STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155223		12/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF COVINGTON THE	1600 E LIBERTY ST COVINGTON, IN 47932

(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
F0000	This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaint #IN 00118787. Complaint #IN 00118787 substantiated. No deficiencies related to the allegations are cited. Survey dates: December 3-7, 11-13, 2012 Facility Number: 000128 Provider Number: 155223 AIM Number: 100289650 Survey team: Laura Brashear, RN, TC Mary Weyls, RN Teresa Buske, RN Census bed type: SNF/NF: 99 Total: 99 Census payor type: Medicare: 28 Medicaid: 60 Other: 11 Total: 99 These deficiencies reflect findings cited in accordance with 410 IAC	F0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.We respectfully request a desk review regarding this survey.	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF COVINGTON THE	1600 E LIBERTY ST COVINGTON, IN 47932

(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
	16.2. Quality review completed 12/20//2012 by Brenda Nunan, RN.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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.			
	Based on observation, interview, and record review, the facility failed to provide care in a manner to enhance dignity for 2 of 2 random observations of staff standing to feed residents requiring the assistance [Residents #3 and #10] and 1 of 1 random observation of resident with a urinary catheter [Resident #38]; and 2 of 2 observations of residents receiving incontinence care or having Foley catheter who met the criteria for dignity [Residents #10 and #149]. Findings include: 1. On 12/3/12 at 12:25 p.m. LPN #13 was observed in the Assisted Dining Room standing up and feeding Resident #10. The resident was observed seated in a Broda chair away from any dining table. Resident #10's clinical record was reviewed on 12/12/12 at 2:00 p.m. The Minimum Data Set [MDS] assessment completed on 10/12/12 coded the resident with cognitive	F0241	F-241 It is the intent of the facility to maintain the dignity and respect of all residents at all times. A. Action Taken: Nursing personnel and Department Directors will be retrained regarding the practice of sitting while assisting residents at meal times, maintaining residents adequately covered during perineal care and ensuring that catheter bags are covered. B. Others Identified: No other residents were identified based on staff observations. C. Measures Taken: The Regional Nurse Consultant will in-service nursing personnel regarding resident dignity during meal times, perineal care and catheter covers. D. How Monitored: 1. Department Directors will monitor meal times to ensure staff are seated while assisting residents. The DON/Unit Managers will monitor perineal care and catheter bag cover usage. 2. The DON/designee will monitor the dining room daily to ensure staff are seated while assisting residents on working days for 2 weeks, then weekly for one month, then continue to monitor monthly, to ensure the	01/12/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	impairment, requiring total assistance of one for eating. 2. On 12/6/12 at 12:37 p.m. the [Director of Nursing [DON] was observed in the Assisted Dining Room standing up and feeding Resident #3. Resident #3's clinical record was reviewed on 12/4/12 at 3:30 p.m. A Minimum Data Set [MDS] assessment, dated 10/13/12, coded the resident with cognitive impairment and required extensive assistance of one for eating. A facility policy titled "Eating Support," dated 01/07, provided by the DON on 12/12/12 at 4:30 p.m. included but was not limited to, "Purpose 1. To assist the resident with feeding as necessary. 2. To provide adequate nutrition. ...Procedure ...8. Never make the resident feel that the meal must be hurried, but that the procedure is pleasant. Give him/her your complete attention. Sit so you are at the same level as the resident when possible." On 12/13/12 at 6:15 p.m. during the exit conference, the Administrator indicated he could not believe the practice occurred as the facility was very aware of the need for staff to be seated when feeding residents.		plan of correction is maintained. 3. The DON/designee will monitor that catheter bags are properly covered daily for 2 weeks, then weekly for one month and then continue to monitor monthly. 4. The CEO/designee will review all audits in the quarterly Quality Assurance Committee meeting Monitoring will continue until 100% compliance is achieved. 5. The DON/designee will ensure ongoing complinace. E. Date Completed: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is 01/12/13.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	3. On 12/5/12, at 10:40 a.m., CNAs #1 and #2 were observed providing incontinence care to Resident #10. The resident was observed in bed with only a shirt on. The CNAs cleansed the resident's perineal area, positioned the resident on the left side and cleansed the resident's bottom. The resident was observed to have loose stools during the procedure. The staff removed gloves, left the bedside to wash hands and one staff member exited the room to obtain additional linens and left the resident uncovered from the waist down before returning to complete the care. Resident #10's clinical record was reviewed on 12/4/12 at 3:30 p.m. A Minimum Data Set [MDS] assessment, dated 10/12/12, coded the resident with cognitive impairment, requiring total assistance of two for bed mobility and total assistance of two for toileting, hygiene. A facility policy titled "Perineal Care," dated 01/07, provided by the DON on 12/12/12 at 4:30 p.m. included, but was not limited to, "Procedure 6. Provide Privacy. The Procedure 34: Perineal care," included with the policy included, but was not limited to,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	"5. Drape Resident 5. Maintains resident's right to privacy by not exposing body. Keeps resident warm." 4. On 12/4/12 at 11:30 a.m., Resident #149 was interviewed. The resident was seated in a personal recliner and observed to have a urinary catheter. The drainage bag was observed hanging on a waste basket positioned away and in front of the resident. The drainage bag was not covered with a dignity bag. The resident and drainage bag were visible from the hallway. On 12/5/12 at 2:30 p.m., the resident was observed propelling self in a wheelchair in the hallway with a Foley catheter drainage bag hanging under the seat of the wheelchair and not covered with a dignity bag. On 12/6/12 at 10:30 a.m., the resident was observed seated in a personal recliner in his room with the urinary Foley catheter bag hanging on the waste basket positioned away from and in front of the resident. The drainage bag was not covered with a dignity bag. The resident and drainage bag were visible from the hallway.