Living) have the potential to be affected by this finding. A list of these targeted residents was compiled. The DON/Designee will monitor 10 residents 3 days weekly for cleanliness and grooming needs being met. Any concerns will be addressed immediately as found. The monitoring will continue until 4 weeks of zero negative findings are achieved. Then, the monitoring will continue randomly ongoing for a period of 6 months to ensure continued compliance. At inservice's held between 6/25/15 and 7/8/15 for nursing staff, the requirement to provide all needed ADL assistance for residents unable to complete their own ADLs was reviewed. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. At the daily CQI meetings any concerns with ADL care will be reviewed, however those concerns will have been addressed as found. As stated previously, staff who fail to comply with their duties to perform ADLs as needed will be disciplined up to an including termination. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our DOC is 7/8/15.</p> | |

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| | <p>through 6/2/15, indicated Resident A had received a shower on 5/7/15, 5/14/15, 5/18/15, and 5/28/15. The bathing log lacked documentation of Resident A was refusing any showers.</p> <p>The clinical record lacked documentation for oral hygiene being offered. The clinical record further indicated Resident A had their own teeth.</p> <p>During an interview on 6/2/15 at 8:57 a.m., the DON (Director of Nursing) indicated the computer reports do not reflect the actual care the resident receives. The DON indicated if someone needed to check on the resident's oral status, then you would look in their mouth. The DON further indicated the CNAs do not have any way of documenting individual tasks.</p> <p>During an interview on 6/3/15 at 10:39 a.m., LPN #2 indicated she was unsure if Resident A had dentures. LPN #2 further indicated Resident A did not refuse showers.</p> <p>2. During an observation on 6/1/15 at 12:48 p.m., Resident B was observed to be dressed and sitting in the dining room waiting for lunch. Resident B was observed to have unkept hair and had particles of food on her teeth.</p> | | | |

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| NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE | STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670 |
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| | <p>The clinical record for Resident B was reviewed on 6/1/15 at 11:23 a.m. Resident B had diagnoses including, but not limited to, malaise, fatigue, injury to the brachial plexus secondary to dislocated left shoulder, difficulty in walking, generalized muscle weakness, lack of coordination, depressive disorder, dementia, and B-complex deficiency. The quarterly MDS (Minimum Data Set) assessment, dated 4/29/15, indicated Resident B was an assist of 2 persons for bathing.</p> <p>The CNA assignment sheet was obtained from CNA #2 on 6/2/15 at 8:19 a.m. The CNA assignment sheet indicated Resident B was to receive a shower 2 (two) times a week on Monday and Thursday evenings.</p> <p>A review of the bathing log indicated Resident B, dated 5/2/15 through 6/2/15, had received a shower on 5/4/15, 5/9/15, 5/25/15, and 6/1/15. The bathing log lacked documentation Resident B had refused any showers.</p> <p>During an interview on 6/3/15 at 10:39 a.m., LPN#1 indicated Resident B did not refuse showers. LPN #2 indicated the resident may become agitated while receiving a shower but never refused</p> | | | |

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| | <p>them.</p> <p>The clinical record lacked documentation of oral hygiene being offered or provided.</p> <p>During an interview on 6/1/15 at 2:48 p.m., LPN #2 indicated Resident B had dentures. LPN #2 indicated Resident B usually had the dentures soaked throughout the night but did not know if the dentures were cleaned during the day.</p> <p>A policy for oral hygiene, obtained from the DON (Director of Nursing) on 6/8/15 at 8:40 a.m. and dated 5/06, indicated dentures were to be kept clean and oral hygiene would be done to cleanse the mouth.</p> <p>A policy for removing facial hair, obtained from the DON on 6/8/15 at 8:40 a.m. and dated 5/06, indicated residents would be free of facial hair.</p> <p>A policy for bathing (partial bath and bed bath), obtained from the DON on 6/8/15 at 8:40 a.m. and dated 5/06, indicated a bath was to be given to cleanse and refresh the resident.</p> <p>This federal tag relates to Complaint IN00170040.</p> <p>3.1-38(a)(3)(A)</p> | | | |

