

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(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	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This survey was in conjunction with the Investigation of Complaint IN00114686.</p> <p>Survey dates: August 13, 14, 15, 16, 17 and 20, 2012</p> <p>Facility number: 000138 Provider number: 155233 AIM number: 100266500</p> <p>Survey team: Jill Ross, RN TC Diana Sidell, RN Penny Marlatt, RN Cheryl Fielden, RN Gloria Reisert, SW</p> <p>Census bed type: SNF/NF: 67 Total: 67</p> <p>Census payor type: Medicare: 4 Medicaid: 45 Other: 18 Total: 67</p> <p>These deficiencies reflect state findings cited in accordance with 410</p>	F0000	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.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(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
	IAC 16.2. Quality review completed on August 27, 2012 by Bev Faulkner, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(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	
F0159 SS=B	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on record review and interview, the facility failed to ensure quarterly statements were provided to residents. This affected 3 of 3 residents in a sample of 3 residents reviewed for facility management of funds. This potentially affected 55 residents with facility managed trust accounts in the population of 67. (Resident's #58, #62, and #65)</p> <p>Findings include:</p> <p>Interview with Resident #58 on 8/13/12 at 1:59 p.m., indicated the facility does not provide quarterly statements.</p> <p>Interview with Resident #62 on 8/14/12 at 10:53 a.m., indicated the facility does not provide quarterly statements.</p> <p>Interview with Resident #65's family on 8/14/12 at 9:03 a.m., indicated that the facility does not provide quarterly</p>	F0159	<p>F 159 Management of Personal Funds</p> <p>It is the intent of this facility to hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility.</p> <p>-</p> <p>1. Actions Taken:</p> <p>The quarterly resident financial statements are now printed at the facility when needed. The resident financial statements for the first two quarters of 2012 will be mailed by no later than 08-31-12. The third quarter resident financial statements will be mailed by no later than 10-26-12. Going forward all quarterly resident financial statement will be sent out by no later than the last business day of the month following that quarter.</p> <p>2. Others Identified:</p>	09/19/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>statements.</p> <p>A review of resident accounts on 8/17/12 at 11:00 a.m., indicated the following:</p> <ul style="list-style-type: none"> -Resident #58 had no second quarter, 2012 statement sent. -Resident #62 had the first quarter 2012 statement sent to a family member, not returned, no second quarter 2012, statement sent. -Resident #65 had no second quarter 2012 statement sent to family. <p>An interview with the Business Office Manager (BOM) on 8/16/12 at 1:30 p.m., indicated "Statements for resident funds accounts are generated by corporate office, after the end of a quarter the facility should receive statements by 30 days past end of quarter, so they can be delivered to the residents or resident's representative. The second quarter (April 1, 2012 to June 30, 2012) statements were not received from corporate offices, the first quarter (January 1, 2012-March 31, 2012) statements were not received from corporate office, statements were generated by the business office and sent out on May 25, 2012. No statements were received for the fourth quarter (October 1, 2011-December 31, 2011) and no</p>		<p>Per the 2567, this potentially affected all the residents with facility managed trust accounts. No further review was needed.</p> <p>-</p> <p>3. Measures Taken:</p> <p>An in-service was conducted by the BOM from our sister facility with our Office Manager.</p> <p>4. How Monitored:</p> <p>a. The CEO/Designee will monitor the Business Office to ensure the resident trust financial statements are being sent in a timely manner. This will be done on the tenth business day of the first month following the quarter and then again on the next to last business day of that same month.</p> <p>b. QA committee will review all audit/inspection reports monthly and will review quarterly with the Medical Director, for four quarters, to determine if further action is needed.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09-19-12.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>statements were received for the third quarter (July 1, 2011-September 30, 2011). An email reminder should come from the corporate office to generate a statement, and send to the resident or resident's representative."</p> <p>A policy and procedure, titled "Resident Trust" and dated 4/2011, was received on 8/17/12 at 11:28 a.m., from the BOM and indicated, "...Procedure: 1. Prior to accepting trust funds for a resident, the Facility must have the resident or responsible party sign a Resident Trust Fund Agreement."</p> <p>A form titled "Delegation of Responsibility for the Management of Personal Trust Funds" received on 8/17/12 at 11:28 a.m. from the BOM indicated, "...Statement Policy: It is understood that the party designated below shall receive quarterly accounting of all transactions to the above-named Resident's account..."</p> <p>3.1-6(g)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(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			
F0160 SS=B	<p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>Based on record review and interview, the facility failed to convey a final accounting of resident's funds. This affected 2 of 3 residents in a sample of 3 residents. (Residents #53 and #112)</p> <p>Findings include:</p> <p>A review of Resident #53's account indicated a date of death as 6/6/12 and the account was closed on 7/10/12. A payout to Resident #53's family member was made for the balance in the account. A balance of .01 cents remained in the account as of 8/16/12 at 1:30 p.m.</p> <p>A review of Resident #112's account indicated a date of death as 2/6/12 and the account was closed on 2/9/12. A payout of Resident #112's account was made to Resident #112's funeral home. A balance of .03 cents remained in the account as of 8/16/12 at 1:30 p.m.</p>	F0160	<p><u>F 160 Conveyance of personal funds upon death</u></p> <p>It is the intent of this facility to convey within 30 days of the death of a resident the funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p><u>1. Actions Taken:</u></p> <p>The resident funds account for residents #53 and #112 has been adjusted to allow for a zero balance.</p> <p>-</p> <p><u>2. Others Identified:</u></p> <p>An audit of the resident funds accounts was conducted by the BOM for all the residents who passed away from 02-06-12 up to and including 08-31-12. No other residents were affected.</p>	09/19/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(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	
	An interview on 8/16/12 at 1:30 p.m., with the Business Office Manager (BOM) indicated the balances in the accounts on 8/16/12 at 1:30 p.m., was due to interest being paid to the accounts after they were closed and paid out. 3.1-6(h)		<p>3. Measures Taken:</p> <p>Each resident will have their resident funds account audited by the BOM within 10 Business days after their death. This will allow for prompt and timely conveyance of the personal funds within the 30-day requirement.</p> <p>4. How Monitored:</p> <p>a. The CEO/Designee will review each resident's funds account 11 to 13 business days after their death and then again on the next to last business day of each month. This will be done for a total of 6 months.</p> <p>b. QA committee will review all audit/inspection reports monthly and will review quarterly with the Medical Director, for four quarters, to determine if further action is needed.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09-19-12.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(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			
F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F0225				09/19/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Based on interview and record review, the facility failed to ensure all allegations of abuse were reported to ISDH. This affected 1 of 5 residents interviewed who met the criteria for abuse in a sample of 23. (Resident #D)</p> <p>Findings include:</p> <p>During an interview on 8/13/12 at 2:38 p.m., Resident #D indicated that a staff member had been rude to him. He indicated that once in a while he asks for something and they say he isn't the only one they have to take care of. He indicated this had happened two or three times on the evening shift, he didn't know the staff member's name, and he hasn't told anyone about this. He also indicated that sometimes it makes him "feel bad."</p> <p>Resident #D's record was reviewed on 8/15/12 at 2:11 p.m. The record indicated Resident #D was admitted with diagnoses that included, but were not limited to, atrial fibrillation, high blood pressure, arthritis, dementia, and seizure disorder.</p> <p>An annual Minimum Data Set assessment, dated 5/29/12, indicated Resident #D was independent,</p>		<p>F 225 <u>Investigate/report allegations by individuals</u></p> <p>It is the intent of this facility to ensure that all allegations of abuse are reported to the Indiana State Department of Health.</p> <p><u>1. Actions Taken:</u></p> <p>In regards to Resident D: All Staff and Department Directors will be in-serviced on immediate reporting of alleged abuse as required per the Abuse Policy & Procedure upon hire, annually and as needed. Emphasis placed on "alleged" must be treated as "real" and reported immediately; then the investigation should be initiated, as required.</p> <p><u>2. Others Identified:</u></p> <p>There were no other allegations of abuse and no other residents were affected.</p> <p><u>3. Measures Taken:</u></p> <p>All Staff and Department Directors will be in-serviced on immediate reporting of alleged abuse as required per the Abuse Policy & Procedure upon hire, annually and as needed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>decisions consistent, reasonable in cognitive skills for daily decision making.</p> <p>Social Service notes, dated 8/14/12, indicated: "SS (Social Services) spoke with res (resident) today concerning res comment on particular staff member. Res made comment that res is not afraid of staff member, however, does not appreciate staff member's attitude and personality. Res was given reassurance res was appreciative of ss spending time with him. Res thanked ss. DON (Director of Nursing) made aware of res concerns."</p> <p>On 8/16/12 at 2:28 p.m., the Social Services Director indicated they did an investigation into the alleged abuse, the resident couldn't remember her name, she got a description of who it was and notified the DON. Resident #D wasn't afraid of the person, he just didn't appreciate her attitude. The staff member was not in the building at the time, they called her to let her know and she was given a written warning.</p> <p>The Administrator provided a partial investigation on 8/16/12 at 2:49 p.m., which included: [Resident #D] stated to them on 8/13/12 : "Was there</p>		<p>Emphasis placed on "alleged" must be treated as "real" and reported immediately; then the investigation should be initiated, as required.</p> <p>4. How Monitored:</p> <p>a. The CEO/Designee will review all reports of alleged abuse; suspend any staff member allegedly involved, report as per the guidelines of the ISDH, and initiate investigation. A follow-up report at the conclusion of the investigation will also be sent to ISDH. This is an on-going process.</p> <p>b. The QA committee will review all allegations of abuse, if and when they occur, in the daily QA stand-up meeting.</p> <p>c. A summary of events/conclusions will be reviewed in the monthly QA Committee meeting, and quarterly with the Medical Director.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09-19-12.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>anyone rude or mean to you? - Oh yes, kind of reddish hair, always evening, average height, short hair...anything I asked her to do was too much [She would say] "I got other people to take care of too." Also: he was asked: "Has anyone ever been rude to you? his answer: "Yes, I can't remember her name. She had reddish hair, average height, short hair, little bit on the heavy side, maybe in her 20's, always work evening."</p> <p>On 8/16/12 at 2:49 p.m., the Administrator indicated they didn't report because they did an interview with Resident #D), and he wasn't afraid.</p> <p>An employee memorandum was provided by the Social Services Director on 8/16/12 at 2:50 p.m., and indicated RN #21 was abrupt in her approach, and this was perceived "as with attitude." This was documented as an oral warning.</p> <p>During an interview on 8/17/18 at 1:18 p.m., the Social Services Director indicated she would interview the resident, make sure he was emotionally ok, and that he wasn't under any emotional distress. When she interviewed him, he was smoking</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>and sitting in his w/c. He said he wasn't afraid, then after that, he was emotionally ok. She interviewed residents on the same hall and did not find any trends. When there is an allegation of abuse, they would initiate the abuse protocol, but with this it was a misunderstanding, and it was not willful, and she documented in his chart what she found out.</p> <p>A policy and procedure for "Abuse Prohibition", with an issued date of 7/1/11, was provided by the DON on 8/15/12 at 9:55 a.m. The policy indicated, but was not limited to: "1. Definitions of key terms: a) Abuse: Willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish...b) Verbal Abuse: The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability.</p> <p>A policy and procedure for "Abuse-Reporting", with an issued date of 7/1/11, was provided by the DON on 8/15/12 at 9:55 a.m. The policy indicated, but was not limited</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>to: "...3...The Administrator (or designee) will report Abuse/Neglect to the Department of Health within 24 hours per the Indiana Department of Health reporting guidelines...."</p> <p>3.1-28(c)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(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	
