

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155483	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2016
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NAME OF PROVIDER OR SUPPLIER  WATERS OF RISING SUN, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 405 RIO VISTA LN RISING SUN, IN 47040
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 26, 27, 28, 29 and May 2, 2016.</p> <p>Facility number: 000405 Provider number: 155483 AIM number: 100273800</p> <p>Census bed type: SNF/NF: 43 Total: 43</p> <p>Census payor type: Medicare: 7 Medicaid: 30 Other: 6 Total: 43</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on May 9, 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: May 31, 2016.</p> <p><b>Facility is respectfully requesting paper compliance for all deficiencies in this POC.</b></p>	

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 0323 SS=E Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure the residents' environment was free of potentially hazardous items related to an unlocked construction staging room, unsecured chemicals, an unsupervised ladder, and improperly disposed of medications. This had the potential to affect 20 residents who were independently mobile of the 43 residents residing in the facility.</p> <p>Findings include:</p> <p>1. During the initial tour on 04/26/2016 at 10:41 A.M., an open, unattended room, across from resident room #1, had a box with three cans of spray paint, a caulking gun, loaded with a tube of caulk, 12 paint scrapers, a bucket containing a metal hammer, a metal pry bar, a paint roller, and a long silver metal rod, a box with a 12 inch dry wall saw and several metal tools, an open box containing three</p>	F 0323	<p>It is the policy of the facility to ensure that the environment of the residents is as free from accident hazards as possible. Also, that residents receive all necessary assistance and/or devices as well as adequate supervision to prevent accidents. Any construction staging areas/rooms are secured and are not accessible to residents. Any chemicals or ladders or tools are kept in accessible to residents. This includes not only construction staging areas/rooms but throughout the facility as well. Further, medications are disposed of properly and according to accepted practices per policy and regulation and never placed in a trash container. Contractors are educated as to the requirement to lock up their storage/work areas as they exit—making these areas inaccessible to residents. Additionally, the cabinet in the Whirlpool Room is kept locked and the key is kept in a location</p>	05/31/2016

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	<p>unopened tubes of caulk, and a large container, with a purple lid, of sanitizing wipes. While observing the open room, a painting sub-contractor entered the room, indicated the room was their staging area and walked out without closing or locking the door.</p> <p>During an interview on 04/26/2016 at 10:49 A.M., the ADON (Assistant Director of Nursing) indicated the room was left open during the time the painters were working in the building.</p> <p>2. During an observation on 04/26/2016 at 10:30 A.M., the Whirlpool Room door was open with no staff or residents inside the room. In the Whirlpool Room, a cabinet was unlocked with the key in the lock. In the cabinet there were supplies including, but not limited to, two bottles of bathroom cleaner and three cans of shaving cream. On the counter there was a container of sanitizing wipes.</p> <p>During an interview on 04/26/2016 at 10:42 A.M., the ADON (Assistant Director of Nursing) indicated chemicals were to be locked up when not in use.</p> <p>3. During an observation on 04/26/2016 from 10:30 A.M., there was an open ladder set up in the doorway of the "RT Storage" room leading to an opening in the ceiling. There were no staff, workers</p>		<p>that is not accessible to residents. The Whirlpool Room is also monitored when not in use and under staff supervision. Bleach wipes are not accessible to residents and are not placed or left on the countertop in the Whirlpool Room. Residents who are mobile in the facility or residents who receive medications have the potential to be affected by this finding. The Administrator/Designee will make facility wide rounds 5 days weekly on various shifts (including some weekend days) to ensure that any area where contractors or workers are working is secured as far as locking up chemicals and equipment including tools as they exit the area. Further, rounds will be made 5 days weekly by the Administrator/Designee to ensure that halls and resident areas (rooms/dining areas/lounge areas) do not contain any items that could cause accidents. Examples would be ladders, tools, cords on floor, unattended chemicals for cleaning and so on. Additionally, during the monitoring the Whirlpool Room will be monitored to see that it there are no hazardous chemical items on the countertop. Any concerns will be corrected immediately as found. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. After that, this monitoring will</p>	