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| F 0329 SS=D Bldg. 00 | <p>3.1-38(a)(3)(C)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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 observation, interview, and record review, the facility failed to ensure 1 of 5 residents reviewed for unnecessary medications was free of unnecessary medications, in that, a psychotropic medication was administered without medical indication. (Resident #39)</p> <p>Findings include:</p> | F 0329 | 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. | 07/08/2015 |

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| | <p>Resident #39 was observed on 5/28/15 at 2:30 p.m., sitting in his room visiting with his daughter. The resident was alert and answered interview questions without difficulty.</p> <p>Resident #39 was observed on 6/3/15 at 4:30 p.m., sitting in the dining room waiting for dinner. The resident was alert, pleasant, and talkative.</p> <p>The clinical record of Resident #39 was reviewed on 6/1/15 at 4:15 p.m. The record indicated the diagnoses of Resident #39 included, but was not limited to, bullous pemphigoid, diabetes II, difficulty in walking, muscle weakness, lack of coordination, anemia, hypertension, depressive disorder, atrial fibrillation, mild cognitive impairment, esophageal reflux, and hypothyroidism.</p> <p>A physician's order dated 4/24/15, indicated Risperidone (an antipsychotic medication) 0.5 mg (milligram) by mouth at bedtime. The record lacked any medical indication for the administration of the medication.</p> <p>Behavior tracking sheets indicated that Resident #39 had no behaviors documented. An interview with the DON (director of nursing) on 6/2/15 at</p> | | <p>Facility is requesting paper compliance for all deficiencies in this POC. F329D Drug Regimen is Free from Unnecessary Drugs Resident #39 is not receiving drugs for any undiagnosed condition. The resident is on a GDR plan. Any resident on a psychoactive medication has the potential to be affected by this finding. An audit of all residents was conducted to obtain a targeted list of residents on a psychoactive medication. These residents were reviewed to determine: a. there is an appropriate diagnosis for the drug b. a GDR is attempted if indicated as possible</p> <p>The SSD will monitor and track residents who are now on or who receive an order for a psychoactive medication to see that the resident has an appropriate diagnosis and that the resident is regularly assessed/monitored for the possibility of a GDR. Behavior Management meetings will be held on a regular basis with the IDT team and the facility's provider for psych services to ensure that unnecessary drugs are not administered to residents. All staff were inserviced between 6/25/15 and 7/7/15 on the Behavior Management program and the necessity to use non-pharmacological interventions for behavior management before drugs are</p> | |

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| | <p>11:05 a.m., indicated that behaviors were documented on the tracking sheets when they occurred and that Resident #39 had no behaviors.</p> <p>The BIMS (Brief Interview Mental Status) in the most recent Quarterly MDS (Minimum Data Set Assessment) dated 5/9/15, indicated Resident #39 experienced moderate cognitive impairment.</p> <p>On 06/04/15 at 10:51 a.m., an interview with the Social Services Director indicated Resident #39 was on the antipsychotic medication for dementia and that she had questioned the doctor about the medication and he indicated it was given for dementia. She also indicated the resident had no behaviors.</p> <p>A policy titled "Behavior Management Psychotropic Medication Protocol," was obtained by the DON on 6/4/15 at 3:30 p.m. The policy included, but was not limited to, the following: "When a resident is prescribed an antipsychotic the specific clinical diagnosis for which the drug is being given must be documented in the resident's record along with documentation of how interventions alone have not been successful enough to manage the condition."</p> | | <p>used. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. The outcome of the Behavior Management meetings will be reviewed at the next following CQI meeting. Any patterns or concerns will be reviewed and the Administrator will discuss with the Medical Director. This practice will be ongoing. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our DOC is 7/8/15.</p> | | |