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	The resident's clinical record was reviewed on 12/6/12 at 11:24 a.m. A Minimum Data Set [MDS] assessment dated 12/4/12, coded the resident with no cognitive impairment, requiring extensive assistance of two for mobility and transfers, non-ambulatory, and utilizing a Foley catheter. 5. On 12/3/12 at 11:20 a.m. Resident #38 was observed in a wheelchair propelling self in the hallway and to have a urinary catheter and drainage bag hanging under the seat of the wheelchair. The drainage bag was not covered with a dignity bag. On 12/6/12 at 10:30 a.m., the resident was observed in bed [from the hallway] with Foley catheter and urinary drainage bag hanging on bed frame. The drainage bag was not in a dignity bag. Resident #38's clinical record was reviewed on 12/12/12 at 2:00 p.m. An admission Minimum Data Set [MDS], dated 11/2/12, coded the resident with cognitive impairment, two person physical assistance for transfers, non-ambulatory, and extensive assistance of one for hygiene.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	A facility policy and procedure titled "Indwelling Catheter Justification/Decision Diagram," dated 6/1/12, provided by the Administrator on 12/13/12 at 10:12 a.m. included, but was not limited to, "Complete Care Plan for Indwelling ...Provide a catheter bag cover to promote dignity." 3.1-3(t)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.			
	Based on observation, interview, and record review, the facility failed to provide services to prevent urinary tract infections and/or medical justification for catheter use for 1 of 2 residents [Resident #149] who met the criteria for urinary catheter use and 1 of 1 random observation of Resident # 38 with an indwelling Foley catheter. Findings include: 1. On 12/4/12 at 11:30 a.m. Resident #149 was seated in a personal recliner and observed to have a urinary catheter. The drainage bag was observed hanging on a waste basket positioned away and in front of the resident. The catheter tubing was observed to be in contact with the floor and the drainage bag in contact with the waste basket plastic bag	F0315	F-315 It is the intent of this facility to provide services to prevent urinary tract infections and justification of catheter use. A. Action Taken: A 100% audit has been completed by the DON of all residents with catheters to ensure that all catheter tubing is appropriately positioned and not dragging on the floor. B. Others Identified: The 100% audit of all residents with catheters did not identify others impacted. C. Measures Taken: Inservice nursing personnel regarding ensuring that catheter tubing is appropriately positioned and not touching the floor. Residents returning from the hospital will be checked for catheter orders. D. How Monitored: 1. The DON, Unit Charge nurses and QA team will monitor and audit daily to ensure catheter tubing is correctly positioned. 2. The CEO/designee will review all audits in daily QA meeting.	01/12/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	liner. On 12/5/12 at 2:30 p.m., the resident was observed propelling self in a wheelchair in the hallway with a Foley catheter drainage bag hanging under the seat of the wheelchair. The catheter tubing was observed to be dragging on the carpeted hallway. On 12/6/12 at 10:30 a.m., the resident was observed seated in a personal recliner in his room with the urinary Foley catheter bag hanging on the waste basket in contact with the waste basket liner. The catheter tubing was observed in contact with the floor. On 12/12/12 at 11:15 a.m., the resident was observed in the hallway in a wheelchair and the catheter tubing dragging on the carpeted floor. The resident's clinical record was reviewed on 12/6/12 at 11:24 a.m. A Minimum Data Set [MDS] assessment, dated 12/4/12, coded the resident with no cognitive impairment, required extensive assistance of two for mobility and transfers, non-ambulatory, and utilized a Foley catheter. 2. On 12/3/12 at 11:20 a.m. Resident		Results of the monitoring will be presented at the quarterly Quality Assurance Committee meeting for review. 3. The DON/designee will monitor for proper catheter tubing positioning daily for 2 weeks, then weekly for 1 month, then continue to monitor monthly, to ensure the plan of correction is maintained. 4. Monitoring will continue until 100% compliance is achieved. 5. The DON/designee will ensure ongoing compliance. E. Date Completed: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is 01/12/13.