

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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
F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 28, 29, 30, October 1, 2, 3, and 5, 2015</p> <p>Facility number: 000510 Provider number: 155507 AIM number: 100285440</p> <p>Census bed type: SNF/NF: 38 Total: 38</p> <p>Census payor type: Medicare: 2 Medicaid: 30 Other: 6 Total: 38</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2 3.1.</p> <p>Quality review completed by 30576 on October 13, 2015.</p>	F 0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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
F 0221 SS=D Bldg. 00	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, interview and record review the facility failed to attempt to reduce a restraint to a less restrictive method and failed to release a resident from a restraint for several hours. This affected 1 of 1 residents reviewed for restraints (Resident #3).</p> <p>Findings include:</p> <p>Review of Resident #3's record on 9/30/15 at 10:45 a.m., indicated diagnoses included but were not limited to hypertension, severe dementia, osteoporosis, depression, kyphosis, arthritis, cardiomegaly, congestive heart failure, peripheral vascular disease and anxiety.</p> <p>Physician's order dated 6/17/14 indicated "Pt to wear full lap tray while in geri chair to support self-feeding, safe geri chair positioning and leisure task participation."</p> <p>Review of Physician's recapitulation</p>	F 0221	<p>F221 Requires the facility to attempt to reduce a restraint to a less restrictive method.1. Resident #3 restraint was discontinued. Resident #3 was placed in a Broda chair per Hospice.2. All residents have the potential to be affected. All physician's orders for positioning devices were reviewed to ensure least restrictive devices are being used. Therapy screens were completed as well. No concerns were noted. See below for corrective measures.3. The Restraint Policy and Procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the on the above procedure.4. The DON or her designee will conduct a minimum of two observations daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter to ensure least restrictive positioning devices are being utilized and ensure resident devices are released hourly until 100% compliance is obtained and maintained. (See attachment B)</p>	10/19/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/05/2015	
NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353			
(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>orders dated 9/1/15 through 9/30/15 indicated full lap tray to be released every two hours for activities and eating.</p> <p>Review of physical restraint use notification in Resident #3's record indicated the form was signed by her Power of Attorney on 4/8/14, potential hazards for the resident was included on the form.</p> <p>9/29/15 at 11:50 a.m., observation of Resident #3 indicated the resident was sitting in her room, in a geri chair with a full lap tray in place.</p> <p>Observation on 9/30/15 at 1:40 p.m., indicated Resident #3 sitting in the TV area, eating and watching the TV. Appears to be sitting upright in correct positioning.</p> <p>10/5/15 at 8:30 a.m., observation indicated Resident #3 in the TV lounge, sitting in a geri chair with her feet up, in a reclined position.</p> <p>Observation on 10/5/15 at 1:30 p.m., Resident #3 sitting in a geri chair in the TV lounge area, resident does not appear to have been released and repositioned since 8:30 a.m., appears to be in the same position in the geri chair with legs raised</p>		<p>The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted.5. The above corrective measures will be completed on or before October 19, 2015.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>up in a reclined position.</p> <p>10/5/15 at 2:45 p.m., observation of Resident #3 indicated the resident was lying in bed.</p> <p>Interview with Assistant Director of Nursing (ADON) on 10/05/15 at 2:47 p.m., indicated Resident #3 was placed in geri chair with a lap tray on 3/18/14 for self feeding, positioning and activities. The restraint order was clarified on 6/17/14. The resident's daughter refuses to allow us to reduce or remove the restraint.</p> <p>10/5/15 at 3:45 p.m., the Director of Nursing present 2 forms titled "Restraint Record" dated September 2015 and October 2015 and indicated the CNA's use this form to show when they release the lap tray and reposition resident #3. The form was dated for every day of the month with each hour of the day beginning with 12 midnight through 11 p.m. preprinted on the form. The form indicated in September and October Resident #3 was in the geri chair with the lap tray every day of each month and it was not documented that the lap tray was released or repositioned for several hours ranging from 4 hours to 15 hours.</p> <p>ADON presented a document titled</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>"Restraint Review" on 10/5/15 at 4:00 p.m., the document dated 1/10/15 indicated "type of review: quarterly... date of last attempt at permanent removal of restraint 1/10/15. Explain what occurs when restraint is removed: resident tries to go forward in chair falling unless caught. Explain rational for continued use of this restraint: safety, self feeding, activities..."