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| F 0364 SS=F Bldg. 00 | <p>3.1-48(a)(4)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>Based on observation, interview and record review, the facility failed to ensure food was palatable, attractive, and served at the proper temperatures, for 7 of 35 residents interviewed during Stage 1 and for 1 of 2 meal observations, in that residents complained of cold food and/or food that did not taste or look good, and hot food was checked at the end of service and was cold. This had the potential to affect all 75 residents. (Resident # 10, 27, 47, 57, 63, 72, and 84)</p> <p>Findings include:</p> <p>1. During Stage 1 interviews on 5/27/15, 5/28/15, and 6/1/15, 7 of 35 residents indicated the food was often served cold, was not good, and did not look appetizing. (Residents #10, 27, 47, 57, 63, 72, and 84)</p> | | | F 0364 | <p>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> <p>Facility is requesting paper compliance for all deficiencies in this POC. F364F Nutritive Value/Appear, Palatable/Prefer Temp Residents 10, 27, 47, 57, 63, 72 and 84 receive food that tastes and looks good and is at a palatable temperature. All residents who consume food from the dietary department have the potential to be affected by this finding. The Dietary Manager/Designee will see that food is temped and recorded prior to its being served in a dining area. This will be an ongoing practice. Further, the</p> | | 07/08/2015 |

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| | <p>2. During an interview with the Resident Council President, on 6/4/15 at 2:06 p.m., the Resident Council minutes were reviewed. The minutes indicated the residents had complained of cold food in March, April, and May, 2015.</p> <p>3. During an observation on 6/3/15 at 11:24 a.m., Cook #1 was observed to be dishing up food onto the food trays for lunch. The food trays then were placed onto a cart to be delivered to the hall residents for dining in their rooms. No temperatures of the foods had been obtained prior to placing the food onto the plates. Upon query of Cook #1, she indicated she had not taken the temperatures of the foods and proceeded to do so.</p> <p>4. During an observation on 6/3/15 at 1:00 p.m., Cook #3 was observed to be obtaining and documenting the food temperatures prior to pureeing the food. After pureeing the foods, Cook #3 was observed to place the food onto the steam table. The food was prepared for the supper meal service due to begin in three hours from the time the food had been pureed and placed on the steam table. Upon query, Cook #3 indicated he retemps the food prior to serving it. Cook #3 indicated he does not document the temperatures of the food at that time.</p> | | <p>Dietary Manager will do a test tray (last tray served in all dining areas) 3 days weekly all 3 meals. Any concerns will be addressed as found. This monitoring will continue until 4 consecutive weeks of zero negative findings are realized. Further, the Dietary Manager will request to attend the Resident Council meetings for 6 months long enough to get feedback from residents on food satisfaction. The Dietician inserviced the dietary and nursing staff between 6/25/15 and 7/7/15 on food temps and food storage guidelines per policy per policy and regulation. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. All monitoring results will be reviewed at the daily CQI meetings. Any patterns will be Identified. As needed an Action Plan will be written by the QA committee. The Administrator will review the plan weekly until resolved. After the 4 consecutive weeks of zero negative findings is achieved, ongoing random monitoring will occur at least monthly for a period of no less than 6 months to ensure ongoing compliance. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our DOC is 7/8/15.</p> | |