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	#38 was observed in a wheelchair propelling self in the hallway with a urinary catheter and drainage bag hanging under the seat of the wheelchair. The catheter tubing was observed to be dragging on the carpeted hallway floor. Resident #38's clinical record was reviewed on 12/12/12 at 2:00 p.m. An admission Minimum Data Set [MDS], dated 11/2/12, coded the resident with cognitive impairment requiring two person physical assistance for transfers, non-ambulatory, and extensive assistance of one for hygiene. The assessment coded the resident without a urinary catheter and as always incontinent of urine. On 12/12/12 at 2:00 p.m., the Director of Nursing [DON] was interviewed. The DON indicated not knowing why the resident had an indwelling catheter, and indicated she was not aware the resident had a catheter. The ADON [Assistant Director of Nursing] was interviewed on 12/13/12 at 11:00 a.m. The ADON indicated the catheter was removed the night before and indicated they had forgotten to address removal of the catheter after the resident returned from a hospitalization on 11/26/12			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	where she was treated for a hand wound infection. A facility policy and procedure titled "Indwelling Catheter Justification/Decision Diagram," dated 6/1/12, provided by the Administrator on 12/13/12 at 10:12 a.m. included, but was not limited to, "Complete Care Plan for Indwelling ..Observe good infection control techniques while performing catheter care. Check catheter tubing for proper drainage and positioning...." 3.1-41(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
F0323 SS=D	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. Based on observation, interview, and record review the facility failed to ensure adequate supervision and assistive devices for 1 of 5 residents who met the criteria for accidents [Resident #144] and for 1 of 1 random observation of [Resident #10] transferred with a mechanical lift not in accordance with manufacturer's directions. Findings include: 1. On 12/4/12 at 10:18 a.m., LPN #13 was interviewed regarding Resident #144. The nurse indicated the resident had repeated falls, utilized alarms but took them off. On 12/7/12 at 11:39 a.m. the resident was observed in his room with his eyes closed and his head on his knees while seated in a wheelchair. On 12/7/12 at 2:00 p.m., the resident was observed in a wheelchair with his eyes closed and his head on his knees in front of the front door of the	F0323	F-323 It is the intent of this facility to ensure all resident environments are free from accident hazards and each resident receives adequate supervision and assistance to prevent accidents. It is also the intent of this facility to transfer residents safely in a mechanical lift. A. Action Taken: In regards to Resident #144, the IDT will meet and re-evaluate a more effective intervention to minimize the fall risk. In regards to Resident #10, nursing personnel will be in-serviced regarding the use of the Invacare Reliant 450 mechanical lift to ensure safe and appropriate usage. Nursing personnel will be in-serviced regarding the use of fall prevention interventions. B. Others Identified: 100% audit of all residents with fall risks will be reviewed for appropriate interventions and care plans. No others identified. C. Measures Taken: Pocket work sheets and care plans will be reviewed for those at risk of fall to ensure apporpriate interventions are in place. DON/designee will do random comptetency checks on the proper use of mechanical	01/12/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	facility. No alarm was observed on the resident's chair. On 12/11/12 at 4:10 p.m., accompanied by CNA #5, the resident was observed propelling self in the wheelchair in his room attempting to get around the roommate who was also in a wheelchair. The resident was observed with a clip alarm box hanging on the top of the wheelchair seat back, not clipped to the resident. CNA #5 was interviewed at that time and indicated the alarm was not attached to the resident and he does remove them. The resident's bed was observed not to have an alarm. The CNA indicated there was no alarm on the resident's bed. The DON was interviewed on 12/11/12 at 3:50 p.m. regarding falls for Resident #144: The DON indicated the resident had a fall on 11/22/12 at 9:00 a.m. and was found on the floor with his back against the television stand. The Director of Nursing [DON] did not have information to indicate if an alarm had been on the resident. The DON indicated the resident was non-compliant with alarms i.e. removed them and threw them away. The Assistant Director of Nursing		lifts daily for 2 weeks, weekly for 2 weeks and then monthly and ongoing. D. How Monitored: 1. During quarterly care plan meeting, care plans related to fall interventions will be reviewed for accuracy. Quality Assurance team to monitor fall interventions in place and pocket worksheet updated by DON/designee.. 2. All falls and care plans will be reviewed during the weekly PAR meeting and daily at the morning stand up meeting to ensure interventions are implemented and to ensure the plan of correction is maintained. 3. CEO/designee will review all audits in the quarterly Quality Assurance Committee meeting. Monitoring will continue until 100% compliance is accomplished. 4. The DON/designee will audit all fall interventions daily for 2 weeks, then weekly for one month, then continue to monitor monthly to ensure compliance. 5. DON/designee will ensure ongoing compliance. E. Date Completed: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is 01/12/13.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	[ADON] who was present during the interview, indicated chair and bed alarms were implemented for the resident. The ADON indicated a clip alarm was utilized in the resident's wheelchair and a pressure alarm pad on the bed. On 12/11/12 at 3:50 p.m., the DON indicated on 11/24/12 at noon, the resident had a fall leaning forward in the wheelchair in his room. The DON did not have information as to if an alarm had been in place and sounded. The DON indicated the resident reported he had gone to sleep in the chair. The alarm was reapplied and the resident was placed on 15 minute checks. On 12/11/12 at 3:50 p.m., the DON indicated on 11/27/12 at 9:00 a.m., the resident was self transferring self and was found sitting on the floor holding his knees with his arms. The resident indicated he had fallen. An alarm was in place on the wheelchair and was sounding. On 12/11/12 