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	<p>or residents nearby.</p> <p>During an observation on 04/26/2016 at 10:41 A.M., an unidentified staff member climbed the open ladder to check if anyone workers were in the ceiling. After confirming the ladder was not in use, the staff member took the ladder down.</p> <p>4. During an observation of medication pass on 04/29/2016 starting at 8:01 A.M., RN #1 prepared medications for Resident #43. During preparation, RN #1 dropped one unidentified medication on top of the medication cart and disposed of it in the trashcan on the side of the medication cart. During preparation of medication for Resident #7, RN #1 dropped one capsule of Omeprazole on top of the medication cart and disposed of it in the trashcan on the side of the medication cart.</p> <p>During an interview on 04/29/2016 at 8:32 A.M., RN #1 indicated she should have disposed of the medications in the sharps container, not the trashcan.</p> <p>During an interview on 04/29/2016 at 8:40 A.M., the Administrator indicated medications were not to be thrown in the trashcan, but were to be destroyed per the facility policy.</p>		<p>continue 3 days weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur. The DON/Designee will monitor a med pass 5 days weekly on various shifts (including some weekend days)to ensure that meds that are not administered after being prepared for administration are disposed of properly and not placed in a trash can or other inappropriate location. Further, theDON/Designee will monitor to see that the ordered dose for each medication is the dose on hand to be given. Any other dose will be removed from the supply if found. Additionally, during this monitoring, the DON/Designee will monitor for proper hand hygiene and glove usage during the med pass as related to infection control accepted practices. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. After that, this monitoring will continue 3 days weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur. At an in-service held for all staff April 19, 2016, the following was reviewed: A.) Resident Rights—with emphasis on safety in the environment B.) Who to do if you see a“setting” that could be potentially “unsafe.” Examples: Unlocked doors to</p>		

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	<p>During an interview on 04/29/2016 at 2:05 A.M., LPN #3 indicated medications that needed to be wasted were to be put in the sharps container, never the trashcan.</p> <p>The current facility policy, titled "Drug Administration -- General Guidelines" and dated 06/19/2016, was provided by the administrator on 04/29/2016 at 9:06 A.M. and was reviewed at that time. The policy indicated, "...Once remove [sic] from the package or container, unused doses should be destroyed..."</p> <p>The current, undated facility policy, titled "Safety Data Sheet &amp; Chemical Safety", was provided by the administrator on 05/20/2016 at 9:19 A.M. and was reviewed at that time. The policy indicated, "...Keep all chemicals out of reach of children and untrained personnel..."</p> <p>The current "Maintenance Safety Checklist" was provided by the Administrator on 05/02/2016 at 10:41 A.M. and indicated, "equipment and tools stored in clean, and orderly condition...chemicals kept locked up...ladders stored in proper places..."</p> <p>3.1-19(f) 3.1-19(aa)(3)</p>		<p>rooms with hazardous chemicals, tools or ladders or any item which could potentially causeharm and so on C.) Questions/Answers At an in-service for nursing staff who administer medications held April 22, 2016, the following was reviewed: A.) Medication Administration Policy/Procedure B.) What to do if you have prepared a medication for administration and for some reason the medication is not administered C.) Medication Destruction D.) Proper hand hygieneand glove usage during med passes E.) Question/Answers Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings the results of the monitoring will be reviewed. 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 weekly until resolution. Note: Any concerns will have been corrected immediately as found.</p>		

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F 0332 SS=D Bldg. 00	<p>3.1-45(a)(1)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure it was free of a medication error rate greater than 5%, with the facility having 2 medication errors out of 27 opportunities for error, resulting in a 7.4% error rate. This affected 2 of 4 residents observed for medication pass. (Resident #6 and #43)</p> <p>Findings include:</p> <p>1. During an observation of medication administration on 04/29/2016 at 8:10 A.M., RN (Registered Nurse) #1 administered one tablet of Nifedipine ER (extended release) 60 mg (milligrams) to Resident #6.</p> <p>The clinical record was reviewed for Resident #6 on 04/29/2016 at 9:40 A.M. The current physician orders for Resident #6 indicated Nifedipine ER tablet, 30 mg,</p>	F 0332	<p>It is the policy of the facility to see that medications are administered as per policy and procedure which would prevent the commission of med errors. Residents #6 and #43 receive their medications at the ordered dose and at the indicated time of day as per the most recent physician's order. Further, discontinued meds or discontinued doses of meds are removed from the med carts/supply areas at the time the order is received to discontinue. Any resident who resides in the facility and receives medication has the potential to be affected by this finding. The DON/Designee will monitor the med supply to see that it coincides with the ordered meds at the same time that the med passes are monitored as stated in the response for F-323. The education and followup and QA for F-332 are included in the education and follow up and QA</p>	05/31/2016