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| | <p>Cook #3 indicated he makes sure the food is cooked prior to serving it to the residents.</p> <p>5. On 6/3/15 at 4:25 p.m., the dementia unit hall evening meal tray cart was delivered to the unit. The dementia unit meal cart was the first cart to be served to the residents. At 4:40 p.m., the last tray was being served. A replacement tray was requested and the food temperatures from the last tray were then checked. The turkey with gravy measured 113.4 Fahrenheit, the scalloped potatoes measured 118 Fahrenheit, and the carrots measured 113.2 Fahrenheit.</p> <p>6. During record review of the food temperature log book on 6/3/15 at 1:20 p.m., food temperatures had not been recorded on 3/2/15, 3/5/15, 3/7/15, 3/10/15, 3/11/15, 3/12/15, 3/15/15, 3/16/15, 3/18/15, 3/19/15, 3/21/15, 3/30/15, 4/3/15, 4/5/15, and 6/1/15 on the evening shift.</p> <p>During an interview on 6/3/15 at 4:50 p.m.. CNA #1 indicated the food is often cold when it is received on the unit.</p> <p>Policy regarding food temperatures were not available, Retail Food Establishment book, under the 410IAC 7-24-187: Potentially hazardous food; hot and cold</p> | | | |

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| F 0371 SS=F Bldg. 00 | <p>holding, it states in sec 187 (a) " except during preparation, cooking, or cooling, or when time is used as the public health control as specified under section 193 of this rule, potentially hazardous food shall be maintained as follows: (Hot Food) (1) At on hundred thirty-five (135) degrees Fahrenheit or above ... "</p> <p>This federal tag relates to Complaint IN00170040.</p> <p>3.1-21(a)(2)</p> <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, interview, and record review, the facility failed to provide, store, distribute, and serve foods under sanitary conditions, in that, the kitchen floor had dirt and debris along the edges of the cove base and in the corners, tile was cracked and missing from the floor, a ceiling vent had debris hanging from it, walls had chipped paint,</p> | F 0371 | 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. Facility is requesting paper | 07/08/2015 |

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| | <p>food temperatures were cold, the paper towel dispenser was lacking paper towels above the handwashing sink, the back splash behind the stove was soiled, a shelf under the serving table was soiled, the freezer thermometer was missing, a bin had a scoop in it, open foods were packaged with no name or dates on them, the dishwasher had not had the temperature recorded every shift, and handwashing was not completed prior to preparing food. This had the potential to affect all 75 residents.</p> <p>Findings include:</p> <p>During an initial tour of the facility on 5/27/15 at 9:40 a.m., the kitchen and dry food storage were as follows:</p> <ol style="list-style-type: none"> 1. The floor was observed to have dirt and debris on it throughout the kitchen area and in the dry storage area. 2. The tile in the kitchen area was cracked and/or missing. 3. The edges along the cove base and in the corners had dirt and debris in them. <p>The paper towel dispenser above the handwashing sink lacked paper towels.</p> <ol style="list-style-type: none"> 4. A table used for serving trays into the dining room had a shelf under it with a dirty wet washcloth and had paint missing. 5. The area on the back of the stove was soiled with a brown substance. | | <p>compliance for all deficiencies in this POC. F371F Food Procure, Store/Prepare/Serve - Sanitary The kitchen has been cleaned/repared. Ceiling vents have been cleaned. Walls have been repaired as needed. Paper towels are available. The stove's back splash is clean. The serving table shelf is clean. The freezer's thermometer is in place. No scoops are in bins. Foods are sealed, labeled and dated when opened. The dishwasher temp is recorded each shift. All required hand washing is taking place. Dietary staff cover all of their hair. There are no soiled cloths in use or lying on top of bins. There are no cobwebs. The Administrator/Designee will monitor dietary cleaning schedules and cleaning schedules 5 days weekly until 4 consecutive weeks of zero negative findings are achieved. Any concern will be corrected as found. After the 4 consecutive weeks of compliance are achieved, random weekly monitoring will occur for at least 6 months. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our DOC is 7/8/15.</p> | | |