at 3:50 p.m., the DON indicated on 11/29/12 at 3:10 p.m., the resident was getting out of bed to the wheelchair spilled some water slipped and fell. The DON indicated the call light had been within reach			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	and did not know if a bed alarm was in place or sounding. On 12/11/12 at 3:50 p.m. the DON indicated on 12/8/12 at 6:00 a.m., the resident slid off of the bed. The DON indicated the call light was within reach and indicated she didn't know if a bed alarm had been in place or was sounding. The DON indicated approaches remained for bed and chair alarms when the resident wasn't messing with them. Resident #144's clinical record was reviewed on 12/7/12 at 11:47 a.m. A Fall risk assessment, dated 10/29/12, assessed the resident with a score of 11. The assessment tool indicated a score above 10 indicating the resident was at high risk for falls. A nursing note, dated 11/29/12 at 3:30 p.m., documented "Resident fell in room around 3:10 p.m. Discovered laying/sitting by bed. Appears that he tried to get out of bed and into chair, spilled water pitcher in the process and slipped and fell. Resident confused and unable to provide accurate account of incident when questioned. Several alarms have been placed on resident. Resident removes alarms. ..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	A nursing note on 11/30/12 at 9:00 a.m. included, but was not limited to, "...res [resident] non compliant with personal alarm constantly removing...." A Minimum Data Set [MDS] assessment, dated 10/31/12, coded the resident with moderate cognitive impairment. Independent in bed mobility, transfers, and ambulation; however, the assessment coded the resident with unsteady balance for surface to surface transfers, seated to standing, walking, turning around, moving on and off of toilet out human assistance of one. On 12/11/12 at 3:50 p.m. the DON indicated the resident had declined since admission. A plan of care, dated 9/12/12 and 9/27/12, addressed the problem of at risk for falls. The care plan indicated to assist with transfers as needed, keep call light within reach, use non-skid shoes, screen quarterly for falls. The plan of care did not include the use of bed and chair alarms. A plan of care addressed the problem of refusal of care i.e.. alarms, activities of daily living, increased falls.. the goal was noted of "Resident will have no further behavior episodes aeb [as evidenced			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	by] absence of refusing alarms, et [and] ADL assistance TNR [through next review.]" A nursing intervention was noted of alarms in place. 2. On 12/5/12 at 11:25 a.m., Resident #10 was observed to be transferred by CNAs #1 and #2 with the Invacare Reliant 450 mechanical lift from the bed to Broda chair. With the base of the lift in the closed position, the resident was lifted from the bed surface. The resident was observed to be at chest height of the staff members and positioned perpendicular to the mast. The lift was pulled away from the bed turned toward the Broda chair and the resident was transferred to the chair. The base of the lift was opened around the side of the Broda chair and the resident was lowered into the chair. Resident #10's clinical record was reviewed on 12/4/12 at 3:30 p.m. A Minimum Data Set [MDS] assessment, dated 10/12/12, coded the resident with cognitive impairment, requiring total assistance of two for bed mobility and transfers, non-ambulatory. The Manufacturer's directions for the Invacare Reliant 450 lift, provided by			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	the Administrator on 12/12/12 at 10:00 a.m. included, but was not limited to, "Positioning the Lift for Use 1. With the legs of the base open and locked, use the steering handle to push the patient lift into position...5. When moving the patient lift away from the bed, turn the patient so that he/she faces assistant operating the position lift. 6. Press the DOWN button (electric)...lowering the patient so that his feet rest on the base of the lift, straddling the mast. Close the control valve. NOTE: The lower center of gravity provides stability making the patient feel more secure and the lift easier to move...6. With one (1) assistant behind the chair and the other operating the patient lift, the assistant behind the chair will pull back on the grab handle or sides of the sling to seat the patient well into the back of the chair. This will maintain a good center of balance and prevent the chair from tipping forward. The illustrations in the direction depict the lift being positioned around the front of the chair, not the side...." 3.1-45(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF COVINGTON THE	1600 E LIBERTY ST COVINGTON, IN 47932

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
F0325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview, and record review, the facility failed to provide nutritional supplements as recommended by the Registered Dietician for 1 of 3 residents reviewed who met the criteria for nutrition with a significant weight loss. [Resident #38] Finding includes: On 12/11/12 at 12:15 p.m., Resident #38 was observed eating lunch in her room. The resident's husband was visiting. The resident was observed to have fish, potatoes, tomatoes, fruit and a Mighty Shake [nutritional supplement]. The resident's husband was present at the time and indicated the resident needed the shakes and did not get them unless he pointed them out. A copy of the dietary slip for the resident's meal did not indicate the	F0325	F-325 It is the intent of this facility to provide adequate nutrition to all residents and supplements as prescribed. A. Action Taken: A 100% audit of the Clinical Dietician's recommendations for residents to receive nutritional supplements will be completed. B. Others Identified: Based on the 100% audit, any other residents identified not receiving the nutritional supplements as prescribed will be