</p> <p>The next restraint review was completed on 4/3/15 indicated "type of review: quarterly... date of last attempt at permanent removal of restraint 4/3/15. Explain what occurs when restraint is removed: goes forward and would fall. Explain rational for continued use of this restraint: safety, self feeding, activities..."</p> <p>The last restraint review was completed on 7/1/15 indicated "type of review: annual... date of last attempt at permanent removal of restraint 7/1/15. Explain what occurs when restraint is removed: goes forward and will fall unless caught. Explain rational for continued use of this restraint: safety, self feeding, activities..."</p> <p>Review of care plan in place for positioning device dated 7/1/15 indicated "Problem: The resident requires the use of: geri chair with full lap tray due to: self feeding and activities . In an effort to maintain the highest practicable physical, mental and psychosocial well-being for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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 resident.</p> <p>Goal: The resident will be free from potential negative outcomes and or decline in functioning associated with positioning device use such as: increased incidents of incontinence, declines in functional range of motion, decreased ability to ambulate, loss of muscle tone, the development of skin problems, increased agitation, reduced social interaction, aspiration, ect. Thru next review.</p> <p>Interventions: observe for potential negative outcomes and or functional decline as intervene as needed. Educate the responsible party and or family regarding the reasons for positioning device use and the potential negative outcomes. Head to toe assessment weekly to assess for skin integrity for redness or breakdown. Observe and report changes in mood, behavior, nutritional status, or urinary status. Evaluate device for efficacy and appropriateness. Notify charge nurse of problems for further evaluation and possible physician and responsible party notification. Refer to therapy as needed. Assist resident to activities of interest."</p> <p>10/5/15 at 3:45 p.m., "Restraint Use (Physical)" policy presented by the Administrator indicated Policy: Restraint use will be employed only by order of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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
F 0241 SS=E Bldg. 00	<p>physician with the type of restraint specified in the order. Restraint use will be limited to circumstances in which the resident has a medical symptom that warrants the use of restraint(s). A restraint shall be applied per nursing personnel trained in proper application...Procedure:... 8. Each physically restrained resident shall be temporarily released from restraint at least every two (2) hours or more often if necessary, except when resident is asleep."</p> <p>3.1-3(w)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review the facility failed promote dignity for residents by not answering the call lights and providing assistance for long periods of time resulting in incontinence of bowel and bladder, brief not being changed and feelings of dissatisfaction for 4 of 5 residents who met the criteria for staffing (Resident #22, Resident #16, Resident #19 and Resident #11).</p>	F 0241	F241 Requires the facility to promote dignity by answering call lights and providing assistance for toileting and incontinence care.1. Resident ##22, #16, #19 and #11 bowel and bladder was updated.2. All residents have the potential to be affected. All residents bowel and bladder was reviewed. No concerns were noted. See below for corrective measures.3. The staff was inserviced on timely call light response in order to	10/19/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/05/2015	
NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353			
(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>Findings include:</p> <p>1.) Interview with Resident #22 on 9/29/15 at 11:14 a.m., indicated there was not enough staff available to make sure she got the care and assistance she needed without waiting a long time. Resident #22 indicated she would push her call light to go to the restroom and staff would come in her room and turn it off and say they would be back to assist her. Resident #22 indicated it "will be thirty minutes" before they come back and the resident stated by then "I will wet my pants" before they come back. Resident #22 indicated the staff should not turn off her call light and then not come back. Resident #22 indicated at times she would have to turn her call light on a second time before staff returned. Resident #22 indicated she knew the staff had other residents to take care of but when she needed to go to the bathroom she had to go.