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| | <p>6. The flour bin in the dry storage area had a scoop stored in it.</p> <p>7. There were bowls of cereal stacked on trays on a cart in the dry storage area with the bottom of the next tray stacked on top of them with no label or date on them.</p> <p>8. The freezer thermometer was missing from the walk-in freezer.</p> <p>During an interview on 5/27/15 at 10:00 a.m., the DM (Dietary Manager) indicated the cereal was for breakfast on 5/28/15</p> <p>During an observation on 6/3/15 at 9:05 a.m., the kitchen and dry storage areas were as followed:</p> <ol style="list-style-type: none"> 1. The floors remained the same, the back of the stove remained the same, and the table continued to have paint missing. 2. There were 3 (three) bags of cake observed in the free standing refrigerator with no label or date on them. 2 (two) bags of English muffins were in the walk-in refrigerator with no label or date on them. 3. A ham was in the freezer wrapped in aluminum foil with no label or date on it. 4. A container of thickener was observed sitting next to the water/juice dispenser with no label or date on it. 5. Cook #3 was observed to have facial hair partially uncovered. 6. Cook #2 was observed with her hair | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155275 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 06/08/2015 |
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| NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE | STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670 |
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| | <p>out of her hair bonnet.</p> <p>7. Cook #1 was observed to enter the kitchen from outside, rinse her hands for 7 (seven) seconds, apply gloves and proceed to prepare food.</p> <p>8. A wet, soiled washcloth was observed lying on the top of the flour bin with a box of plastic bags on it.</p> <p>9. A rolling cart had a crack in the middle of it.</p> <p>10. An air vent located in the kitchen between the 3-compartment sink and a cart with clean pots and pans had cobwebs and dirt on it.</p> <p>11. The ceiling above the steam table had brown spots on it.</p> <p>During an interview on 6/3/15 at 3:10 p.m., the Adm (Administrator) indicated the kitchen had issues and it was scheduled to have remodeling done.</p> <p>During an interview on 6/4/15 at 9:15 a.m., the DM indicated the kitchen staff cleans the kitchen. The DM indicated the kitchen staff had a cleaning schedule to follow.</p> <p>On 6/4/15 at 9:30 a.m., the cleaning schedule was obtained from the DM. The cleaning schedule indicated the kitchen had not been cleaned since March, 2015.</p> | | | |

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| F 0431 SS=E Bldg. 00 | <p>A policy, for cleaning of the kitchen, indicated food shall be stored in a clean, dry area, free from contaminants. The policy further indicated food shall be stored at the appropriate temperatures and using appropriate methods to ensure the highest level of food safety.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> | | | |

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| | <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, and record review, the facility failed to ensure medications were secure and expired medications were disposed of, in that, expired medications were not destroyed in a timely manner and that the refrigerator on the West unit, in which narcotics were kept, did not have locks on the EDK (Emergency Drug Kit) box inside the refrigerator, and the refrigerator was not locked for 2 of 2 medication rooms.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 6/3/15 at 9:00 a.m., the West medication cart was checked and found to have a bottle of Novolin (an insulin used for diabetes) 500mg (milligram) with a 4/27/15 open date. When LPN # 3 was queried about expiration date she was unsure how long the insulin was good for after opening. On 6/3/15 at 9:20 a.m., the medication storage room on East hall was observed | F 0431 | <p>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> <p>Facility is requesting paper compliance for all deficiencies in this POC. F431E Drug Records, Label/Store Drugs & Biologicals All meds in the facility are secure. Expired meds are disposed of timely. EDK boxes Inside the refrigerator are locked. Any residents who receive meds at the facility have the potential to be affected by this finding. The DON/Designee will monitor for the following 3 days weekly on random shifts in all med rooms/carts. a. Meds are secure b. Expired meds are destroyed timely/properly c. EDK boxes are locked This monitoring will continue until 4 consecutive weeks of zero</p> | 07/08/2015 |