corrected. C. Measures Taken: All residents with a nutritional supplement order will have the order placed on the MAR and administered by the nurse. D. How Monitored: The nurse will initial the MAR when the nutritional supplement is administered. The DON/designee will monitor the MAR daily to ensure compliance. The CEO/designee will review all audits in the quarterly Quality Assurance Committee meeting. The DON/designee will ensure	01/12/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	resident was to receive a nutritional supplement. On 12/12/12 at noon, the resident was observed in her room with her lunch tray. A nutritional supplement was not served with the meal. The resident's clinical record was reviewed on 12/12/12 at 12:36 p.m. An admission date was noted of 10/28/12 and an admission weight of 145 pounds. A weight on 11/10/12 was noted of 138 pounds indicating a 4.8 per cent loss and a weight on 12/5/12 of 137 pounds, indicating a 5.5 per cent loss since admission. A Registered Dietician's note, dated 11/27/12, indicated "Res [resident] to hospital 11/21-26 secondary to cellulitis with lymphangitis left hand, seiz [seizure] disorder, copd [Chronic obstructive pulmonary disease] pvd/gerd, [peripheral vascular disease/ gastro esophageal reflux disease], anxiety, wt [weight] on Return 138 lbs down 7 lbs 5:% from admit ...Would recommend increasing sugar free Mighty Shake to tid [three times daily] and reg [request] Arginaid [nutrition supplement] pkt [packet] bid [two times daily] to aid healing left hand. Continue to monitor and fu [follow up] prn [as needed]."		ongoing compliance. E. Date Completed: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is 01/12/13.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	A physician's order, dated 11/30/12, indicated "regular diet with diabetic precautions send 600 cc [cubic centimeters] fluids each meal send double egg at breakfast send mighty shake at hs [hour of sleep]. Arginaid 1 packet po [by mouth] bid [two times daily] dietary recommendation." On 12/12/12 at 1:10 p.m., dietary aid #14 was interviewed. The aid indicated he served the resident's breakfast. The aid indicated he would provide a regular diet as indicated on the breakfast dietary card and also indicated he would send increased protein. The aide indicated new cards came out 4-5 days ago, which reflected the increased protein so he would also send Power cereal at breakfast. The aid indicated prior to that he would not have served extra protein. The aid Indicated dietary does not send Mighty Shakes with meals. LPN #6 was interviewed on 12/12/12 at 1:19 p.m. The LPN indicated nursing would pass the supplements if listed on the Medication Administration Record [MAR]. The resident's November and December 2012 MARs were reviewed on 12/12/12 at 2:00 p.m. The dietary			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155223		12/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF COVINGTON THE	1600 E LIBERTY ST COVINGTON, IN 47932

(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
	supplement Mighty Shake was not included on the record. The Assistant Director of Nursing [ADON] was interviewed on 12/12/12 at 2:00 p.m. The ADON indicated the activity department served residents' snacks and nutritional supplements sent out by the dietary department at 10:00 a.m., 3:00 p.m. and 8:00 p.m. The ADON provided lists of residents on the skilled unit, where Resident #38 resided. The list for 12/2/12 at 3:00 p.m. included the resident's name and a zero by name. No indication of the resident's type of diet or supplement was noted on the list. A list, dated 12/4/12 at 10:00 a.m., provided did not included the resident's name. A list, dated 12/5/12 for 10:00 a.m., had the resident's name and the documentation of "anything." A list, dated 12/5/2 for 3:00 p.m., with the resident's name and a zero, did not indicate a diet type or supplement. A list for 12/6/12 for 10:00 a.m. included the resident's name and a zero, with no type of diet or supplement indicated. The ADON indicated it could not be ensured through the current system that the resident was being provided Shakes tid. The ADON indicated she added the supplement to the MAR to ensure that nursing would provide the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF COVINGTON THE	1600 E LIBERTY ST COVINGTON, IN 47932

(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
	supplement to the resident tid. A telephone order was also received on 12/12/12 for the resident to have a health shake tid. Nursing to administer at 8:00 a.m., 2:00 p.m., and 10:00 p.m. 3.1-46(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
F0441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to	F0441	F-441 It is the intent of the this facility to ensure and maintain an	01/12/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	maintain an infection control program to provide a safe, sanitary environment for 1 of 4 residents with current Clostridium Difficele [C-diff] infection, failed to implement procedures to prevent the spread of infections, i.e.: 2 of 2 blood glucose testings observed; 1 of 1 gastrostomy tube medication administration observed; 1 of 1 insulin injection observed; 1 of 2 observation of incontinence care. The facility failed to ensure surveillance to identify and track infections and failed to ensure disinfecting chemicals effective against c-diff was used to sanitize all floors. This deficient practice had the potential to affect all residents of the facility. Findings include: 1. Upon review of Resident #64's clinical record on 12/6/12 at 11:15 a.m., a physician's order, dated 11/30/12, was noted of "Flagyl 500 milligram one by mouth twice daily for 10 days due to positive for Clostridium Difficile." A physician's order, dated 11/8/12, was noted of "resident placed on contact isolation for diagnosis of Clostridium Difficile." The most recent Minimum Data Set (MDS) assessment dated 9/14/12		infection control program to provide a safe and sanitary environment for residents with Clostridium Difficile. A. Action Taken: 1. Regarding resident #64, on 12/06/12, the resident was immediately placed on Contact Isolation and a sign was placed on the resident's door alerting staff and visitors to see the nurse before entering the resident's room. 2. On 12/06/12, an isolation set-up was placed outside the door of the resident's room. 3. An appropriate cleaning agent of bleach and water was immediately put in place by the Housekeeping Department. 