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	<p>give one tablet by mouth one time a day. The order had a start date of 04/29/2016 at 8:00 A.M.</p> <p>During an interview on 04/29/2016 at 9:50 A.M., RN #1 indicated she must have given the incorrect medication dosage since the order had changed from 60 mg to 30 mg of Nifedipine.</p> <p>During an interview and observation on 04/29/2016 at 9:56 A.M., the DON (Director of Nursing) removed the Nifedipine 60 mg medication card from the medication cart and showed the Nifedipine 30 mg medication card that had already been placed into the cart, but had not been used yet. The DON indicated the 60 mg card should have been removed when the new medication card had been placed in the cart.</p> <p>2. During an observation of medication administration on 04/29/2016 at 8:12 A.M., RN #1 administered one tablet of Levothyroxine 100 mcg (micrograms) to Resident #43.</p> <p>The clinical record was reviewed for Resident #43 on 04/29/2016 at 9:42 A.M. The current physician orders for Resident #43 indicated Synthroid Tablet (Levothyroxine Sodium), give 156 mcg by mouth one time a day.</p>		responseto F-323.	

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	<p>During an interview on 04/29/2016 at 9:56 A.M., the DON indicated there were two different dosage strengths of Levothyroxine, one 100 mcg tablet and one half of a 112 mcg tablet, to equal a total dosage of 156 mcg. She further indicated both the full and half tablets were to be given at the same time.</p> <p>The current facility policy, titled "Medication Administration Procedure" and dated 06/19/2012, was provided by the Administrator on 04/29/2016 at 9:06 A.M. and was reviewed at that time. The policy indicated, "...Read each order entirely...If there is any discrepancy between the MAR [Medication Administration Record] and the label, check physician orders before administering medication...if the medication is discontinued or outdated, remove medication..."</p> <p>The current facility policy, titled "Drug Administration -- General Guidelines" and dated 06/19/2012, was provided by the Administrator on 04/29/2016 at 9:06 A.M. and was reviewed at that time. The policy indicated, "...Medications are administered in accordance with written orders of the attending physician...The right dose: verify against the MAR..."</p>			

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F 0441 SS=E Bldg. 00	<p>3.1-25(b)(9) 3.1-48(c)(1)</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and</p>			

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	<p>transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to ensure proper infection control procedures were maintained in relation to glove use and hand washing during medication administration. This deficient practice affected 5 of 7 residents observed during medication administration. (Resident #6, 7, 12, 14, and 43)</p> <p>Findings include:</p> <p>Medication administration was observed on 04/29/2016 at 8:01 A.M. RN (Registered Nurse) #1 prepared medications, including insulin, for Resident #12. After administering the resident's oral and inhalant medications, RN #1, without donning gloves, lifted the resident's shirt, swabbed Resident #12's stomach with an alcohol pad, and administered the resident's insulin injection. The RN then disposed of the insulin needle in the sharps container, washed her hands appropriately, turned off the water with a paper towel and then dried her hands with the same paper towel.</p> <p>After returning to the medication cart, RN #1 prepared medications for Resident #6. The RN administered the medications</p>	F 0441	<p>It is the policy of the facility to provide a safe, sanitary and comfortable environment for the residents that helps to prevent the development or transmission of disease and infection. Residents #6, #7, #12, #14 and #43 receive their medications including insulin by nursing staff using proper technique in regards to infection control. The DON/Designee monitors for F-323 and F-332 will include hand hygiene and proper glove usage during med passes as related to infection control practices. See responses for monitoring/education/followup and QA for F-323 and F-332.</p>	05/31/2016

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	<p>to the resident before returning to the cart. RN #1 did not wash her hands or use hand sanitizer after administering Resident #6's medications.</p> <p>RN #1 then prepared Resident # 43's medications. During preparation, RN #1 dropped one medication from the medication card into her bare hand and placed it into the medication cup. The RN then dropped a different medication onto the top of the medication cart, picked the medication up with her bare hand, and disposed of the medication. After preparing the rest of Resident #6's medications, RN #1 administered the medications and returned to the medication cart without washing her hands or using hand sanitizer.</p> <p>RN #1 then prepared medications for Resident #7. During preparation, RN #1 dropped one capsule of omeprazole onto the top of the medication cart, picked the medication up with her bare hand, and disposed of the medication. After preparing the rest of Resident #7's medications, RN #1 administered the medications to the resident, rubbed her hand over her face, and returned to the medication cart without washing her hands or using hand sanitizer.</p> <p>RN #1 then prepared medications for</p>			