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| | <p>with an open bottle of Ativan (an antianxiety medications) on a shelf in medication room. A syringe with a bent needle and cap was observed lying next to the Ativan. The needle cap was observed to have droplets of liquid in it and the cap was not able to be removed. Upon query, LPN #3 indicated she did not know why the Ativan and syringe was sitting on the shelf. LPN #3 removed the medication and syringe and delivered it to the DON (Director of Nursing). 2 (two) EDK (Emergency Drug Kit) boxes were observed without safety locks.</p> <p>The East unit EDK boxes had empty compartments and an inventory list with the following medication medications missing: Box #1: Novolog flexpen (an insulin used in the treatment of diabetes) Box #2: Levimir flexpen (an insulin used in the treatment of diabetes) and Novolog flexpen</p> <p>The dementia unit EDK box had medications missing as follows: Macrobid (an antibiotic) on 5/15/15, Amoxicillin on 5/9/15, Keflex (an antibiotic) on 4/21/15, Bactrim (an antibiotic) and Omnicef (an antibiotic) on 4/13/15, and Clonidine 0.1 mg (a medication used in the treatment of</p> | | <p>negative findings is achieved. Any concern will be addressed as found. After the 4 weeks of compliance are achieved, random checking will be done weekly on various shifts for 6 months to ensure ongoing compliance. At inservice's for nurses held between 6/25/15 and 7/7/15 the Medication Storage policy was reviewed. Also reviewed was the disposition of expired meds information as well as EDK storage and handling and security. Any staff who fail to comply with the points of The inservice will be further educated and or progressively disciplined as indicated. At the daily CQI meetings the results of the monitoring will be reviewed, however any Discrepancies will have been addressed as found. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our DOC is 7/8/15.</p> | |

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| | <p>hypertension) on 5/18/15.</p> <p>On 6/3/2015 9:25 a.m.. the DON indicated which meds were missing from the EDK box. She indicated the Novolog flexpen and the Levimir flexpen were missing. She indicated after medication was obtained from the EDK box, the box was sent to the pharmacy. The DON indicated the box would be replaced in 1-2 days. When queried regarding the Ativan, the DON indicated she did not know why the Ativan and syringe were on the shelf. The DON indicated she had placed a call to the staff who had worked the night before. The DON indicated the EDK boxes were to be locked but the refrigerators were never locked. The DON further indicated discontinued narcotics could not be returned to the pharmacy and would be destroyed by the facility with the medications being destroyed observed by 3 (three) nurses.</p> <p>Interview LPN #1 indication 6/3/15 at 9:35 a.m. LPN #1 indicated they had difficulty with pharmacy replacing medications from the EDK box. LPN #1 indicated the facility received other medications promptly, but not the medications that had been used from the EDK box. LPN #1 indicated the narcotic counts were correct at the beginning of the day shift on 6/3/15. LPN #1 indicated</p> | | | |

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| | <p>the refrigerators were never locked. LPN #1 indicated all controlled medications that required refrigeration were locked in 1 medication room which was located on the East hall. LPN #1 indicated if the West unit required an refrigerated medication, the nurse would need to go to the East unit to obtain it.</p> <p>On 6/3/15 at 9:45 a.m. the West unit medication room was observed and the EDK box was locked.</p> <p>On 6/8/15 at 10:33 a.m., a list of all the medications in the EDK box was received from the DON. The list included: Ativan 3 vials, Levimir Flextouch, Novolog Flexpen, Humalog vial, Novolog 70/39 Flexpen, Humulin R vial, Humulin N vial, and a Lantus Solostav Flexpen.</p> <p>On 6/3/15 at 10:52 a.m., a policy on Controlled Substances Disposition was received from the DON. The policy indicated the DON would retain the controlled medications with the numbered count sheets in a secure double - locked area.</p> <p>A policy on "Proper Disposal of Controlled Substance Medications Discontinued" dated 2/5/13 indicated medications were to be disposed safely in</p> | | | |