F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to implement the abuse policy and procedure related to reporting. This affected 1 of 5 residents who met the criteria for abuse in a sample of 23. (Resident #D)</p> <p>Findings include:</p> <p>During an interview on 8/13/12 at 2:38 p.m., Resident #D indicated that a staff member had been rude to him. He indicated that once in a while he asks for something and they say he isn't the only one they have to take care of. He indicated this had happened two or three times on the evening shift, he didn't know the staff member's name, and he hasn't told anyone about this. He also indicated that sometimes it makes him "feel bad."</p> <p>Resident #D's record was reviewed on 8/15/12 at 2:11 p.m. The record</p>	F0226	<p><u>F 226 Develop/implement Abuse/Neglect policy & procedures</u></p> <p>It is the intent of this facility to ensure the written policies and procedures related to reporting are followed.</p> <p><u>1. Actions Taken:</u></p> <p>In regards to Resident D: All Staff and Department Directors were in-serviced on the written policies and procedures related to reporting any allegation of abuse.</p> <p><u>2. Others Identified:</u></p> <p>There were no other allegations of abuse and no other residents were affected.</p> <p><u>3. Measures Taken:</u></p> <p>All Staff and Department Directors were in-serviced on the</p>	09/19/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>indicated Resident #D was admitted with diagnoses that included, but were not limited to, atrial fibrillation, high blood pressure, arthritis, dementia, and seizure disorder.</p> <p>An annual Minimum Data Set assessment, dated 5/29/12, indicated Resident #D was independent, decisions consistent, reasonable in cognitive skills for daily decision making.</p> <p>Social Service notes, dated 8/14/12, indicated: "SS (Social Services) spoke with res (resident) today concerning res comment on particular staff member. Res made comment that res is not afraid of staff member, however, does not appreciate staff member's attitude and personality. Res was given reassurance res was appreciative of ss spending time with him. Res thanked ss. DON (Director of Nursing) made aware of res concerns."</p> <p>On 8/16/12 at 2:28 p.m., the Social Services Director indicated they did an investigation into the alleged abuse, the resident couldn't remember her name, she got a description of who it was and notified the DON. Resident #D wasn't afraid of the person, he just didn't</p>		<p>written policies and procedures related to immediate reporting of alleged abuse. This information will continue to be enforced and educated on upon hire, annually and as needed.</p> <p>4. How Monitored:</p> <p>a. The CEO/Designee will review all reports of alleged abuse; suspend any staff member allegedly involved; report as per the guidelines of the ISDH, and an investigation will be initiated. A follow-up report at the conclusion of the investigation will also be sent to ISDH. This is an on-going process.</p> <p>b. The QA committee will review all allegations of abuse, if and when they occur, in the daily QA stand-up meeting.</p> <p>c. A summary of events/conclusions will be reviewed in the monthly QA meeting and quarterly with the Medical Director.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09-19-12.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>appreciate her attitude. The staff member was not in the building at the time, they called her to let her know and she was given a written warning.</p> <p>The Administrator provided a partial investigation on 8/16/12 at 2:49 p.m., which included: [Resident #D] stated to them on 8/13/12 : "Was there anyone rude or mean to you? - Oh yes, kind of reddish hair, always evening, average height, short hair...anything I asked her to do was too much [She would say] "I got other people to take care of too." Also: he was asked: "Has anyone ever been rude to you? his answer: "Yes, I can't remember her name. She had reddish hair, average height, short hair, little bit on the heavy side, maybe in her 20's, always work evening."</p> <p>On 8/16/12 at 2:49 p.m., the Administrator indicated they didn't report because they did an interview with Resident #D), and he wasn't afraid.</p> <p>An employee memorandum was provided by the Social Services Director on 8/16/12 at 2:50 p.m., and indicated RN #21 was abrupt in her approach, and this was perceived "as with attitude." This was documented</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>as an oral warning.</p> <p>During an interview on 8/17/18 at 1:18 p.m., the Social Services Director indicated she would interview the resident, make sure he was emotionally ok, and that he wasn't under any emotional distress. When she interviewed him, he was smoking and sitting in his w/c, he said he wasn't afraid, then after that, he was emotionally ok. She interviewed residents on the same hall and did not find any trends. When there is an allegation of abuse, they would initiate the abuse protocol, but with this it was a misunderstanding, and it was not willful, and she documented in his chart what she found out.</p> <p>A policy and procedure for "Abuse Prohibition," with an issued date of 7/1/11, was provided by the DON on 8/15/12 at 9:55 a.m. The policy indicated, but was not limited to: "1. Definitions of key terms: a) Abuse: Willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish...b) Verbal Abuse: The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>their hearing distance, regardless of their age, ability to comprehend, or disability.</p> <p>A policy and procedure for "Abuse-Reporting", with an issued date of 7/1/11, was provided by the DON on 8/15/12 at 9:55 a.m. The policy indicated, but was not limited to: "...3...The Administrator (or designee) will report Abuse/Neglect to the Department of Health within 24 hours per the Indiana Department of Health reporting guidelines...."</p> <p>3.1-28(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(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	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to honor the dignity of 2 of 5 residents reviewed for dignity as evidenced by one resident's clothing with obvious stains for more than 3 hours after a meal and by the resident's call light not being answered in a timely manner in which to prevent incontinence. (Resident #17 and D)</p> <p>Findings include:</p> <p>1. On 8-15-12 at 4:01 p.m., Resident #17 was observed lying in bed, with a hospital gown on. Stains of dark yellow, orange and brown spots were on the gown's chest area. White food particles were observed in the resident's beard. Observation on 8-15-12 at 4:44 p.m., indicated his gown remained unchanged. Food particles were no longer on his beard, but had fallen onto the gown.</p> <p>Observation on 8-16-12 at 8:41 a.m., indicated the same or a similar gown appeared to be on Resident #17 with</p>	F0241	<p>F 241 Dignity and respect of individuality</p> <p>It is the intent of this facility to honor the dignity of our residents by removing soiled clothing after a meal and by answering call lights in a timely manner to prevent incontinence.</p> <p>-</p> <p>1. Actions Taken:</p> <p>a. In regards to Resident # 17: new clothing/gown will be donned daily and PRN if soiled during a meal.</p> <p>b. In regards to Resident D: Staff will make rounds at a minimum of every 2 hours on night shift to assist with toileting; and on each shift, the Charge Nurse will ensure call lights are answered timely.</p> <p>2. Others Identified:</p> <p>An audit of the current residents was conducted and no other</p>	09/19/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>colored stains in the chest area as the previous day.</p> <p>In interview with CNA #11 on 8-16-12 at 9:52 a.m., she indicated, " I try to check on him at least every 1-2 hours. I'm getting ready to go get him cleaned up if he will let me. He sometimes won't let us touch him, but that's his choice. He normally wears a hospital gown. I've offered to let him wear other things, but he always tells me 'gown.' Maybe it's just easier for him. I didn't notice any stain on his gown this morning. I guess it would be from his breakfast this morning."</p>		<p>residents were affected.</p> <p>3. Measures Taken:</p> <p>a. Charge Nurse on each Unit will monitor for timely answering of call lights; and initial 24 hour report for compliance. This will be an on-going process.</p> <p>b. Department Heads will do daily rounds; monitoring for resident appearance, clean shaven, well groomed, clean clothing. Rounds tool will be utilized to ensure this occurs; this tool will be reviewed in the daily QA stand-up meeting to ensure all issues were resolved. This is a continuous on-going process.</p> <p>c. All Staff was in-serviced on Resident Rights with emphasis on dignity, individuality, grooming, and timely answering of call lights.</p> <p>4. How Monitored:</p> <p>a. The CEO/Designee will review all completed daily rounds forms in the Daily QA stand-up meeting to ensure all issues were resolved.</p> <p>b. CEO/Designee will review a summary of the Daily Rounds Forms at the monthly QA</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>2. Resident #D's record was reviewed on 8/15/12 at 2:11 p.m. The record indicated Resident #D was admitted with diagnoses that included, but were not limited to, atrial fibrillation, high blood pressure, arthritis, dementia, and seizure disorder.</p> <p>An annual Minimum Data Set assessment, dated 5/29/12, indicated Resident #D was independent, decisions consistent, reasonable in cognitive skills for daily decision making and was occasionally incontinent of bowel and bladder.</p> <p>During an interview on 8/17/12 at 12:50 p.m., Resident #D indicated he has to wait too long at least once a day for his call light to be answered and is incontinent. He said this happens most frequently on the night shift.</p>		<p>meeting; and will review quarterly with the Medical Director.</p> <p><u>5.</u> This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09-19-12.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(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
	3.1-3(t)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(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			
F0242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to ensure residents had a choice of bath time, frequency or type of bath and failed to ensure residents had a choice of bed time for 2 of 17 residents interviewed in the sample of 23 who met the criteria for choices. (Residents #C and D)</p> <p>Findings include:</p> <p>1. Resident #D's record was reviewed on 8/15/12 at 2:11 p.m. The record indicated Resident #D was admitted with diagnoses that included, but were not limited to, atrial fibrillation, high blood pressure, arthritis, dementia, and seizure disorder.</p> <p>An annual Minimum Data Set assessment, dated 5/29/12, indicated Resident #D was independent, decisions consistent, reasonable in</p>	F0242	<p><u>F 242 Self-determination & right to make choices</u></p> <p>It is the intent of this facility to ensure the resident has the right to choose their bathing time, frequency, and type of bath, and to choose their bedtime.</p> <p><u>1. Actions Taken:</u></p> <p>a. In regards to Resident D, a care plan conference was held allowing the resident to verbalize preferences in regards to an am bath schedule, frequency, and type of bath her preferred. The resident also identified his preferred bedtime. These choices will be honored to every extent possible.</p> <p>b. In regards to Resident C, a care plan conference was scheduled with the spouse. Upon conclusion of this meeting, we will honor preferences to every extent possible.</p>	09/19/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>cognitive skills for daily decision making.</p> <p>An activity progress note dated 5/29/11 indicated a summary for: "Res (resident) enjoys snacking, choosing bedtime...choose method of bathing - somewhat important, choose bedtime - very important.</p> <p>During an interview on 8/13/12 at 2:24 p.m., Resident #D indicated he didn't get to choose how many times a week he takes a bath or shower, he has no choice, they give him a shower with a spray thing and it's either too cold or too hot. He indicated he would like a tub bath, but figures he doesn't have much of a choice, he usually gets a shower, and hasn't seen a tub. Resident #D said, "It is set up by them, they don't give me a choice." He also indicated he could not choose whether he takes a shower, tub, or bed bath. He said he would "like to go to bed about 8:30 p.m., and sometimes it is 10:00 p.m. before he gets to bed, they only have 2 or 3 staff assisting him to bed."</p> <p>On 8/17/12 at 10:56 a.m., Resident #D indicated he told the CNA's he wanted a shower in the morning, but they told him they start at the end of the hallway and work toward the other</p>		<p><u>2. Others Identified:</u></p> <p>100% audit of the current residents was conducted and no other residents were identified.</p> <p><u>3. Measures Taken:</u></p> <p>a. The resident choice for bath time, frequency, type and bedtime will be reviewed with each new resident/representative at the time of admission, and during the Care Conference process.</p> <p>b. Staff was in-serviced on Resident Rights with emphasis on choices.</p> <p><u>4. How Monitored</u></p> <p>a. The DON/Designee will audit all completed Bathing & Bedtime Choices forms for all new admissions to ensure accuracy of care plans and schedules. This will be an on-going process.</p> <p>b. The CEO/Designee will review new admission preferences and bathing schedules as completed; then monthly with the QA Committee for two quarters, and will review quarterly with the Medical Director, for two quarters,</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>end.</p> <p>On 8/17/12 at 11:00 a.m., CNA #20 indicated in the shower book that Resident #D was showered on Monday and Thursday on the 2 p.m. to 10 p.m. shift.</p> <p>2. Resident #C's record was reviewed on 8/13/12 at 10:10 a.m. The diagnoses included but were not limited to Alzheimer's disease, hyperlipidemia, and hypertension.</p> <p>An interview on 8/13/12 at 4:18 p.m., with Resident #C's spouse indicated the normal routine at home for Resident #C was to shower every morning. A choice of when to bathe and what type of bathing was not offered to the resident or resident's spouse, Resident #C "must be worked in for a shower." Resident #C's usual routine at home was to go to bed at 9:30 p.m. to 10:00 p.m., a choice of bedtime was not offered to resident or spouse.</p> <p>An admission Minimum Data Set (MDS), dated 4/10/12, indicated that it was somewhat important for Resident #C to choose between a tub, shower, bed, or sponge bath and to also</p>		<p>to determine if further action is needed.</p> <p><u>5.</u> This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09-19-12.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>choose a bedtime.</p> <p>A care plan titled "Self care deficit" initiated on 6/20/12 indicated the "problem rt (related to) dementia, goal-clean, odor free & approp (appropriately) dressed qd (every day), approach-daily partial bath, shower/shampoo 2 x (times) weekly & prn (as needed), offer assist prn, refer to therapy as indicated, notify family & MD of changes."</p> <p>An interview on 8/14/12 at 11:20 a.m., with Employee/CNA #11 indicated that Resident #C's routine in the morning was to "clean (Resident #C) up, wash face and hands, make sure [resident] is clean and changed, help cue to wash, showers are 2 X a week, all residents are on a schedule. Wednesday and Saturday are [Resident # C's] days to shower. Shower sheets are filled out." The resident is "toileted every 2 hours" and goes to bed when the staff get [Resident 3#C] ready for bed.</p> <p>Shower sheets for Resident #C were provided on 8/17/12 at 11:00 a.m., by the Director of Nurses (DON). A review of the shower sheets titled "CNA Bath Checklist" indicated bathing on 8/15/12 at 7:20 p.m., and on 8/11/12 at 9:30 p.m.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

