

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2016
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NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00208883.</p> <p>Complaint IN00208883 - Substantiated. Federal/State deficiencies related to the allegations are cited at F241.</p> <p>Survey dates: September 27 & 28, 2016</p> <p>Facility number: 000138 Provider number: 155233 AIM number: 100266500</p> <p>Census bed type: SNF/NF: 66 Total: 66</p> <p>Census payor type: Medicare: 10 Medicaid: 45 Other: 11 Total: 66</p> <p>Sample: 5</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on October 3, 2016</p>	F 0000	<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's date of alleged compliance is: October 24, 2016. Facility is respectfully requesting paper compliance for all deficiencies in this POC.</p>	
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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 0241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to maintain residents' dignity related to long wait periods for bed transfer and toileting assistance. This affected 3 of 5 residents reviewed for Dignity. (Residents #F, #E, and #C)</p> <p>Findings include:</p> <p>1. During the initial tour on 9/27/2016 at 7:39 p.m., Resident #F was observed leaning up against the railing outside his bedroom. The resident indicated "staff just don't care about me", and he had asked three different staff members for assistance to go to bed and was advised he had to wait, since they were busy.</p> <p>During a second tour on 9/27/2016 at</p>	F 0241	<p>F-241</p> <p>It is the policy of the facility to ensure that residents have their dignity maintained including receiving assistance with bed transfers and toileting without having to wait longer than an acceptable period of time per the desire and expectation of the resident. Resident F has his needs met timely and he is well satisfied with all aspects of the provision of his personal care.</p> <p>Resident E has her needs met timely and is well satisfied with the provision of their care. Resident E is promptly assisted upon return from any transports. Resident C and their family agree that Resident C's needs are met timely including toileting</p>	10/24/2016

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	<p>7:58 p.m., Resident #F continued to lean against the railing in the hallway, with his head on his arm outside his bedroom. Multiple staff walked by the resident and indicated they were busy and would return when available. The resident was closing his eyes and laying his head on the rail.</p> <p>Resident #F was observed to be assisted by two staff members into bed on 9/27/2016 at 8:13 p.m.</p> <p>During a confidential interview, on 9/27/2016 at 8:15 p.m., Staff #1 indicated there were times when residents had to wait awhile to be placed in bed and 7:00 p.m., was one of the worst times. The staff member indicated some residents had to wait up to an hour to be placed in bed and were falling asleep in their wheel chairs.</p> <p>During a confidential interview, on 9/28/2016 at 10:20 a.m., Staff #3 indicated he has seen residents wait from 45 minutes up to 90 minutes for assistance for bed transfer and toileting.</p> <p>The record for Resident #F was reviewed on 9/28/2016 at 9:30 a.m., and diagnosis included, but were not limited to, CVA (cerebrovascular accident). Resident #F had impaired mobility on the left upper</p>		<p>needs.</p> <p>Residents who reside in the facility and require assistance with care have the potential to be affected by this finding. The Administrator and DON have reviewed the staffing schedule as related to resident acuity and to ensure that staff is scheduled so as to be able to meet the needs of the residents who require assistance to ensure that timeliness to address their needs is possible. The DON/Designee or SSD will interview 10 residents (or families) as to the satisfaction with timeliness of the resident's care and assistance. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, the monitoring will continue with 5 residents (or families) weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur ongoing. Any concerns will be addressed as discovered. Any concerns revealed during the monitoring will be addressed and corrected.</p> <p>At an in-service for the nursing staff held October 19, 2016 the following was reviewed:</p>	

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	<p>and lower extremities and required extensive assistance of two staff members for transfer.</p> <p>2. Resident # E's family member was interviewed, on 9/28/2016 10:30 a.m., and indicated the facility did not have enough staff. She has visited the facility daily and twice in the last week has walked up and down the hallway looking for staff to assist the resident with toileting. While the resident had to wait 30 to 45 minutes for assistance she would become upset when she had an incontinent episode.</p> <p>The family member indicated on 8/31/2016, Resident #E had returned from the local hospital after receiving a blood transfusion. The family member advised the nursing staff of their return. After waiting 40 minutes she went to the nurses station again and was advised by the nurse that she did not know the resident was back. When the resident was returned by the facility transport van, she was left sitting up in her wheelchair to be assessed by the nurse and for assistance to be placed in bed. The family member was afraid to leave the resident until nursing staff acknowledge her return.</p> <p>The written nurses's progress note, dated</p>		<p>A.) Resident Rights</p> <p>B.) Dignity</p> <p>C.) ADLs/Assistance—Timely Response by nursing staff</p> <p>D.) Tips on time management as related to resident care/assistance</p> <p>E.) Questions/Answers</p> <p>Any staff who fail to comply with the points of the in-service 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 concerns will have been addressed as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored by the Administrator until resolution.</p>	

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	<p>8/31/2016 at 1:30 p.m., indicated the hospital called and stated Resident #E would need transportation to come back to the facility at 6:00 p.m.</p> <p>During an interview, on 9/28/2016 at 11:45 a.m., the Maintenance Manager indicated on some occasions he drives the facility transport van. The Maintenance Manager indicated he was the driver that transported Resident #E back to the facility on 8/31/2016 around 6:00 p.m., and notified the nurse promptly upon placing the resident in her room.</p> <p>The nurse's progress note dated 8/31/2016 indicated Resident #E returned to the facility from the hospital at 6:40 p.m.</p> <p>The record for Resident #E was reviewed on 9/28/2016 at 11:30 a.m., the diagnoses included, but were not limited to, anemia, heart failure, arthritis, and dementia.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 9/21/2016, indicated the resident was frequently incontinent of bowel and bladder, and required extensive assistance of two staff members for toileting and transfer.</p> <p>Review of the ADL care plan, with an initial date of 11/28/2014 and the most</p>			

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	<p>recent update of 9/13/2016, indicated the resident required extensive assistance with transfers and toileting. The interventions included, but were not limited to, assist as needed so resident was clean and dry.</p> <p>3. Resident # C's family member was interviewed, on 9/27/2016 8:19 p.m., and indicated the facility did not have enough staff and upon visiting had found her family member left incontinent. Her family member would be embarrassed about being wet and not being able to wait for assistance. She was in the facility every day and would look up and down the hallway for staff to assist their family member and would have to wait for 60 to 90 minutes for staff to assist with toileting.</p> <p>During a confidential interview, on 9/28/2016 at 5:48 a.m., Staff #2 indicated there were shifts when she had residents on both sides of the building. When she was on the other side of the building there was only one aide to assist the residents. Some residents would have to wait 30 to 40 minutes for assistance if two or more residents needed help at the same time.</p> <p>The record for Resident #C was reviewed, on 9/28/2016 at 10:10 a.m.,</p>			

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	<p>and indicated diagnoses included, but were not limited to, spinal stenosis, osteoporosis, hypertension and pain.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 9/2/2016, indicated the resident was always continent of bowel and bladder, and required extensive assistance of two staff members for toileting.</p> <p>This Federal tag relates to Complaint IN00208883.</p> <p>3.1-3(t)</p>				