4. A surveillance infection report will be completed for all infections, nosocomial and admitted with, by the licensed nurses. The Infection Survellance Report will then be forwarded to the DON/designee for review and tracking. 5. In-service has been scheduled for nursing personnel regarding colostomy care and glucometer care. B. Others Identified: 100% audit of those residents with C-Diff was conducted. No other residents were affected. C. Measures Taken: An in-service regarding isolation precautions and procedures, including housekeeping cleaning agents and cleaning procedures, will be conducted for staff. D. How Monitored: 1. The DON/designee will ensure those residents on isolation precautions have a sign	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	indicated the resident had severe impairment to cognitive decision making skills and was independent in walking in room and corridor. The resident was tested multiple times for Clostridium Difficile and tested positive for Clostridium Difficile on 7/18/12, 8/15/12, 9/25/12, 10/13/12, 11/2/12, 11/6/12, and 11/29/12. A current plan of care was noted with problem of Resident has "C-Diff" [Clostridium Difficile], dated 5/6/12 with the last update on 10/15/12. The approaches included, but were not limited to, "1. administer medications as ordered,...4. Isolate per Contact Precautions -Gowns and Gloves..." On 12/6/12 at 11:55 a.m., Resident #64 was observed not to be in contact isolation in that a sign posted on the resident's door alerting staff and visitors to see nurse before entering was lacking. In addition, an isolation set up was observed not to be present at the resident's room. On 12/3/12 at 11:50 a.m. during initial tour, Resident #64 was observed not be in contact isolation. Residents #137, #146 were observed to be in contact isolation for Clostridium Difficile , and Resident #91 was observed to be in respiratory isolation.		on the door and isolation set-up outside the room, during walking rounds, on working days, Monday thru Friday. The Manager on Duty will perform walking rounds on the weekends and will ensure all signage and set-ups are present. 2. The DON/designee wil ensure all residents with infections are placed on the monthly tracking tool. 3. The DON/designee will ensure nurse aide pocket worksheets indicate those residents on isolation precautions. 4. Housekeeping Supervisor will observe random competency check-offs regarding the cleaning of rooms of residents affected with C-Diff; daily on working days for 2 weeks, then weekly for one month then continue monthly. 5. All residents with isolation precautions will be reviewed at the daily morning stand up meeting. 6. The DON/designee will observe licensed staff and CNAs during colostomy care for 2 weeks, then weekly for one month, then on going, to ensure the plan of correction is maintained. 7. The DON/designee will observe licensed staff performing glucometer care daily for 2 weeks, then weekly for one month, then monthly ongoing, to ensure the plan of correction is maintained. E. Date Completed: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	These residents resided on the same unit as Resident #64. Resident #64 was observed to ambulate with a walker to dining room. Upon interview of LPN #12 on 12/6/12 at 11:55 a.m., LPN #12 indicated Resident #64 was being treated with Flagyl for Clostridium Difficile and that the resident did not have protective equipment due to the resident having a colostomy. During interview of CNA #8 on 12/6/12 at 11:59 a.m., the CNA indicated Resident #137, Resident #91, Resident #146 and Resident #64 were in isolation precautions on the unit she was working. The CNA indicated she was told Resident #64 was in contact isolation but that she does not "mess with" the resident's colostomy. The CNA indicated Resident #64 did not have a contact isolation set up outside the resident room door due to the resident having a colostomy. The CNA indicated Resident #64 was alert but confused. The CNA also indicated the resident had a history of playing with her colostomy. Upon further interview of LPN #12 on 12/6/12 at 12:40 p.m., LPN #12 indicated nurses emptied the		completion is 01/12/13. It is the intent of this facility to ensure proper hand washing, glove usage, insulin pen administration and g-tube med administration is utilized to be compliant with Infection Control Policy. A. Action Taken: Employees involved were identified and retrained relative to acceptable infection control practices. B. Others Identified: All residents have the potential to be affected. C. Measures Taken: An in-service on proper hand washing, glove use and insulin and g-tube med administration will be conducted for the nursing personnel. D. How Monitored: 1. The DON/designee will perform random hand washing and glove use competency check offs; daily on working days for 2 weeks, then weekly for one month then continue monthly. 2. The DON/designee will perform random insulin and g-tube med administration daily on working days for 2 weeks, then weekly for one month then continue monthly. 3. The CEO will review all findings at the quarterly Quality Assurance Committee meeting with the Medical Director. E. Date Completed: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is 01/12/13.