	<p>An interview on 8/17/12 at 8:20 a.m., with the Social Service Director (SS) regarding choices on bathing and bedtime-"Staff will ask the resident, 'when do you like to shower?', 'do you prefer male or female to help you?', offer a bed bath if they do not like shower...info from daily shower sheets are kept by the MDS Coordinator. We try to honor ADL's (activities of daily living), we accommodate as best as can." For bedtime staff will ask "what time do you normally go to bed?"</p> <p>3.1-3(u)1 3.1-3(u)3</p>			
--	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
-----------------------------------------------------	--------------------------------------------------------------------	--------------------------------------------------------------	--------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(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: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(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	
F0248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure the activities provided to a resident met his interests and needs to enhance his highest practical well being. This deficient practice has the potential to adversely affect 1 of 4 cognitively impaired residents reviewed for activities. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 8-13-12 at 3:22 p.m. His diagnoses included, but were not limited to traumatic brain injury, aphasia (inability to speak) and seizure disorder. Review of the Minimum Data Set (MDS) assessment information for 5-7-12 and 7-30-12 did not indicate the resident's interests.</p> <p>Resident #B was observed on 08-13-2012 at 9:50 a.m., lying on his back in bed with his eyes closed and the television (TV) on. At 11:31</p>	F0248	<p>F 248 <u>Activities meet the interests and needs of each resident</u></p> <p>It is the intent of this facility to ensure the activities provided to a resident meet their interests and needs to enhance their highest practical well-being.</p> <p><u>1. Actions Taken:</u></p> <p>a. In regards to Resident B: The one on one activity's were increased to five times a week. Therapy will screen for safe positioning in w/c or geri-chair to enable participation in out of room activities.</p> <p><u>2. Others Identified:</u></p> <p>a. 100% audit was completed; four other dependent residents were identified, their activities have also been increased to five times per week.</p>	09/19/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>a.m.,the resident was observed turned to his right side with the TV on; at 12:48 p.m., the resident was lying on his back with his eyes open and the TV on. At 2:20 p.m., the resident was observed turned on his left side with the TV on.</p> <p>On 8-14-12 at 9:50 a.m., Resident #B was observed in bed with the TV on. He was also observed at 11:56 a.m., and at 1:58 p.m. in bed with the TV on.</p> <p>On 8-15-12 at 8:45 a.m., staff were observed completing his medication administration and gastric feeding. On 8-15-12 at 11:44 a.m., the Activities Director was observed during a one on one activities program with Resident #B. She was observed massaging the resident's feet with lotion and talking with him in an attempt to awaken him and interact with him. The resident did not respond to the staff member's actions and the staff member indicated she would attempt another interaction later in the day.</p> <p>In interview with the Activities Director on 8-15-12 at 11:44 a.m., she indicated Resident #B received one on one activities 3 times weekly. She indicated the nursing staff have stated</p>		<p>3. Measures Taken:</p> <p>a. Therapy will screen this resident for safe positioning in w/c or geri-chair to enable participation in out of room activities.</p> <p>b. Activity Staff in-serviced in regards to on-going program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>4. How Monitored:</p> <p>a. The AD/Designee will audit/review the Activity record book weekly during PAR (Persons at Risk) to identify any resident who may need increased one on one activity arrangements. A summary of the audits will be written monthly and reviewed with the CEO/Designee and the IDT. This will be an on-going process.</p> <p>b. The audit/review summary of the Activity records will be reviewed at the monthly QA Committee meeting, and reviewed quarterly with the Medical Director.</p> <p>5. This plan of correction</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(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			
	it is unsafe for him to be up in wheelchair and out of his room, which is why he receives one on one services. She indicated he receives pastoral visits as well as frequent visits from family, primarily of an evening. She indicated activities have a cart for different textures, like cotton balls, play dough, sand paper, clay, different fabrics like towel material, silky ribbons, hard like jean material, different shapes, but has not used the textile materials with him because the staff are not supposed to get too close to him because he will grab on them. She indicated she does use his stuffed animals and hands him different things. She indicated, "I am a licensed massage therapist and I massage his feet. We read the newspaper and his church bulletin. I have a small 5 pound therapy dog that he just loves. He never grabs at the dog. We never tried audio books. Maybe should try massage more. Would like to see him out more. I have taken him outside once and he seemed to love it. Took him down the halls. Would love to see him get up and out more. I don't really know what had been done about looking into his behaviors. Maybe that needs looked into. Definitely would like to see him up and out of his room. I've only been in this position a week.		constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09-19-12.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Would like to see him coming to 2 or 3 activities a week. It's a big area; we could have an activity aide sit with him. I plan to update his care plan with his annual [assessment and evaluation] and talk with the family. I could talk with the family. Will need to get the okay from nursing to get him up, then I can talk with the family to get their approval. I will send an activity calendar to the family so they can select what activities he might be interested in."</p> <p>In interview with a family member on 8-14-12 at 8:48 a.m., the family member indicated she felt, "He is difficult to deal with related to his outbursts and they're afraid that he might hurt the staff or others."</p> <p>In an interview with the Director of Nursing (DON) on 8-16-12 at 2:02 p.m., she indicated, "I won't even pretend that I know [name of Resident #B's] history..I am not that familiar with him. I would think activities should be more than 3 times a week." The DON has been employed at the facility for 2 months.</p> <p>Review of Resident #B's care plan on 8-15-12 at 10:35 a.m., indicated a revision of the care plan, dated 7-13-12, that the resident would</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>benefit "from sensory stimulation and socialization." Approaches indicated were to offer to turn the TV on to a country music station, offer texture materials for sensory stimulation; offer stuffed animals for the resident to hold; offer to read local newspaper to resident and offer pet visits when available during one on one sessions. One on one activity sessions were indicated to occur 3 times weekly.</p> <p>3.1-33(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(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			
F0279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review, observation, and interview, the facility failed to develop a care plan which addressed safety related to the gap between a resident's headboard and mattress (Resident #12); dental issues (Resident #C); pressure ulcer prevention (Resident #97); and for wheelchair positioning (Resident #68) for 4 of 25 residents reviewed for development of a care plan.</p> <p>Findings include:</p>	F0279	<p><u>F 279 Develop Comprehensive Care Plans</u></p> <p>It is the intent of this facility to develop a care plan which addresses safety related to the gap between a headboard and mattress, dental issues, pressure ulcer prevention and wheelchair positioning.</p> <p><u>1. Actions Taken:</u></p> <p>a. In regards to Resident C: An appointment will be scheduled to</p>	09/19/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>1. Resident #C's record was reviewed on 8/13/12 at 10:10 a.m. The diagnoses included but were not limited to Alzheimer's disease, hyperlipidemia, and hypertension.</p> <p>An interview on 8/13/12 at 1:30 p.m., with Resident #C's family indicated the resident had a dental issue of a broken upper partial plate.</p> <p>An admission Minimum Data Set (MDS), dated 4/10/12, indicated no broken or loosely fitting full or partial denture.</p> <p>A quarterly MDS, dated 7/6/12, indicated no broken or loosely fitting full or partial dentures.</p> <p>A dental visit on 7/11/12 performed in the facility did not reveal an upper partial plate or dentures.</p> <p>An interview on 8/17/12 at 8:20 a.m., with the Social Services Director (SSD) indicated the facility was unaware the resident had an upper partial plate and that it was broken. A review of the clinical record, at the time of interview with the SSD, indicated an upper partial plate as noted on the resident's inventory sheet. No care plan for dental issues was found in the resident's record.</p>		<p>have the broken upper partial plate repaired; the care plan was be updated accordingly.</p> <p>b. In regards to Resident # 97: the care plan was updated in regards to pressure ulcer prevention.</p> <p>c. In regards to Resident # 68: the care plan was update to include positioning when up in wheelchair and related to the occupational therapy recommendations.</p> <p>d. In regards to Resident # 12: a care plan was put in place to reflect safety concerns in regards to the headboard and mattress; the resident removal of the bolsters and his refusal to utilize them. A mattress of the appropriate size will be ordered to replace the current mattress.</p> <p>2. Others Identified:</p> <p>a. The Maintenance Supervisor conducted an inspection of all resident beds; no other residents were affected.</p> <p>b. 100% audit of all resident care plans for the identified issues will be completed any other residents lacking care plans for these issues will be updated.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>2. Resident # 97's record was reviewed on 8/14/12 at 10:30 a.m. The diagnoses included but were not limited to anemia, heart failure, HTN (high blood pressure) and depression.</p> <p>A care plan, dated 6/20/12, for "potential for wt loss-med pass, potential-for skin breakdown, impaired mobility, admitted with unstageable, stage 3's on 5/22/12, will be free from skin breakdown, approaches-ensure skin is clean & dry, skin assmnt (assessment) on adm (admission) & weekly, encourage to t&r (turn and reposition) q (every) 2 (hours) and prn (as needed), report skin changes to md and family, TX (treatment) per MD order, Zinc per order, low air mattress, med pass 2.0 per order, cushion in WC (wheelchair), wound vac as ordered by md, wound clinic as scheduled." No measurable goal/objective or timetable dates were noted in the care plan.</p> <p>A review of the medical record on 8/15/2012 at 11:30 a.m., with LPN #17, revealed no other care plans related to pressure ulcers. No measurable goal/objective or timetable dates, revisions or updates to the care plan were found.</p>		<p>3. Measures Taken:</p> <p>a. 100% audit of all care plans will be reviewed/updated to ensure they include measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs.</p> <p>4. How Monitored:</p> <p>a. The DON/MDS coordinator/and Designees will review/update all resident care plans on an on-going basis and along with the MDS schedule to ensure all identified issues are care planned and all necessary interventions are in place.</p> <p>b. The DON/MDS Coordinator will maintain record of all care plans reviewed weekly and review this report with the CEO/IDT at the monthly QA meeting; and quarterly with the Medical Director.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09-19-12.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>3. On 8/13/12 at 12:15 p.m., Resident #68 was observed in the dining room in her wheelchair. Her wheelchair was sitting next to the table with the resident reaching to her right for her food.</p> <p>On 8/15/12 at 9:55 a.m., the resident was observed to be sitting in her wheelchair outside on the patio with her daughter. Her head was leaning to the left side with a neck pillow. The pillow was not keeping her head in good alignment.</p> <p>On 8/15/12 at 11:26 a.m., the resident was observed to be in her room in her wheelchair with her head leaning over to the left side. A pillow was there but not in place for positioning her head.</p> <p>8/16/12 at 7:05 a.m., the resident was sitting in the dining room in her wheelchair. She was sitting sideways to table feeding herself.</p> <p>8/16/12 at 9:30 a.m., the resident was sitting in her wheelchair in her room with her head leaning over to the left. The neck pillow was on the right shoulder. LPN #1 repositioned the resident's head. She moved the neck pillow to the left side. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>resident's head was better aligned. LPN #1 said, "There is nothing more I can do for her."</p> <p>8/16/12 at 1:20 p.m., the resident was in her room in her wheelchair. Her head was leaning way over to the left. The neck pillow was down in front on her chest.</p> <p>On 8/15/12 at 10:05 a.m., an interview with COTA #1 (Certified Occupational Therapy Assistant) indicated she brings the resident into the therapy area to work on positioning. This resident tends to turn her head to the left when on her back or in the wheelchair. They are trying to get her to lay on her right side to prevent contractures of her neck. COTA #1 indicated they would be educating staff on her positioning. "We have been seeing her in OT (occupational therapy) off and on since she came to this facility."</p> <p>Record review on 8/14/12 at 1:10 p.m., indicated Resident #68 had diagnoses which included but were not limited to: Left hemiparesis (paralysis), stroke, A-Fib (atrial fibrillation - rapid, irregular heart rate), diabetes, HTN (high blood pressure), Seizure, Phlebitis/thrombophlebitis left leg, depression, and dementia.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Review of the care plan indicated a plan had not been developed regarding the positioning of the resident when up in the wheelchair. The care plan was last reviewed on 6/19/12.</p> <p>On 8/16/12 at 10:50 a.m., review of the Occupational Therapy notes - "Subjective - Current status includes: Cooperative; Decreased ROM; Increased stiffness; Need for contracture management; Need for maintenance program. Objective - Posture- Posture examination findings Cervical Spine - Lateral Flexion left; Cervical Spine - Rotation left; Shoulders - Protracted. Current assessment level findings; 8/13/12 Description Position w/c in prep for transfers Current level - Poor+ Assessment - Impairment/functional Goals - Position w/c (wheelchair) in prep for transfers - Fair+"</p> <p>4. Review of the clinical record for Resident #12 on 8/13/2012 at 1:30 p.m., indicated the resident had diagnoses which included, but were not limited to: abnormality of gait, arthritis, degenerative joint disease, and degenerative changes of the lumbar spine.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>During a resident observation on 8/13/2012 at 3:00 p.m., the resident's mattress was observed to be too short for the frame with a gap between the bed frame and the headboard when the bed was in the flat position. The mattress was observed to be 4 (four) inches too short for the bed frame. There also was a gap of 5 (five) inches from the end of the bed frame to the headboard for a total gap of 9 (nine) inches.</p> <p>During an interview with the DoN (Director of Nursing) on 8/14/12 at 10:30 a.m., the DON stated, "We did get him a new mattress that is longer but there is a small gap still. The resident refuses to allow us to use bolsters and has some in his closet where he had removed them from his bed."</p> <p>During an interview with Resident #12 on 8/14/12 at 11:00 a.m., he indicated: "I removed the bolsters from my bed and they just were not working and I didn't like them. They tried them at the head and the foot of the bed - they're afraid of people getting their heads caught in that gap and in the side rails. I'm not afraid of doing that."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Review of the 4/24 and 7/23/12 Quarterly Minimum Data Set (MDS) Assessments indicated the resident's cognition was good after some cueing and he was independent for bed mobility, transfers and ambulation.</p> <p>Documentation was lacking of a care plan which addressed the safety issue of the gap between the mattress and the headboard.</p> <p>A policy titled, "Care Plans" was received from the DON (Director of Nursing) on 8/17/12 at 10:26 a.m. The policy states, "Guidelines: It is the intent of the facility that each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care. Responsibility: All members of the interdisciplinary team. Coordinated by the MDS (Minimum Data System) Coordinator...Procedure...2. A comprehensive assessment. All areas of concern will be addressed by the interdisciplinary team. The documentation is to be in the departmental notes and/or on the care plan. 3. For each problem, need or strength a resident-centered goal is developed. Whenever possible</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the goal should be measurable. 4. The interdisciplinary team along with the resident and/or family members will identify resident problems, needs and strengths. 6. Staff approaches are to be developed for each problem/strength/need. When possible, more than one discipline per approach is to be documented on the care plan or ALL disciplines are responsible for that approach. 7. All goals and approaches are to be reviewed and revised as appropriate by a team of qualified persons after each assessment and upon significant change of condition. 8. Each department's notes are to reflect a review of all appropriate care plan goals and approaches."</p> <p>3.1-35(b)(1)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(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: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(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
F0280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview, observation, and record review, the facility failed to review and revise a resident's care plan related to delivery of fluids for a resident who cannot drink without assistance (Resident #37) and activities of daily living for a dependent resident. (Resident #B)</p> <p>These deficient practices affected 2 of 25 residents reviewed for care plan revision.</p> <p>Findings include:</p> <p>1. Resident #37's record was</p>			F0280	<p>F 280 <u>Right to participate in planning care and revising Care Plans</u></p> <p>It is the intent of this facility to revise a resident's care plan related to delivery of fluids for a resident who cannot drink without assistance; and activities of daily living for a dependent resident.</p> <p><u>1. Actions Taken:</u></p> <p>a. In regards to Resident # 37: the care plan was updated to address when fluids would be given between meals in order to</p>		09/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>reviewed on 8/15/12 at 10:41 a.m. The record indicated Resident #37 was admitted with diagnoses that included, but were not limited to, anemia, acute renal insufficiency, atrial fibrillation, dementia, diverticulosis, obesity, history of stroke, peripheral vascular disease, urosepsis, multiple sclerosis, diabetes, oropharyngeal dysphagia, high blood pressure, neurogenic bladder with frequent urinary tract infections, chronic incontinence, and urinary retention.</p> <p>Physician's recapitulation orders, dated 8/2012, indicated diet orders for a pureed diet with nectar thick liquids and the resident was to have 1/2 portions except for protein - full portions.</p> <p>An annual Minimum Data Set assessment, dated 6/6/12, indicated the resident was severely cognitively impaired, had no swallowing problems, required extensive assistance of one person for eating and drinking, had no weight loss, and received a mechanically altered, therapeutic diet.</p> <p>On 8/15/2012 at 5:05 p.m., Resident #37 was observed in the main dining room. She received her tray at 5:19</p>		<p>meet the daily fluid requirements, and who would assist the resident with the delivery of the fluids.</p> <p>b. In regards to Resident # B: the care plan for personal care was updated to address any triggers for behavioral outbursts and means to calm the resident during care.</p> <p>2. Others Identified:</p> <p>a. An audit of all care plans is being conducted; all care plans will be reviewed/ revised as needed. The audit will be completed by 09-19-12</p> <p>-</p> <p>3. Measures Taken:</p> <p>a. Nursing staff were in-serviced in regards to reviewing/ revising a residents' care plan, to have measurable goals, and to reflect the resident's needs and interventions to meet those goals/needs.</p> <p>4. How Monitored:</p> <p>a. The DON/MDS coordinator will audit all reviewed/ revised Care Plans as completed, and then along with the MDS schedule; a summary report will be</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>p.m., which had thickened milk and water in regular cups, pureed food in a divided plate, and applesauce in a bowl. RN #21 encouraged the resident to drink thickened water after handing her the cup. Resident #37 took a couple of sips and then sat there looking around.</p> <p>On 8/16/12 at 10:09 a.m., the Dietary Manager indicated an activity person and a dietary person passes snacks, but a CNA will go behind and assist residents who need help to drink.</p> <p>On 8/17/12 at 9:07 a.m., CNA #19 indicated Resident #37 is assisted with fluids when in her room and if she is in her wheel chair she can hold the cup and someone stays with her while she drinks. CNA #19 indicated fluids are given at meals, and when the hydration cart is passed.</p> <p>A care plan initiated on 2/6/12 and last reviewed on 4/11/12, indicated a problem of history of stroke with oropharyngeal dysphagia, (difficulty swallowing), and had a goal: "Will receive dietary items of appropriate consistency TNR (through next review)."</p> <p>A care plan, dated 1/20/12, indicated: "Problem/strengths concerns: The</p>		<p>maintained and reviewed weekly with the CEO/Designee. This will be an on-going process.</p> <p>b. CEO/Designee will review the summary with the QA committee monthly, on the status of the care plan updates, and with the Medical Director quarterly.</p> <p><u>5.</u> This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09-19-12.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>resident requires a restorative program for eating/swallowing to restore or maintain their ability to eat, drink, and swallow. The resident participates in the restorative program as follows: Will give self drinks with cueing/reminders from standard cups, 180/360 with meals 5-7 days a week. Goal: The resident will participate in their eating/swallowing program to the best of their ability and exhibit no decline thru the next review. Approaches/interventions; 1. Administer the program per schedule...4. Provide assistance as needed...."</p> <p>The care plan as written failed to address when fluids would be given between meals in order to meet the daily fluid requirements, and who would assist the resident with the delivery of the fluids.</p> <p>On 8/17/12 at 10:38 a.m., the MDS Coordinator indicated the dietary department puts out the needs (for fluids) on the meal tickets, CNA's document the fluid intakes on the meal intake books, the Dietitian and DON monitors the intakes. The CNA's make sure the resident gets the fluids from the hydration cart. The MDS Coordinator indicated the care plan does not show the delivery of</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>fluids.</p> <p>2. Resident #B's clinical record was reviewed on 8-13-12 at 3:22 p.m. His diagnoses included, but were not limited to traumatic brain injury, aphasia (inability to speak) and seizure disorder.</p> <p>In an interview with CNA #6 on 8-16-12 at 11:42 a.m., she indicated she has worked with Resident #B for less than a month. She indicated staff have been told not to go in there alone. She indicated earlier the same morning, she had given him a partial bed bath and he was kicking and attempting to bite her. She indicated he usually really likes oral care and seems always to have a dry mouth, because he is NPO [receives no food or fluids by mouth]. "I use the mouth swabs and he seems to get along real good. His teeth seem to be in pretty good shape. I don't know if he has many teeth missing." She indicated he receives oral care at least twice daily.</p> <p>In interview with CNA #7 on 8-16-12 at 2:39 p.m., she indicated she tries to have a certain routine she uses with his care that she shares verbally with other CNA's when she is unable to assist with his care. She indicated</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>he has been known to grab staff and injure them in the past. She indicated it would be helpful to have information on the "Resident Care Information Pocket Sheets" regarding resident likes and dislikes. "It would be nice to have little tidbits about the resident."</p> <p>Review of his care plan on 8-15-12 at 10:35 a.m., indicated a problem identified as self care deficit related to traumatic brain injury and inability to follow one step commands, dated 6-21-12, with goals to be of clean, odor free and dressed appropriately daily. Approaches included daily partial bath with shower and shampoo twice weekly and as needed, a bed bath with the assistance of 2 persons once weekly and as needed and shower once weekly requiring the assistance of 3 persons. A care plan for oral care indicated he was a mouth breather and has several missing teeth. It indicated oral care should be provided each shift and as needed using pink toothettes (mouth swabs). Additionally, it indicated the toothettes should be available in the bathroom for the family to use, as well as referrals to the dentist as needed and to monitor for any redness of the mouth. Documentation in the care plans for personal care did not</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicate any triggers for behavioral outbursts or means to calm the resident during care as indicated in the concerns by the staff and family.</p> <p>The most recent dental assessment visit, dated, 7-11-12, indicated, the dental service was unable to assess Resident #B due to him being uncooperative.</p> <p>3.1-35(b)(1) 3.1-35(d)(2)(B)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(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	