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| F 0465 SS=E Bldg. 00 | <p>conformance with applicable laws and safety regulations.</p> <p>A policy on "Medication Storage in the Facility," dated 6/12 and received from the DON on 6/3/15 at 10:53 a.m., indicated, "All drugs classified as Schedule II of Controlled Substances Act will be stored under double locks..."</p> <p>A policy for "Syringe and Needle Disposal," dated 2/5/13 and received from the DON on 6/3/15 at 10:53 a.m., indicated to avoid the risk of needle-sticks, needles are not to be recapped after use.</p> <p>3.1-25(m)(o)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, clean, sanitary environment for 13 of 26 rooms observed, in that, wood was missing from doors and bedside tables, walls, floors, cove base, and caulking were soiled, closet doors were loose, door frames</p> | F 0465 | 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 | 07/08/2015 |

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| | <p>were marred, covers for the switches on the heating/air conditioning units were missing, a sink was slow to drain, screws on the commode base were uncovered, walls and furniture had chipped paint, and bathrooms had urine odors present. (Room 102, Room 103, Room 104, Room 105, Room 106, Room 108, Room 110, Room 111, Room 120, Room 124, Room 127, Room 204, Room 221)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During an observation on 5/28/14 at 10:47 a.m., Room 102 was observed to have dirt and debris built up along the edges of the cove base and in the corners of the room and bathroom. The closet doors were scraped and a wooden wedge was used to hold the bedroom door open. The bedroom floor had black marks on it. The bathroom door frame had paint chipped and the commode seat had black marks on it. The caulking around the base of the commode was brown. The same was observed on 6/3/15. 2. During an observation on 5/28/15 at 11:02 a.m., Room 103 was observed to have dirt and debris built up along the edges of the cove base and in the corners of the bedroom and bathroom. The cover for the switches was missing from the heating/air conditioner unit. The closet | | <p>with State and Federal Laws. Facility is requesting paper compliance for all deficiencies in this POC. F465E Safe/Functional/Sanitary/Comfortable Environment The facility is providing a safe, clean, sanitary environment. Rooms 102, 103, 104, 105, 106, 108, 110, 111, 120, 124, 127, 204 & 221 have been placed on a priority list. repairs/replacements and painting has taken place in each room to compliance. All residents have the potential to be affected by this finding. Facility wide rounds were conducted by the Administrator and the Maintenance Director. The physical plant needs were listed. All findings were placed on a schedule. The Administrator met with the Maintenance Director and reviewed the list of "needs." The list will be reviewed weekly by the Administrator and the Maintenance Director to track progress. This tracking will be ongoing. Weekly at the CQI meetings the Administrator will review progress on the environmental repairs/replacements list. Any new maintenance orders will be added as they are reported. Facility environmental rounds will take place by the Administrator/Designee at least monthly ongoing to observe for issues of concern. Concerns will</p> | | | | |

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| | <p>doors had wood scraped off on the bottom. The bathroom exhaust fan was not functioning and the cover had bent slats. The bathroom door frames had chipped paint. On 6/3/15 at 3:32 p.m., the same was observed as well as having a screw on the left side of the commode exposed and a screw was missing from the right side of the commode.</p> <p>3. During an observation on 5/28/15 at 8:41 a.m., Room 104 was observed to have a chair in the room with chipped paint. The bedroom and bathroom had dirt and debris along the edges of the cove base and in the corners of the rooms, The closet doors had tape marks on them and had chipped wood on the bottom of them. The bedroom wall behind the entry door were observed to have chipped paint. The bedroom wall next to the closet had paint chipped off. The bedroom and bathroom door frames were marred. The bathroom door frame had holes in it. The commode had black stains on it. The same was observed on 6/3/15 at 3:28 p.m.</p> <p>4. During an observation on 5/28/15 at 9:15 a.m., Room 105 was observed to have dirt and debris along the cove base and in the corners of the room and bathroom. The room had cracked tile in it. The cover for the heating/air</p> | | be added to the plan for repairs as sighted. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our DOC is 7/8/15. | |