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	resident's colostomy and utilized universal precautions i.e. gown and gloves and that the bag was emptied into the trash. The LPN was unaware of the resident playing with the colostomy. The LPN also indicated the resident ambulated throughout the facility. During interview of environmental staff person #10, on 12/6/12 at 11:50 am, the staff person indicated she worked on Unit 3 the past weekend (December 1 and 2, 2012). The staff person indicated Unit 3 had two residents (Residents #91 and #137) in precautions during the past weekend. The staff person indicated she was aware if a resident was in precautions, when a sign was on the door of the resident's room and from information received from the nursing staff. Environmental person #10 indicated if the resident was in precautions for c-diff, a disinfectant titled "Dispatch" was utilized on surfaces in the resident's room and bathroom, except for the floor. Environmental staff person #10 indicated "Virex II 256", was the chemical used on the floor. During interview of environmental staff person #11, on 12/6/12 at 12 noon, the staff person indicated Unit			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	3 was her usual assignment. The staff person indicated when a resident is in precautions, a sign indicating to "see nurse" was on the resident's door and information from the nurse was received. The Environmental Supervisor was interviewed on 12/6/12 at 12:45 PM. The supervisor indicated the resident rooms on Unit 3, were carpeted and were not routinely cleaned when a resident was in precautions for c-diff. Information, received from the Environmental Supervisor on 12/6/12 at 12:45 PM. titled "Virex II 256" indicated the chemical disinfectant did not kill the c-diff bacteria. A facility policy titled "Housekeeping, Cleaning a room with C-Diff" dated 5/3/12, and received on 12/6/12 at 2:15 PM, from the Corporate RN, indicated "Mop the floor with bleach solution-change mop head and water before entering another resident room..." On 12/6/12 at 1:15 p.m. the Interim DON and Corporate RN were interviewed regarding the facility's infection control program. The DON indicated any resident on an antibiotic for an infection is tracked for infection			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	control. The DON indicated an Infection Surveillance Report Form is initiated and included information about the resident regarding hospitalizations, culture and sensitivity results, antimicrobial treatments, risk factors at onset of infection, site, infection and clinical evidence of infections. The Corporate RN indicated guidelines for true infections were followed for Respiratory, gastro-intestinal, urinary tract, eyes, ears, nose, throat, upper respiratory, and skin were tracked. The RN indicated the facility determined if infections were nosocomial and were tracked including type of organism and were mapped by room on a facility layout. Monthly totals were completed to identify trends and/or increase in infections. The facility reviewed the results of tracking c-difficile infections for the months of July through November, 2012. Resident #64 who tested positive for c-diff in July, August, September, October, and November was not included in the monthly tracking for July, August, and September 2012. Upon review of Resident #137's clinical record on 12/7/12 at 10:30			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	a.m., documentation was noted of the resident having positive testing for Clostridium Difficile on 8/24/12, 8/25/12, 9/22/12, 10/9/12, 11/7/12, and 12/1/12. Monthly tracking of the resident's c-diff infections for the months of September and October, 2012 was lacking. During the interview of the DON and Corporate RN on 12/6/12 at 1:15 p.m. the staff indicated that the facility only mapped and tracked nosocomial infections. The staff indicated residents admitted with infections were not included in the tracking and mapping. The DON indicated the facility had three c-diff nosocomial infections for July 2012, three nosocomial c-diff infections for August 2012, two nosocomial c-diff infections for September 2012, two nosocomial c-diff infections for October 2012, and three nosocomial c-diff infections for November 2012. The results did not include information regarding Residents #64 and #137. The results reflected 12 different residents were identified with nosocomial infections of c-diff from July 2012 through November 2012. The DON indicated residents with c-diff would have a green cart outside of the room with protective protective			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	equipment in it and a sign placed on the resident's door for staff and visitors to check at the nursing station before entering. The information would also be provided to housekeeping staff for appropriate cleaning measures. The DON indicated Resident #64 was not put in precautions as stool was contained with a colostomy. A report of inservice training completed on 2/29/12, provided by the DON on 12/6/12 at 2:55 p.m., included but was not limited to, "To Stop the Spread of Infection It Begins Here: b. Contact precautions: This type of isolation is utilized when the resident has draining wounds or difficulty controlling body fluids within either the dressing or the brief. If the resident is in contact precautions a red sign will be placed on the door to see nurse's station, isolation cart outside door, notation made to pocket worksheet, and notation made to 24 hour report. All staff and visitors must put on gowns and gloves before each entry into resident's room. Red bags will be placed in trash cans. Gown and gloves must be removed before exiting the room. ..." A facility policy titled "Surveillance and Reporting of Nosocomial			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	Infections," dated 7/1/11, provided by the DON on 12/6/12 at 4:00 p.m. included, but was not limited to, "Guidelines: It is the intent of the facility that each episode of infection be assessed for evidence that is nosocomial. The process of observing, recording and reporting any occurrence and distribution of nosocomial infection will be done prospectively and systematically within the resident population and/or targeted areas when deemed appropriate. Nosocomial infection data will be collected each month, analyzed and compiled into a monthly infection report which will be reviewed by the Infection Control Committee, Administration, Medical Director, QA [Quality Assurance], and Patient Service Areas as applicable. Nosocomial infection data will be reviewed to determine if any corrective action is indicated to minimize future occurrences and unusual occurrences will be investigated in a timely manner." Additional information included in the policy addressed how the incidence of nosocomial infections was calculated. 