F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Review of the clinical record for Resident #E on 8/13/2012 at 3:05 p.m., indicated the resident had diagnoses which included, but were not limited to: dementia, depression and history of cerebral vascular accident.</p> <p>Review of the August 2012 Medication Administration Record indicated the resident had an order for Fluoxetine (Paxil - an antidepressant) 20 mg QD (daily) dated 8/25/2011.</p> <p>A care plan initiated on 5/18/2011 for "Depression AEB (as exhibited by) sad facial expressions" indicated a new approach was added on 9/22/2011, "Attempt gradual dose reductions routinely and PRN."</p> <p>Documentation was lacking of the care plan having been followed in that no gradual dose reductions had been attempted since the medication had been started on 8/25/2011.</p>	F0282	<p>F 282 Services by qualified persons as per the Care Plan</p> <p>It is the intent of this facility to ensure the care plans are followed as written for bathing and for gradual dose reduction.</p> <p>1. Actions Taken:</p> <p>a. In regards to Resident A, a care plan conference was held allowing the resident to verbalize preferences in regards to an am bath schedule, frequency, and type of bath preferred. The resident also identified his preferred bedtime. These choices will be honored to every extent possible.</p> <p>b. In regards to Resident E, a review of any antipsychotic medications, antidepressants, and/or anti-anxiety medications will be completed by the Social Services Director in regards to behavior tracking, effectiveness of medications, and need for gradual dose reduction. Upon completion of this review, this will be reviewed with the physician for</p>	09/19/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>During an interview with the Social Worker at 10:25 am on 8/15/2012, she indicated no dose reductions have been attempted.</p> <p>3.1-35(g)(1)</p>		<p>possible reduction and/or discontinuation.</p> <p>2. Others Identified:</p> <p>a. A 100% audit of the current residents was conducted in regards to bathing preferences, and no other residents were identified.</p> <p>b. A 100% audit of all other residents will be completed. This would have the potential to affect any resident taking antipsychotic, antidepressants, and/or antianxiety medications.</p> <p>-</p> <p>3. Measures Taken:</p> <p>a. The DON/Designee will review all completed Bathing & Bedtime Choices forms for all new admissions in regards to preferences, schedules, and care plans. This will be an on-going process.</p> <p>b. An in-service for nursing staff was conducted regarding the importance of following a physician's order and the Care Plan interventions, and the documentation thereof.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>c. An in-service for Social Services will be conducted regarding the Behavior Management/Monitoring, Psychotropic medication review/reduction per the Policy and the Care Plan; and pharmacy recommendations and the follow-up thereof.</p> <p>-</p> <p>4. How Monitored:</p> <p>a. Don/Designee will monitor/review the shower sheets/ADL grid 5 days a week for 2 weeks, then the same for 3 days a week for 3 weeks, and then the same for 1 day a week for 6 weeks.</p> <p>b. The SSD/Designee will monitor all psychotropic medications per the Behavior Management Psychotropic Medication Policy & Procedure. The Psychotropic Medication Review form will be completed by the SSD per the MDS schedule and reviewed in the weekly Persons at Risk (PAR) meeting. This will be an on-going process.</p> <p>c. CEO/Designee will review the results with the QA committee monthly and quarterly with the Medical Director, for four quarters, to determine if further action is needed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Based on interview and record review, the facility failed to ensure care plans were followed as written for bathing and for a gradual drug reduction for 2 of 5 residents reviewed for care plans (Resident #A and #E)</p> <p>Findings include:</p> <p>1. Resident #A's clinical record was reviewed on 8-17-12 at 9:05 a.m. It indicated he was admitted with diagnoses that included, but were not limited to diabetes, osteomyelitis, a wound to the right heel that had not healed for over 1 year and had an amputation to a big toe several years previously. In interview with the resident on 8-17-12 at 9:59 a.m., he indicated he could not bear any weight onto the right leg until late July 2012.</p> <p>In interview with Resident #A on 8-17-12 at 9:59 a.m., he indicated when he was admitted to the facility in May 2012, he indicated to the staff</p>		<p><u>5.</u> This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09-19-12.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>that he wished to have a daily bed bath. He indicated he was told that the facility did not have adequate staff to be able to do that, but was scheduled for twice weekly complete bed baths. He indicated he had his surgeon write an order for daily bed baths. He indicated after the order was written, he had several occasions in which he went for 2 days before he received a bath. He could not provide specific dates of those occurrences. The physician's order for daily bed baths was documented in the resident's clinical record on 6-27-12.</p> <p>On 8-20-12 at 8:50 a.m., the Director of Nursing provided a copy of a care plan, dated 6-5-12, which indicated the problem of "ADL assist required RT [related to sign for decreased] mobility [sign for secondary to] osteomyelitis." Approaches indicated for this problem included, "Daily bed baths."</p> <p>In interview with RN #13 on 8-17-12 at 10:57 a.m., she indicated the aide's pocket sheet did have him listed as a daily bed bath. She also indicated the bathing documentation was indicated on "shower sheets" which are filed in a separate location. She indicated, "He did ask us about the daily bath when he came in and it</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>was implemented right away. I don't recall that being an issue. He stopped me one morning and asked about getting a daily bed bath, the following week after he was admitted. That was implemented right away."</p> <p>RN #13 provided copies of "CNA Bath Checklist" also known as "shower sheets" on 8-17-12 at 12:43 p.m., for dates 6-22-12, 7-3-12 and 7-9-12. She indicated, "I know this isn't all you had asked for, but this is all I could find was these three dates." Additional documentation of Resident #A's daily bed baths were included on "Activities of Daily Living Documentation" for June, July and August, 2012. These documents indicated this resident received baths on 6-2-12, 6-7-12, 6-9-12, 6-23-12, 6-26-12, 7-1-12, 7-3-12, 7-4-12, 7-5-12 and 7-6-12. No bathing information was documented for August 2012. These two documents indicated in the 68 days the resident was in the facility, he had documented baths for 12 days.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(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	
F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review, interview and observation, the facility failed to provide the necessary care for Resident #68 to maintain the highest practicable physical well-being in that staff did not maintain proper positioning of this resident's neck when she was up in the wheelchair. This affected 1 of 3 residents reviewed for positioning.</p> <p>Findings include:</p> <p>On 8/13/12 at 12:15 p.m., Resident # 68 was observed in the dining room in her wheelchair. Her wheelchair was sitting next to the table with the resident reaching to her right for her food. Her head was turned to the right.</p> <p>On 8/15/12 at 9:55 a.m., the resident was observed to be sitting in her wheelchair outside on the patio with her daughter. Her head was leaning</p>	F0309	<p>F 309 <u>Provide care/services for highest well-being.</u></p> <p>It is the intent of this facility to provide the necessary care to maintain the highest practicable physical well-being by maintaining proper positioning of a residents' neck when up in a wheelchair.</p> <p><u>1. Actions Taken:</u></p> <p>a. In regards to Resident # 68: The CNA QA pocket worksheet updated to include the instructions for proper positioning of the resident in the wheelchair.</p> <p><u>2. Others Identified:</u></p> <p>a. 100% audit of the current residents was completed. No other residents were identified.</p> <p>-</p> <p><u>3. Measures Taken:</u></p>	09/19/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>to the left side with a neck pillow below her head. The pillow was not keeping her head in good alignment.</p> <p>On 8/15/12 at 11:26 a.m., the resident was observed to be in her room in her wheelchair with her head leaning over to the left side. A pillow was there but not in place for positioning her head.</p> <p>On 8/15/12 at 11:50 a.m., Resident #68 was sitting in her w/c (wheelchair) in the dining room with her head leaning over to the left. The Director of Nursing (DON) was queried about the position of Resident #68 in the wheelchair. She indicated there was a problem and would get the staff to get her to her room for repositioning. Two aides and the COTA (Certified Occupational Therapy Assistant) repositioned the resident. No neck pillow was used at this time as the resident would be moving her head while eating her lunch. The resident continued to sit next to the table and reach for her food to her right due to the wheelchair would not fit under the table and the resident had vision problems.</p> <p>During observation of Resident #68 on 8/16/12 at 9:30 a.m., the resident was sitting in her wheelchair in her</p>		<p>a. All Nursing staff was in-serviced on reviewing and updating the CNA QA pocket worksheet daily with care plan revisions.</p> <p>4. How Monitored:</p> <p>a. DON/MDS Coordinator/Designee will review/audit all CNA QA pocket worksheets daily with care plan revision updates to ensure all resident information is included on the worksheets. This is an on-going process.</p> <p>b. DON/MDS Coordinator/Designee will review the summary of the audit results monthly with the QA Committee, and review quarterly with the Medical Director.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09-19-12.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>room with her head leaning way over to the left. The neck pillow was on her right shoulder. LPN #2 repositioned her head. She moved the neck pillow to left side. Her head was better aligned. LPN #2 said, "There is nothing more I can do for her."</p> <p>On 8/16/12 at 1:20 p.m., the resident was in her room in her wheelchair with her head leaning way to the left. Her neck pillow was down in front on her chest.</p> <p>On 8/17/12 at 12:00 p.m., the resident was observed in her wheelchair in her room. Her head was leaning to the left. The COTA demonstrated to the DON and the surveyor the use of the bedside table in front of the resident for her to eat. To the facility staff the resident looked awkward and the bedside table was difficult to get under her chair. They indicated they would see if they could find another kind of table to fit over her so she would be sitting straighter to eat.</p> <p>On 8/15/12 at 10:05 a.m., an interview with COTA indicated she takes the resident into the therapy area to work on positioning. "This resident tends to turn her head to the left when on her back or in the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>wheelchair. They are trying to get her to lay on her right side to prevent contractures of her neck." The COTA indicated they would be educating staff on her positioning and using the neck pillow to achieve better alignment. "This resident has been seen in OT (occupational therapy) on and off since she came to this facility."</p> <p>On 8/16/12 at 10:50 a.m., review of the Occupational Therapy notes included, "Subjective - Current status includes: Cooperative; Decreased ROM; Increased stiffness; Need for contracture management; Need for maintenance program. Objective - Posture- Posture examination findings Cervical Spine - Lateral Flexion left; Cervical Spine - Rotation left; Shoulders - Protracted. Current assessment level findings; 8/13/12 Description Position w/c in prep for transfers Current level - Poor+ Assessment - Impairment/functional Goals - Position w/c (wheelchair) in prep for transfers - Fair+"</p> <p>Review of the "Resident Care Information Pocket Sheet" (CNA worksheet) received on 8/16/12 at 1:22 p.m., indicated no instructions for the CNAs as far as positioning of the resident.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A policy titled, "Turning and Positioning Program" received on 8/17/12 at 10:27 p.m., states, "...Procedure...3. Communication to staff at the scheduled times is to be made by the Charge Nurse as needed...Provide cards or put on Nursing Assistant assignments, communicated verbally, through report or throughout the day..."</p> <p>3.1-37(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(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	
F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on interview and record review, the facility failed to provide daily bed baths as ordered and care planned for 1 of 3 residents reviewed for bathing who was assessed as requiring extensive assistance with bathing. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 8-17-12 at 9:05 a.m. It indicated he was admitted with diagnoses that included, but were not limited to diabetes, osteomyelitis, a wound to the right heel that had not healed for over 1 year and had an amputation to a big toe several years previously.</p> <p>Review of the Admission Minimum Data Set assessment, dated 6-5-12, indicated Resident #A required limited assistance of one person for hygiene and extensive assistance of one person for bathing.</p> <p>In interview with Resident #A on</p>	F0312	<p>F 312 ADL care provided for dependent residents</p> <p>It is the intent of this facility to ensure a physicians' order and a care plan for a daily bed bath are followed.</p> <p>1. Actions Taken:</p> <p>a. In regards to Resident A, a care plan conference was held allowing the resident to verbalize preferences in regards to an am bath schedule, frequency, and type of bath preferred. The resident also identified his preferred bedtime. These choices will be honored to every extent possible.</p> <p>2. Others Identified:</p> <p>a. A 100% audit of the current residents was conducted in regards to bathing preferences, and no other residents were identified.</p>	09/19/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>8-17-12 at 9:59 a.m., he indicated when he was admitted to the facility in May 2012, he indicated to the staff that he wished to have a daily bed bath. He indicated he could not to bear any weight on the right leg until late July 2012. He indicated he was told that the facility did not have adequate staff to be able to do that, but was scheduled for twice weekly complete bed baths. He indicated he had his surgeon write an order for daily bed baths. He indicated after the order was written, he had several occasions in which he went for 2 days before he received a bath. He could not provide specific dates of those occurrences. The physician's order for this was documented in the resident's clinical record on 6-27-12.