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| | <p>conditioning unit switches was missing. The plastic panel on the entry door was loose. The bathroom door frame had holes in it and was marred. The commode had black stains in it. The same was observed on 6/3/15 at 3:26 p.m.</p> <p>5. During an observation on 5/28/15 at 9:22 a.m., Room 106 was observed to have dirt and debris along the edges of the cove base and in the corners, The closet doors were off the track at the bottom of the doors. The bedside table had wood chipped off of it. The bathroom door had holes in it The bathroom wall had paint chipped off. The bathroom floor was soiled. On 6/3/15 at 11:06 a.m., the same was observed as well as, screws at the base of the commode were exposed.</p> <p>6. During an observation on 5/28/15 at 2:26 p.m., Room 108 was observed to have the chair rail with chipped paint. The room had dirt and debris along the cove base and in the corners. The bathroom wall was observed to have missing paint. The bathroom sink had cracked caulking. The caulking around the commode had dirt and debris present. The tile between the bathroom and the room was cracked. The bathroom sink was took 3-5 minutes to drain after the</p> | | | |

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| | <p>water was turned off. The top of the commode did not fit and screws were exposed at the base of the commode. The same was observed on 6/3/15 at 11:15 a.m.</p> <p>7. During an observation on 5/28/15 at 2:52 p.m., Room 111 was observed to have dirt and debris build up along the edges of the cove base and in the corners. There was a crack between the entry door and the hall between the tile and the hardwood floors. The same was observed on 6/3/15 at 3:23 p.m.</p> <p>8. During an observation on 5/28/15 at 1:51 p.m., Room 116 was observed to have wood missing from the bathroom door. The same was observed on 6/3/15 at 8:39 a.m.</p> <p>9. During an observation on 5/28/15 at 2:04 p.m., Room 120 was observed to have dirt and debris along the edges of the cove base and in the corners of the room and bathroom. The bottom of the closet doors were observed to be missing wood from them. The bathroom was observed to have wax build up on the floor. The caulking around the vase of the commode had a brown substance on it. There was a crack in the floors between the room entry door and the hall. The same was observed on 6/3/15 at 8:44</p> | | | |

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| | <p>a.m.</p> <p>10. During an observation on 5/28/15 at 3:45 p.m., the caulking around the sink was cracked. The bathroom door frames were observed to be marred and and paint chipped off. The bathroom doors were scraped. The screws on the base of the commode was exposed. The same was observed on 6/3/15 at 3:44 p.m.</p> <p>11. During an observation on 5/28/15 at 3:13 p.m., Room 127 was observed to have paint chipped on the wall next to the bed and the back of the wall behind the commode. The bathroom doors were scraped. The same was observed on 6/3/15 at 3:47 p.m., as well as, screws were exposed at the base of the commode.</p> <p>12. During an observation on 5/28/15 at 3:54 p.m., the bathroom had a strong urine odor present. The same was observed on 6/3/15 at 3:51 p.m.</p> <p>13. During an observation on 5/28/15 at 3:54 p.m., Room 221 was observed to have a strong odor of urine in the bathroom. The same was observed on 6/3/15 at 3:53 p.m.</p> <p>During an interview on 6/3/15 at 4:14 p.m., the Adm (Administrator) indicated</p> | | | |

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| NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670 | | |
| (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 facility had remodeled some of the halls and the rooms in question were slated to be remodeled soon. The Adm indicated she was aware the environment was not as good as it should be. The Adm indicated the facility was budgeted for the remodel in the future.</p> <p>During an interview on 6/3/14 at 4:20 p.m., the Maintenance Supervisor indicated it would be a full-time job to keep up with the painting of the facility. The Maintenance Supervisor further indicated he had been finding one problem after another since starting work at the beginning of the year.</p> <p>A policy provided by the Environmental Supervisor on 6/8/15 at 8:33 a.m., indicated a clean, attractive, and safe environment was to be provided for patients, visitors, and staff. The policy further indicated a clean, orderly and attractive environment would assist in preventing the spread of infection.</p> <p>3.1-19(f)</p> | | | | |