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	<p>Resident #14. After taking the resident's pulse, RN #1 washed her hands for 17 seconds, holding her hands under running water for the duration of scrubbing. RN #1 then administered Resident #14's medications, returned to the cart, removed the trashbag from the medication cart, and washed her hands.</p> <p>During an interview on 04/29/206 at 8:40 A.M., the Administrator indicated hands should be washed or hand sanitizer should be used between each resident during medication administration.</p> <p>During an interview on 04/29/2016 at 2:05 P.M., LPN (Licensed Practical Nurse) #3 indicated medications should not be handled with bare hands and if a medication was dropped staff should put on a glove to pick it up. She further indicated hands should be washed or hand sanitizer should be used between each resident during medication administration and gloves should always be worn when administering injections.</p> <p>During an interview on 05/02/2016 at 2:49 P.M., LPN #2 indicated hands should be washed between each room when administering medications. She further indicated medications were never to be handled with bare hands and gloves were to be worn when injections were</p>			

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	<p>given. LPN #2 indicated proper handwashing included 20 seconds of scrubbing and that a paper towel was used to dry hands and a new paper towel was used to turn off the water.</p> <p>The current facility policy, titled "Insulin Injection Administration Procedures" and dated 06/19/2012, was provided by the Administrator on 04/29/2016 at 9:06 A.M. and was reviewed at that time. The policy indicated, "...3. Proper hand washing before and after administration of insulin. 4. Apply gloves..."</p> <p>The current facility policy, titled "Medication Administration Procedure and dated 06/19/2012, was provided by the Administrator on 04/29/2016 at 9:06 A.M. and was reviewed at that time. The policy indicated, "...Wash hands before beginning, whenever you contaminate your hands, and if contact is made with the medications..."</p> <p>The current facility policy, titled "Hand Hygiene" and dated 08/21/2013, was provided by the Administrator on 04/26/2016 at 2:44 P.M. and was reviewed at that time. The policy indicated, "...If hands are not visibly soiled, use an alcohol-based hand rub...before and after contact with residents, before putting on and taking</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155483	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2016
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NAME OF PROVIDER OR SUPPLIER  WATERS OF RISING SUN, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 405 RIO VISTA LN RISING SUN, IN 47040
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F 0458 SS=D Bldg. 00	<p>off gloves...after contact with an inanimate object in the immediate vicinity of the resident..." and "...rub hands together vigorously for at least 20 seconds...4. Rinse hands with warm water and dry thoroughly with a disposable towel. 5. Use towel to turn off faucet..."</p> <p>The current facility policy, titled "Drug Administration -- General Guidelines" and dated 06/19/2012, was provided by the Administrator on 04/29/2016 at 9:06 A.M. and was reviewed at that time. The policy indicated, "...Cleanse hands before beginning each medication pass. Cleanse hands when contact is made with a medication. Cleanse hands whenever they are contaminated. You may use antiseptic foam or gel...Punch medications directly into cup and never into your hand..."</p> <p>3.1-18(l)</p> <p>483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. Based on observation, interview and record review, the facility failed to provide at least 80 square feet per</p>	F 0458	It is the policy of the facility to provide the required amount of square footage per resident per rooms as stated in the	05/31/2016

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	<p>resident for 4 of 28 resident rooms. (Rooms 3, 4, 5 and 7).</p> <p>Findings include:</p> <p>During the initial tour on 04/26/2016 at 10:30 A.M., and per facility documentation provided by the Administrator, the following rooms were observed to have less than 80 square feet per resident:</p> <p>*Room 3, SNF/NF, had the capacity of 3 resident beds and was 229 square feet, equaling 76.3 square feet per resident.</p> <p>*Room 4, SNF/NF, had the capacity of 3 resident beds and was 238 square feet, equaling 79.3 square feet per resident.</p> <p>*Room 5, SNF/NF, had the capacity of 3 resident beds and was 202 square feet, equaling 67.3 square feet per resident.</p> <p>*Room 7, SNF/NF, had the capacity of 3 resident beds and was 207 square feet, equaling 69 square feet per resident.</p> <p>During an interview on 05/02/2016 at 11:27 A.M., the Administrator indicated they would use the beds as last options and indicated he would like to continue the room waiver.</p>				<p>regulations. Rooms #3, #4, #5 and #7 have been allowed for use under previous waiver.</p> <p>Note: These rooms are used as last options. Only residents admitted to these rooms would be affected by this finding. The Administrator is aware of the regulation and stated previously, would use these rooms as a last option. These rooms would be/are used for 2 residents as opposed to 3 residents if they were/are used to provide more living area as far as square footage per resident.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/26/2016

FORM APPROVED

OMB NO. 0938-0391

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	3.1-19(1)(2)(A) 3.1-19(1)(3) 3.1-19(1)(8)				