</p> <p>In interview with RN #13 on 8-17-12 at 10:57 a.m., she indicated the aide's pocket sheet did have him listed as a daily bed bath. She also indicated the bathing documentation was indicated on "shower sheets" which are filed in a separate location. She indicated, "He did ask us about the daily bath when he came in and it was implemented right away. I don't recall that being an issue. He stopped me one morning and asked about getting a daily bed bath, the following week after he was admitted.</p>		<p>-</p> <p><u>3. Measures Taken:</u></p> <p>a. The DON/Designee will review all completed Bathing & Bedtime Choices forms for all new admissions in regards to preferences, schedules, and care plans. This will be an on-going process.</p> <p>b. An in-service for nursing staff was conducted regarding the importance of following a physicians' order and the Care Plan Interventions as listed, and the documentation thereof.</p> <p><u>4. How Monitored:</u></p> <p>a. Don/Designee will monitor/review the shower sheets/ADL grid 5 days a week for 2 weeks, then the same for 3 days a week for 3 weeks, and then the same for 1 day a week for 6 weeks.</p> <p>b. CEO/Designee will review the results with the QA committee monthly and quarterly with the Medical Director, for four quarters, to determine if further action is needed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>That was implemented right away."</p> <p>RN #13 provided copies of "CNA Bath Checklist" also known as "shower sheets" on 8-17-12 at 12:43 p.m., for dates 6-22-12, 7-3-12 and 7-9-12. She indicated, "I know this isn't all you had asked for, but this is all I could find was these 3 dates." Additional documentation of Resident #A's daily bed baths were indicated on "Activities of Daily Living Documentation" for June, July and August, 2012. These documents indicated this resident received baths on 6-2-12, 6-7-12, 6-9-12, 6-23-12, 6-26-12, 7-1-12, 7-3-12, 7-4-12, 7-5-12 and 7-6-12. No bathing information was documented for August 2012. These two documents indicated in the 68 days the resident was in the facility, he had documented baths for 12 days.</p> <p>On 8-20-12 at 8:50 a.m., the Director of Nursing provided a copy of a care plan, dated 6-5-12, which indicated the problem of "ADL assist required RT [related to sign for decreased] mobility [sign for secondary to] osteomyelitis." Approaches indicated for this problem included, "Daily bed baths."</p>		<p><u>5.</u> This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09-19-12.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(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
	3.1-35(g)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(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			
F0329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure gradual dose reductions were implemented for antidepressants for 2 out of 10 residents reviewed for unnecessary medications. (Residents #56 and #E).</p> <p>Findings include:</p> <p>1. On 8/16/12 at 9:00 a.m., record review for Resident #56 indicated</p>	F0329	<p>F 329 Drug regimen is free from unnecessary drugs</p> <p>It is the intent of this facility to ensure gradual dose reductions are attempted/implemented for residents' utilizing anti-depressants.</p> <p>1. Actions Taken:</p> <p>a. In regards to Resident # 56 and Resident # E, the GDR was</p>	09/19/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>diagnoses included but were not limited to: anemia, Vitamin B 12 deficiency, hypothyroidism, CAD (coronary artery disease), HTN (high blood pressure), Rheumatoid arthritis, ulcerative colitis, TIA (mini strokes), Gout, CHF (congestive heart failure), DJD (degenerative joint disease), CRI (chronic kidney insufficiency), Vitamin D deficiency, anxiety and depression.</p> <p>On 8/17/12 at 1:00 p.m., received information from the DON (Director of Nursing) regarding GDR (gradual dose reduction). The Pharmacy Consultant had made a recommendation for the GDR for Clonazepam and Fluoxetine on 6/25/12. The MD (doctor) declined the GDR for the Clonazepam 0.5 mg on 7/3/12. The form for the GDR for the Fluoxetine showed it was faxed to the doctor on 7/26/12, but there had not been a reply back and no follow-up had been done. According to the GDR Tracking report, dated 6/28/12, this resident was due for a GDR on Clonazepam on 5/7/12 and for Fluoxetine 5/11/12.</p> <p>On 8/17/12 at 1:43 p.m., the Social Service Director indicated they have no policy and procedure for GDR and they follow the state and federal guidelines.</p>		<p>implemented.</p> <p>2. Others Identified:</p> <p>a. 100% audit of all residents utilizing anti-depressants will be completed.</p> <p>3. Measures Taken:</p> <p>a. An in-service for Social Services, Licensed Nurses, was conducted regarding the importance of drug reduction per the facility policy/procedure, care plan interventions, and pharmacy recommendations and the follow-up thereof.</p> <p>b. The SSD/Designee the will meet weekly with the IDT, during PAR (Persons at Risk), to review the Psychotropic Behavior Monitoring Review for each resident as per the MDS schedule, they will also review the pharmacy consultant reports to ensure recommendations have been responded to.</p> <p>4. How Monitored:</p> <p>a. SSD/Designee will provide a written review/report of all residents reviewed weekly during PAR for GDR, weekly at the QA</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>On 8/17/12 at 5:00 p.m., the DON indicated they have no procedure in place at this time for following up on faxes.</p> <p>2. Review of the clinical record for Resident #E on 8/13/2012 at 3:05 p.m., indicated the resident had diagnoses which included, but were not limited to: dementia, depression and history of cerebral vascular accident.</p> <p>Review of the August 2012 Medication Administration Record indicated the resident had an order for Fluoxetine (Paxil - an antidepressant) 20 mg QD (daily) dated 8/25/2011.</p> <p>A care plan initiated on 5/18/2011 for "Depression AEB (as exhibited by) sad facial expressions" indicated a new approach was added on 9/22/2011, "Attempt gradual dose</p>		<p>stand-up meeting on Fridays.</p> <p>b. SSD/Designee will review all residents reviewed for GDR monthly at the QA committee meeting; and will review the results quarterly with the Medical Director.</p> <p><u>5.</u> This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09-19-12.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>reductions routinely and PRN."</p> <p>A Consultant Pharmacy review, dated 7/26/12, indicated a recommendation to the physician to review the resident's Fluoxetine (Paxil - an antidepressant) 20 mg QD (daily) ordered 8/25/2011 for a possible gradual dose reduction. Documentation was lacking of a gradual dose reduction having been attempted since the medication was ordered on 8/25/2011.</p> <p>During an interview with the Social Worker at 10:25 a.m., on 8/15/2012, she indicated no dose reductions have been attempted.</p> <p>3.1-48(a)(2) 3.1-48(a)(3)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(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
F0353 SS=E	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on interview and record review, the facility failed to ensure sufficient nursing staffing to attain and/or maintain the highest practical physical, mental and psychosocial well being of the residents. This deficient practice has the potential to adversely affect all 67 residents.</p> <p>Findings include:</p> <p>In interview with CNA #7 on 8-16-12 at 2:39 p.m., she indicated the facility is short staffed "a couple times a</p>	F0353	<p>F 353 Sufficient 24-hr. nursing staff per care plans</p> <p>It is the intent of this facility to ensure sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p>	09/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>week." She indicated on those occasions of "short staffing," she does not feel the staff have adequate time to get the residents "turned [and repositioned] like they should be. It's harder when short staffed to find the help when you need 2 assists [2 persons to assist a resident with care]. [It]Takes longer to locate the help to help you."</p> <p>In interview with LPN #8 on 8-16-12 at 3:04 p.m., she indicated she usually works 12 hour night shifts. She indicated, "I don't feel we have enough aides. Have had only two aides on the ICF on eves and nights; we have 42 residents back here after 7 p.m. This means we have to get them ready for bed, snacks and smoke breaks and any other issues that come." She indicated "Lately have had a lot issues with [name of Resident #B] being upset and [I] have spent a lot time with him to try to calm him. He likes a few particular staff and I try to make sure they can care for him, especially if seems upset."</p> <p>In interview with the Director of Nursing on 8-17-12 at 9:39 a.m., she indicated, "Obviously, everyone would like to see more staff in every place. I cannot say that we have had any particular complaints from residents</p>		<p><u>1. Actions Taken:</u></p> <p>a. Staffing patterns have been reviewed and adjusted to provide more staffing hours to be utilized for nursing care.</p> <p><u>2. Others Identified:</u></p> <p>a. Per the 2567, this potentially affected all residents. No further review was needed.</p> <p>-</p> <p><u>3. Measures Taken:</u></p> <p>a. Staffing levels will be reviewed every weekday at the Department Head morning meeting. Weekend staffing will be reviewed at the Friday Dept. Head morning meeting. Adjustments will be made as needed to ensure there is sufficient staffing.</p> <p><u>4. How Monitored:</u></p> <p>a. QA committee will review the DON/Designee summary of staffing levels monthly, for 3 months, and will review quarterly with the Medical Director, for four quarters, to determine if further action is needed.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>or families about staffing, that I am aware of. However, I do believe that staff have shared with the residents that the census is down and that has changed the staffing patterns."</p> <p>In interview with Resident #A on 8-17-12 at 9:59 a.m., he indicated it would take 20 to 30 minutes to get his call light answered.</p> <p>In interview with a concerned family member on 8-14-12 at 8:48 a.m., she indicated, "Not enough staff for the amount of patients or patients like [name of resident]. He is the last one taken care of or fed from what we have noticed. There is not enough staff in my opinion. Weekends are worst. Other family members have noticed this to and discussed this with me."</p> <p>In an interview with a concerned family member on 08/14/2012 8:54 a.m., the family member indicated Resident #B is bathed and cleaned up, "but not nearly enough. It goes back to staffing. His mouth is always dirty." In interview with a family member on 8-14-2012 at 8:57 a.m., the family member indicated the resident has mouth sores a lot, but didn't know why.</p>		<p><u>5.</u> This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09-19-12.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>In an interview with CNA #6 on 8-16-12 at 11:42 a.m., she indicated she has worked with Resident #B for less than a month. She indicated staff have been told not to go in there alone. She indicated earlier the same morning, she had given him a partial bed bath and he was kicking and attempting to bite her.</p> <p>In interview with CNA #7 on 8-16-12 at 2:39 p.m., she indicated she tries to have a certain routine she uses with Resident #B's care that she shares verbally with other CNA's when she is unable to assist with his care. She indicated he has been known to grab staff and injure them in the past.</p> <p>Review of the "Pocket Sheet" for Resident #B on 8-16-12 at 2:25 p.m., indicated he must have 2 persons present for all care and must have one on one supervision whenever he is out of bed. Review of Resident B's care plan indicated he must have 3 persons in attendance for his weekly showers that are given on the night shift.</p> <p>Review of the Nursing Schedule for July 29 through August 25, 2012 indicated the evening shift had 4 to 4.5 CNA's scheduled for the entire</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>building. The break down of CNA distribution was indicated as two CNA's on the "Front Hall" and two CNA's for the "ICF or Back Hall" for the evening shift according to CNA #22 in interview on 8-16-12 at 3:15 p.m. Review of the night shift indicated four CNA's are routinely scheduled for the entire building. Review of the staffing of licensed staff for the 12 hour shifts of 6:00 p.m. to 6:00 a.m., indicated three were scheduled routinely for the building, usually one licensed staff for each unit and a supervisory nurse.</p> <p>As referenced above, Resident #B requires a minimum of 2 staff being present with any care, that indicates 29% of the staff are present for him and unavailable to 66 other residents. If for any reason the facility would have a call-in that could not be covered, that percentage then becomes 33.3% of the available staffing caring for Resident #B (or any other resident that requires 2 persons for care) and unavailable for 66 other residents.</p> <p>In review of the "Resident Census and Conditions of Residents," provided by the Director of Nursing on 8-14-12, the document indicated a census of 67 residents. Of these 67</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>residents, none were independent with bathing, 60 required the assistance of 1 or 2 staff and 7 were totally dependent. Of the 67 residents, 6 were independent with dressing, 54 required the assistance of 1 or 2 persons to dress and 7 were totally dependent. Of the 67 residents, 23 residents were independent with transferring, 29 required the assistance of 1 or 2 persons and 15 were totally dependent with transfers. Of the 67 residents, 15 residents were independent with toileting, 41 required the assistance of 1 or 2 persons and 11 were totally dependent on staff with toileting. Of the 67 residents, 52 residents were independent with eating, 8 required the assistance of 1 or 2 persons and 7 were totally dependent on staff with eating.</p> <p>3.1-17(a) 3.1-17(b)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(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			