2. On 12/6/12 at 12 p.m., Resident #146 (in contact isolation for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	Clostridium Difficile) was observed to have incontinence care provided by CNA #8 and QMA #7. The resident was observed to be incontinent of loose bowel movement. CNA #8 was observed to remove the resident's brief and to cleanse the resident's periarea. The CNA was observed to remove her gloves during care and obtain disposable chux from the resident's closet. The CNA was observed not to wash her hands after removing the contaminated gloves and applying new gloves. The CNA continued with the resident's incontinence care after applying the new gloves. QMA #7 was observed to touch the resident's skin when assisting with turning. Without changing their contaminated gloves, CNA #8 and QMA #7 were observed to use a bath blanket as a draw sheet under the resident, and reposition the resident. The CNA and QMA were then observed to remove their contaminated gloves and wash their hands. 3. LPN #6 on 12/11/12 at 11:25 a.m. was observed to complete blood glucose monitoring on Resident #52. The LPN was observed to place the clean blood glucose meter on the resident's unsanitized overbed table without a barrier. The LPN completed			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	the monitoring and removed her gloves and disposed of the supplies appropriately. The LPN was observed to place the soiled meter on top of the medication cart without a barrier. The meter was cleansed by the LPN and placed in a clean area of the cart. The LPN was then observed to complete the blood glucose monitoring of Resident # 8. The LPN was observed to apply new gloves prior to testing with Resident #8, however, the LPN was observed not to wash hands or use hand gel after removal of soiled gloves after providing care to Resident # 52. The LPN did not cleanse the area of the cart where the soiled meter had been placed after testing Resident #52. The LPN completed the testing with Resident #8. During the testing, the LPN placed the second cleansed meter on Resident #8's unsanitized overbed table without a surface barrier. After the testing, the LPN was observed to remove soiled gloves and place the soiled meter in same uncleansed area on the medication cart top. The LPN cleansed the soiled meter, placed meter in clean area of cart top, and then washed her hands. Upon review of the facility's current policy and procedure titled "Glucometer Cleaning" dated 7/1/11			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	on 12/12/12 at 11:33 a.m., documentation indicated "....Remove and discard gloves in appropriate receptacles after every procedure that involves potential exposure to blood or body fluids, including fingerstick blood sampling. Perform hand hygiene (i.e. hand washing with soap and water or use of an alcohol -based hand rub) immediately after removal of gloves and before touching other medical supplies intended for use of other residents..." Upon interview with the Interim Director of Nursing on 12/12/12 at 11:33 a.m. indicated if staff placed the meter on a surface during the blood glucose monitoring in a resident's room then a surface barrier should be placed between the meter and surface unless the surface was sanitized. 4. On 12/11/12 at 12:20 p.m., LPN #6 was observed to administer insulin to Resident #8. The LPN was observed to place the resident's insulin pen on the resident's overbed table without a surface barrier prior to administration of the insulin. The LPN, after insulin administration was then observed to return the resident's insulin pen into a basket with other insulins in the medication room refrigerator without			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	cleansing the insulin pen. Upon interview of the Interim Director of Nursing on 12/12/12 at 4:28 p.m., the DON indicated staff should place a surface barrier if the insulin pens were placed on a table top unless the table top surface had been cleansed. 5. On 12/12/12 at 1:40 p.m., LPN #12 was observed to provide liquid antibiotic Vancomycin to Resident #146. The resident was in contact isolation for c-diff. The nurse donned gown and mask, washed hands, put on gloves, and placed liquid medication and glass of water on the resident's overbed table. The LPN stopped the feeding pump, attached a syringe to the resident's gastronomy tube, instilled air into the tube and auscultated the resident's abdomen with a stethoscope. The LPN poured the medication into the tube followed by two 60 ccs [cubic centimeters] of water. The nurse reattached the tube feeding, went to the bathroom, with the same gloves on turned on the faucet, got more water in a cup for flushes, returned to resident, removed tube, attached syringe, and poured in two more syringes of water. After completion, the nurse reattached tube feeding, started the feeding pump, adjusted the resident's bed sheet			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932	

(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
	while wearing the same gloves. A facility policy titled "Medication Administration Via Enteral Tubes," dated 2004, provided by the DON on 12/12/12 at 4:30 p.m. included, but was not limited to, "3. Use aseptic technique. Wash hands prior to and after giving meds." 3.1-18(a) 3.1-18(b)(1)(a) 3.1-18(l)			