F0371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation , interview, and record review, the facility failed to ensure appropriate standard precautions were utilized while passing meal trays for residents dining in their rooms; appropriate use of hair nets to restrain the hair of dietary employees working in the kitchen and failed to ensure food in the pantry was stored properly. These practices had the potential to affect 65 of 67 residents.</p> <p>Findings include:</p> <p>1. Observation on 8/13/12 8:20 a.m., Dietary Aide (DA) #18 wore a pair of gloves while loading meal trays on to a cart for delivery to the residents dining in their rooms. While loading trays on to the cart, DA #18 touched her face then put lids on drink cups that were located on resident's meal trays. DA #18 also served a resident a fruit cup by grabbing the top of the dish, handing the resident the dish,</p>	F0371	<p>F 371 Food procure, store/prepare/serve – sanitary</p> <p>It is the intent of this facility to ensure appropriate standard precautions are utilized while passing meal trays, appropriate use of hair nets to restrain the hair of dietary employees working in the kitchen, and to ensure the food in the pantry was stored properly.</p> <p>1. Actions Taken:</p> <p>a. All staff in-service on Standard Precautions was conducted.</p> <p>2. Others Identified:</p> <p>Per the 2567, this potentially affected all but one resident. No further review was needed.</p> <p>3. Measures Taken:</p>	09/19/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(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 continued to load meal trays. When the resident was finished with the fruit cup, DA #18 took the dirty dish from the resident by grabbing the top of the dish and returning it to the kitchen through the serving window, and returned to loading meal trays. During this time, gloves were not changed and hands were not washed.		<p>a. In-services were conducted with dietary staff on standard precautions including: glove usage, hand washing procedures, hair restraints, and HACCP and foodborne illness (how poor hygiene can affect residents). An in-service was conducted on Date Marking and Food Storage, including proper temperatures for refrigerators and freezers.</p> <p>b. In-services were conducted for the housekeeping staff in regards to keeping the pantries clean and the refrigerator/freezers clean and defrosted, a schedule has be written for cleaning/monitoring of the pantries.</p> <p>4. How Monitored:</p> <p>a. The FSD will conduct audits five days a week for three weeks to ensure compliance with hand washing, hair restraints, and food storage. FSD will do the same for three days a week for six weeks then one time a week for another six weeks. After that it will be two times a month thereafter.</p> <p>b. The Housekeeping Supervisor will conduct audits five days a week for three weeks to ensure the pantries are clean and the refrigerators are clean and defrosted. Housekeeping Supervisor will do the same for three days a week for six weeks</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>2. On 8-15-12 at 1:40 p.m., two dietary staff were observed with head coverings (hair nets) not covering their bangs, exposing 2-3 inches of hair. These staff members were standing near the food service area refrigerator in the kitchen.</p> <p>A policy entitled, "Code of Dress and Personal Appearance" was provided by the Dietary Manager on 8-15-12 at 2:07 p.m. This policy indicated, "All</p>		<p>then one time a week for another six weeks. After that it will be done monthly.</p> <p>c. The FSD will review the audit results monthly with QA Committee; and will review quarterly with the Medical Director, to determine if further action is needed.</p> <p>d. The Housekeeping Supervisor will review audit results monthly with the QA Committee; and will review quarterly with the Medical Director, to determine if further action is needed.</p> <p><u>5.</u> This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09-19-12.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Dining Services employees will comply with printed and posted personal hygiene and sanitation practices of this facility...Personal hygiene guidelines will be followed to ensure safe food production and service...Hairnets, hair restraints, and beard guards shall be worn. Hands shall be washed after touching face or hair."</p> <p>3. During observation of the pantry on the rehab unit on 8/17/12 at 9:40 a.m., there was noted to be a container of snacks with an opened, unsealed, 12 ounce bag of vanilla wafers 1/2 full. The refrigerator/freezer in the pantry on the skilled unit had a thermometer in it which was coated with ice. The freezer was also coated with ice There were eleven popcicles, two small cups of ice cream, a Lean Cuisine meal & a Dairy Queen cup with a straw that was half full.</p> <p>During interview with the Director of Nursing on 8/17/12 at 9:45 a.m., the freezer temperature was 10 and the refrigerator temperature was 25. She indicated she would get someone right away to get the refrigerator/freezer taken care of.</p> <p>3.1-21(i)(3)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(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: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(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	
F0428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure the consultant pharmacist identified and reported potential irregularities to the physician when a resident received 4 medications for blood pressure on a daily basis (Resident #15); failed to follow-up with the physician when the consultant pharmacist made recommendations for gradual dose reduction of an anti-depressant (Resident #E) and an anti-psychotic medication (Resident #56) for 3 of 10 resident drug reviews.</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #15 on 8/17/2012 at 2:21 p.m., indicated the resident had diagnoses which included, but were not limited to: coronary artery disease, chronic congestive heart failure, myocardial infarction, and history of hypertension.</p>	F0428	<p><u>F 428 Drug regimen review, report irregular and act on</u></p> <p>It is the intent of this facility to ensure the consultant pharmacist identifies and reports potential irregularities to the physician when a resident receives 4 medications for blood pressure on a daily basis; to follow-up with the physician when the consultant pharmacist makes recommendations for gradual dose reduction of an anti-depressant and an anti-psychotic.</p> <p><u>1. Actions Taken:</u></p> <p>a. In regards to residents # 15, # 56 and # E: the pharmacy consultant recommendations have been acted on and completion follow-up conducted.</p>	09/19/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Review of the August 2012 Medication Administration Record (MAR) indicated the resident was on the following medications for hypertension (high blood pressure): Coreg 12.5 mg BID (twice daily) (ordered 2/8/10); Norvasc 5 mg QD (once daily) (ordered 2/8/10), Zestril 5 mg QD (once daily) (ordered 2/8/10), ISMO 20 mg BID (twice daily) (ordered 2/8/10).</p> <p>During an interview with the Director of Nursing on 8/17/2012 at 1:10 p.m., she indicated she was unable to locate any recommendations from the Consultant Pharmacist for more frequent monitoring of the resident's blood pressure since she was taking multiple medications daily for her hypertension. She also indicated nursing or the Consultant Pharmacist should made a recommendation to the physician for increased monitoring of the resident's blood pressure.</p> <p>On 8/17/2012 at 1:30 p.m., the Director of Nursing presented a copy of the facility's current policy on "Consultant Pharmacist." Review of this policy at this time included, but was not limited to:..."Communicating to the responsible physician potential or actual problems detected relating to medication therapy..."</p>		<p><u>2. Others Identified:</u></p> <p>a. The pharmacy consultant reviewed all of the resident's records. Recommendations were sent to the physicians for review and response.</p> <p>b. 100% audit of all residents receiving medications for Hypertension, to ensure parameters are set for MD notifications and daily blood pressures.</p> <p>-</p> <p><u>3. Measures Taken:</u></p> <p>a. The pharmacy consultant will continue to review the resident charts monthly and report any irregularities to the DON for review with the physicians. Follow-up will be completed within one week of sending to the physician.</p> <p>b. An in-service for Social Services and Licensed Nurses was conducted regarding the importance of acting on the pharmacy consultant recommendations and the completion follow-up thereof; and the Psychotropic medication review policy/procedure.</p> <p><u>4. How Monitored:</u></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>2. Review of the clinical record for Resident #E on 8/13/2012 at 3:05 p.m., indicated the resident had diagnoses which included, but were not limited to: dementia, depression and history of cerebral vascular accident.</p> <p>A Consultant Pharmacy review ,dated 7/26/12, indicated a recommendation to the physician to review the resident's Fluoxetine (Paxil - an antidepressant) 20 mg QD (daily) ordered 8/25/2011 for a possible gradual dose reduction. No follow-up to the recommendation could be located in the clinical record.</p> <p>During an interview with the Director of Nursing on 8/15/2012 at 10:35 a.m., she indicated "that the facility receives the recommendation within a week of the consultant pharmacist making the recommendation and that they would be sent right out to the physicians for review." She indicated that there was no specific system in place at the present time to track the responses or lack of responses by the physicians. She also indicated that at this time, no response has been received from the physician regarding the review of the resident's Fluoxetine</p>		<p>a. DON/Designee will audit/review all pharmacist consultant recommendations to ensure they have been reported to the physician and followed up on. This will be reviewed with the CEO/IDT monthly at the QA Committee meeting, as recommendations are received; and quarterly with the Medical Director.</p> <p>b. SSD/Designee will provide a written review/report of all residents reviewed weekly during PAR for GDR, weekly at the QA stand-up meeting on Fridays.</p> <p>c. SSD/Designee will review all residents reviewed for GDR monthly at the QA committee meeting; and will review the results quarterly with the Medical Director.</p> <p><u>5.</u> This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09-19-12.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>and possible reduction.</p> <p>On 8/15/2012 at 1:54 p.m., the DoN presented a copy of the physician's response to the 7/26/2012 Consultant Pharmacist's recommendation to consider gradual dose reduction of the resident's Fluoxetine. Review of this response indicated "8/15/2012 - Pt (patient) appropriate on current medication. Reduction tried & failed before entering nursing facility." During an interview with the DoN at this time, she indicated the physician should have been more specific as to why the medication reduction was a failure and that there should have been an attempt since the resident had resided in the facility since 5/18/2011.</p> <p>3. On 8/15/12 at 10:30 a.m., Resident #56's record review indicated diagnoses included but were not limited to; anemia, Vitamin B12 deficiency, hypothyroidism, CAD (coronary artery disease), HTN (high blood pressure), Rheumatoid arthritis, ulcerative colitis, TIA (mini strokes), Gout, CHF (congestive heart failure), DJD (degenerative joint disease), CRI (chronic renal insufficiency), Vitamin D deficiency, depression and anxiety.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>On 8/17/12 at 1:00 p.m., information was received the DON (Director of Nursing) regarding GDR (gradual dose reduction) for Resident #56. The Pharmacy Consultant had made a recommendation for the GDR for Clonazepam and Fluoxetine on 6/25/12. The MD (doctor) declined the GDR for the Clonazepam 0.5 mg on 7/3/12. The form for the GDR for the Fluoxetine showed it was faxed to the MD on 7/26/12, but there was no reply back and no follow-up had been done. According to the GDR Tracking report, dated 6/28/12, the resident was due for a GDR on Clonazepam on 5/7/12 and for Fluoxetine 5/11/12.</p> <p>On 8/17/12 at 1:43 p.m., the Social Service Director indicated the facility had "no policy and procedure for GDR and they follow the state and federal guidelines."</p> <p>On 8/17/12 at 2:07 p.m., "Form Summary" received from the DON, indicated the facility had a Behavior Management Committee which was to monitor behaviors and all psychoactive medications residents may be on. It is their responsibility to "...2. e) The Behavior Management Committee will review the documentation to determine a plan as</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>needed . The Committee will continue to routinely review the resident as long as the resident has an established behavior program and/or continues to receive antipsychotic/psychoactive medications. f) The Committee will recommend the initiation, when applicable, of a gradual dose reduction, unless clinically contraindicated, in an effort to maintain the resident at the lowest possible dose or to discontinue the medication..."</p> <p>On 8/17/12 at 5:00 p.m., the DON indicated they have no procedure in place at this time for following up on faxes. The DON indicated GDR's can be initiated by the staff but it is usually the Pharmacy Consultant that does it.</p> <p>3.1-25(h) 3.1-25(i)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(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: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(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			
F0431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to store medications under sanitary</p>	F0431	<p>F 431 <u>Drug records, label/store drugs & biologicals</u></p> <p>It is the intent of this facility to</p>	09/19/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>conditions for 1 of 2 medication rooms.</p> <p>Findings include:</p> <p>On 8/16/12 at 9:24 a.m., with RN #13, the following was observed:</p> <p>In the "ICF" medication room, the second refrigerator on the right had a green liquid substance that had dripped down from the small freezer compartment. The green liquid was on the outside of two bags that contained vials of tuberculosis vaccine.</p> <p>In the treatment cart, 2 calmoseptine packets, labeled with a resident's name and directions for use, had been opened and left in a clear plastic baggie, and the contents of the packets had oozed out onto the other packets.</p> <p>On 8/20/12 at 3:05 p.m., the Administrator indicated the pharmacy consultant was here in July and did not make any recommendations for the medication room.</p> <p>On 8/17/12 at 1:30 p.m., the Director of Nursing (D.O.N.) provided a policy and procedure for "Consultant Pharmacist Services". This policy</p>				<p>ensure storage of the medication under sanitary conditions.</p> <p>1. Actions Taken:</p> <p>DON/Designee checked both medication storage rooms and all medication carts for proper storage of medications, cleanliness and expired medications and corrected any noncompliant issues. Housekeeping cleaned the med rooms and the refinished the floors.</p> <p>2. Others Identified:</p> <p>All of the residents had the potential to be affected.</p> <p>3. Measures Taken:</p> <p>a. Pharmacy Consultant will do med cart and med room spot checks each month.</p> <p>b. DON/Designee will do the same in between the Pharmacy Consultant visit.</p> <p>c. Weekdays the Housekeeping Dept. will clean and mop the med rooms as needed; a nurse will remain in the medication room while cleaning is being</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>indicated, but was not limited to, "Policy: Regular Consultant Pharmacist services are provided to residents for nursing facilities that have a written agreement for such services. Procedures...The Consultant Pharmacist, or adjunctive licensed pharmacy personnel under the control of the Consultant Pharmacies, provides consultant pharmacist services, including but not limited to the following...Checking the medication storage facilities and the medication carts for proper storage of medications, cleanliness and removal of expired medications. (This is a shared responsibility of the consultant pharmacist, adjunct licensed pharmacy personnel, and/or facility staff.)..."</p> <p>3.1-25(m)</p>		<p>completed.</p> <p>4. How Monitored:</p> <p>a. DON/Designee will check medication storage rooms and audit medication carts for proper storage of medications, cleanliness and expired medications once a week for three weeks, then monthly thereafter.</p> <p>b. The Pharmacy Consultant will do med cart and med room spot checks each month.</p> <p>c. QA committee will review reports and audits monthly; and quarterly with the Medical Director.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09-19-12.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(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=E	<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 transport linens so as to prevent the spread of infection.</p> <p>Based on record review, observation,</p>	F0441	F 441 <u>Infection control.</u>	09/19/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>and interview, the facility failed to ensure routine hand hygiene was followed and failed to ensure standard precautions in regards to wound vac's and its tubing were followed. This affected 3 of 3 residents in a sample of 3 residents reviewed for infection control. (Resident #B, #87 #97, Activity Director)</p> <p>Findings include:</p> <p>1. During observation of pressure ulcer care on 8/16/12 at 10:49 a.m., with LPN #2, Resident #97 was observed to handle the wound vac tubing. On two occasions, the resident placed the tubing in her mouth to hold it out of the way while changing positions. LPN #2 had on gloves, picked up the wound vac from the floor, checked the pressure of the wound vac and placed it back on the floor. LPN #2 did not change her gloves or wash her hands. The resident was in a standing position and her sacral wound was observed. the sacral wound was covered by a clear dressing. LPN #2 brushed her gloved hand along the dressing. LPN #2's gloves were removed and hands were washed for 5 seconds and a new pair of clean gloves were</p>		<p><u>prevent spread, linens</u></p> <p>It is the intent of this facility to ensure routine hand hygiene is followed and to ensure standard precautions in regards to wound vac's and its tubing are utilized.</p> <p><u>1. Actions Taken:</u></p> <p>a. In regards to resident # 97: education was provided in regards to the wound vac, not placing tubing in mouth, not placing wound vac on the floor, and the infection control precautions thereof. This education was documented and care planned.</p> <p>b. In regards to resident # 87: education was provided in regards to the wound vac, not placing tubing in mouth, not placing wound vac on the floor, and the infection control precautions thereof. This education was documented and care planned.</p> <p>c. The Activity Director was educated in regards to standard precautions, glove usage, and hand washing. A pre and posttest was taken.</p> <p>-</p> <p><u>2. Others Identified:</u></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>applied. LPN #2 brushed the residents hair from the area of the scalp pressure ulcer. The necrotic area was then cleansed with betadine.</p> <p>No comments or education were provided by LPN #2 to the resident regarding placing the wound vac tubing in her mouth.</p> <p>Record review on 8/16/12 at 2:30 p.m., did not reveal any education to the resident regarding the wound vac.</p> <p>A policy and procedure received on 8/17/12 at 8:20 a.m., from the Director of Nurses (DON) titled "Handwashing". "...Procedure: 3. Wash hands well for approximately 15 seconds to aid in the mechanical removal of bacteria...."</p>		<p>a. This has the potential to affect all of the residents.</p> <p>-</p> <p>3. Measures Taken:</p> <p>a. An Infection Control and Hand washing In-service was conducted for all staff and education was provided. A pre and posttest was taken.</p> <p>b. An in-service for proper hand washing will be conducted quarterly for the next four quarters.</p> <p>4. How Monitored:</p> <p>a. DON/Designee will conduct Infection Control proficiency audits (including hand washing) with two randomly chosen employees one time a week for four weeks, then the same once a month for three months.</p> <p>b. QA committee will review the audit results monthly, and will review quarterly with the Medical Director, to determine if further action is needed.</p> <p>5. This plan of correction constitutes our credible allegation</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>2. Resident #87's record was reviewed on 8/15/12 at 1:26 p.m. The record indicated Resident #87 was admitted with diagnoses that included, but were not limited to, left foot ulcer, chronic venous stasis ulcer, psoriasis, history of cellulitis, arthritis, and osteoporosis.</p> <p>A care plan, with no date, had a problem/need of attention seeking behaviors AEB (as evidenced by) makes false claims of injury, makes false statements about staff and/or peers, will not keep wound vac charged properly - will carry it about with her all day, will not position wound vac on wheel chair, holds in her lap. no goal or target date, approaches, monitor for signs of compulsive behavior. Redirect prn, (as needed) give reassurance and direct her towards positive thoughts, notify SS, provide with factual information, remind to charge wound vac, and offer assist.</p> <p>Physician's recapitulation orders, dated 8/2012, indicated the wound vac was to be on the left ankle at 75</p>		of compliance with all regulatory requirements. Our date of compliance is 09-19-12.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>MMHG continuously.</p> <p>During an interview on 8/15/12 at 10:27 p.m., Resident #87 indicated she had open wounds from poor circulation and staff told her it was ok to place the wound vac box on the floor. She indicated they wanted her to put it behind her on the wheel chair, but she said she couldn't reach it, and she puts it on the floor and puts her blanket on it. Res was observed in her wheel chair watching TV, her left foot was covered with a soft knitted bootie and rested on her wheel chair foot rest, and the wound vac was observed on a blanket on the floor.</p> <p>On 8/13/12, during the noon meal at 12:05 p.m., Resident #87 was observed as she placed her wound vac on the floor beside her wheel chair and dropped a small blanket over the wound vac.</p> <p>On 8/16/12 at 2:30 p.m., Resident #87 was observed as she sat in her room in her wheel chair. The resident had placed the wound vac on the floor beside her wheel chair.</p> <p>During an interview on 8/17/12 at 11:15 a.m., the ADON said staff has tried to teach the resident not to place</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the wound vac on the floor and will try to find the teaching. She indicated it is an infection control problem to allow the wound vac to be on the floor.</p> <p>During an interview on 8/17/12 at 1:05 p.m., the ADON said they had done teaching with Resident #87, but it is not documented what they talked about. She indicated they talked about placing the wound vac on the wheel chair, and not in the floor because of the infection control risk and what is tracked in on the floors, but the resident places it on the floor anyway.</p> <p>3. On 8-15-12 at 11:44 a.m., the Activities Director was observed during a one on one activities program with Resident #B. She was observed massaging the resident's feet with lotion and her ungloved, bare hands. After completing the foot massage, the Activities Director was observed to gather her items onto a cart and exit the room without washing her hands. She was observed to stop in another resident's room to talk with the resident and then to proceed down the hall to her office. While in the office, she was observed speaking to another person while brushing hair away from her</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(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
	face and touching her face with her hands prior to washing her hands. 3.1-18(b)(4) 3.1-18(l)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(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	
F0465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>A. Based on observation and interview, the facility failed to ensure medication storage rooms were clean for 2 of 2 medication rooms.</p> <p>B. Based on observation and interview, the facility failed to ensure the carpeting was clean and in good repair in that the carpet in the building was dirty and wrinkled. This had the potential to affect all 67 residents.</p> <p>Findings include:</p> <p>A.1. On 8/16/12 at 9:24 a.m., with RN #13, the following was observed:</p> <p>On the "ICF" medication room floor, there were bits of paper, debris, a dried, squashed spider, an unused lancet, and several small, round, gray and black soiled areas.</p> <p>On the wall behind the handwashing sink was an area approximately 4 inches by 5 inches of missing paint, and below this area were scattered</p>	F0465	<p>F 465 <u>Safe/Functional/sanitary/comfo</u> <u>table environment</u></p> <p>It is the intent of this facility to ensure medication storage rooms are clean; and to ensure the carpeting is clean and in good repair.</p> <p><u>1. Actions Taken:</u></p> <p>a. Housekeeping cleaned the med rooms and refinished the floors.</p> <p>b. Bids are being obtained to remove and replace the existing carpet in the entryway, rehab hallway, nurses' station and the Chalet room.</p> <p><u>2. Others Identified:</u></p> <p>All of the residents had the potential to be affected.</p> <p>-</p> <p><u>3. Measures Taken:</u></p>	09/19/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>areas of paint that had been scraped off the wall below.</p> <p>The handwashing sink had no paper towels.</p> <p>The light green countertops around the sink had scattered, dark green stains and inside the stainless steel sink were water spots and rust stains.</p> <p>On 8/17/12 at 11:15 a.m., the Assistant Director of Nursing indicated housekeeping is supposed to sweep and mop the med room every day.</p> <p>A.2. On the skilled hall med room, with RN #16, on 8/17/12 at 10:21 a.m., there were a few small scraps of paper on the floor. RN #16 said she did not know when the floor is cleaned as housekeeping takes care of it.</p>		<p>a. Weekdays the Housekeeping Dept. will clean and mop the med rooms as needed. A Nurse will remain with the housekeeper during the cleaning time.</p> <p>b. As soon as the bids are obtained and the vender can get it schedule the carpet in question will be replaced.</p> <p>-</p> <p><u>4. How Monitored:</u></p> <p>a. Housekeeping Supervisor/Designee will check medication storage rooms for cleanliness daily.</p> <p>b. Maintenance Supervisor and Corporate Property Manager will monitor until complete.</p> <p>c. Daily/Weekly audits will be reviewed by the QA committee monthly; and with the Medical Director quarterly, to determine if further action is needed.</p> <p>-</p> <p><u>5.</u> This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.</p> <p>a. Our date of compliance is 09-19-12.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

	<p>B.1. Upon entrance to the facility on 8/13/12 at 9:10 a.m., the carpet in the entry way was noted to have large dark spotted areas. The dark spots were soiled and the carpet was worn. The carpet extended down the front hall to the left as you entered the facility. This hall was the front rehab unit . There were large wrinkles in the carpet in 6 places in the entry way and down the front rehab unit, which could cause a fall. The carpet in the Chalet Room was also noted to be soiled and wrinkled. The Chalet Rooms used for family gatherings and parties for the residents.</p> <p>On 8/14/12 at 8:30 a.m., the carpet remained the same.</p> <p>During an interview with the Administrator on 8/14/12 at 2:15 p.m., he indicated he had professional cleaners in last Thursday and "they are coming back in 2 weeks to clean again.". There are plans to replace the carpet but he didn't have a date for this as of yet.</p>		<p>b. <u>We respectfully request a 30-day extension for the new floor covering installation. Which if granted would make the date of full compliance to be 10-19-12.</u></p>	
--	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>On 8/16/12 at 9:40 a.m., the Housekeeping Supervisor was shampooing the carpet in the entryway.</p> <p>On 8/17/12 at 8:00 a.m., the carpet looked a little better. Spots were not as dark as before. The front rehab hall carpet and the carpet in the Chalet Room had not yet been cleaned.</p> <p>On 8/21/12 at 8:00 a.m., the carpet remained soiled and wrinkled.</p> <p>On 8/17/12 at 2:00 p.m., per the Administrator, they have no policy for keeping the carpet clean.</p> <p>On 8/20/12 at 2:15 p.m., received a cleaning schedule for the carpet from the Administrator. It indicated each week on Monday, Wednesday, and Friday the carpet is to be spot treated. Also received at this time a copy of an e-mail sent on 8/6/12 at 2:24 p.m., to the [carpet cleaning company] to let them know what they had done did help and plans were for them to come back again to clean the carpet in 2 weeks.</p> <p>3.1-19(f)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
--------------------------------------------------------------	-------------------------------------------------------------------------------

(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