</p> <p>The October 2015 physician recapitulation (recap) for Resident #22 indicated the resident's diagnoses included, but were not limited to, right total knee prosthesis, irritable bowel syndrome, cellulitis, abscess of the leg, cardiomegaly, debility, kidney and ureter disorder, osteoarthritis, fall risk, bilateral</p>		<p>assistance with toileting and incontinence care. The staff was inserviced on the on the above procedure.4. The DON or her designee will conduct a minimum of two call light observations daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter to ensure staff is answering call lights timely in order to assist with toileting and incontinence care until 100% compliance is obtained and maintained. (See attachment B) The goal is for the call lights to be answered in five minutes or less. The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted.5. The above corrective measures will be completed on or before October 19, 2015.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>knee degenerative joint disorder, neuropathy hypertension and flexion contractures of the right knee.</p> <p>The bowel and bladder assessment for Resident #22, dated 6/30/15, indicated the resident's perception of the need to void was present and diminished. The resident can ask to void at times and occasionally was incontinent. The resident's perception of the need to defecate was present and diminished . The resident ask to be toileted and was sometimes incontinent.</p> <p>The Admission Minimum Data (MDS) assessment for Resident #22, dated 7/8/15, indicated the resident was able to make herself understood and she was able to understand others. The resident was cognitively independent with her decisions and was consistent and reasonable. The resident required extensive assistance of two people to transfer, walk in her room and use the toilet. The resident used a walker and a wheelchair. The resident was frequently incontinent of her bladder and occasionally incontinent of her bowels.</p> <p>Interview with Resident #22 on 10/2/15 at 1:10 p.m., indicated she had to wait 30 minutes for assistance, the resident indicated she knew it was 30 minutes</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>because she had timed it with the clock in her room. Observation of the resident's clock, the clock had the correct time. The resident indicated it happened "all the time" and she knew the staff couldn't help it they were busy. The resident stated "oh yes I can tell when I need to go the bathroom" and waiting had caused her to "wet" herself.</p> <p>Interview with CNA #3 and CNA #4 on 10/5/15 at 2:45 p.m., indicated Resident #22 was able to tell them when she needed to use the bathroom, "but has already been incontinent sometimes too."</p> <p>2.) Interview with Resident #16's family member on 9/28/15 at 11:34 a.m., indicated there was not enough staff available in the facility to make sure that residents got the care and assistance they needed without waiting a long time. The family member indicated there was lack of staffing and it had been an ongoing problem. The family indicated there were times they would come in and the resident would have dried bowel movement on him and not clean. The family member indicated approximately a week ago when they had come to visit the resident, he had on the same brief from the previous day. The family member indicated they knew it was the same brief because it had a hole in it that the family</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>had made in the brief the previous day. The family member indicated the resident was not suppose to have a brief on unless the family took him outside per families request.</p> <p>Review of the September 2015 physician recap for Resident #16 indicated the resident's diagnoses included, but were not limited to, anxiety, quadriplegia due to traumatic brain injury, cardiomyopathy, motor vehicle accident with severe head trauma, hypertension, seizures, anemia, neurogenic bladder, respiratory failure, chronic vegetative state, asthma, bladder spasms and history of deep vein thrombosis.</p> <p>The Quarterly MDS assessment for Resident #16, dated 9/23/15, indicated the resident was totally dependent of two staff for bed mobility, transfers, dressing and toilet use. The resident did not walk in his room or the corridor. The resident was totally dependent of one person for personal hygiene.</p> <p>Interview with Resident #16's family on 10/2/15 at 9:45 a.m., indicated he worried about quality of care of the residents. The family member indicated it was brought to his attention approximately a week ago that the resident's brief had not been changed from the previous day by a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>CNA. The family member indicated the CNA told him that if he said something maybe it would make a difference and felt like it would not do any good if it was reported by the CNA. The family member indicated the family had cut a hole in his brief for the tubing to his Texas catheter and when he came to the facility in the morning the resident had on the same brief from the previous afternoon. The family member indicated he knew it was the same brief because he was the one that had cut the hole in the resident's brief.</p> <p>3.) Interview with Resident #19 on 9/28/15 at 1:37 p.m., indicated no there was not enough staff available to make sure she got the care and assistance she needed without waiting a long time. The resident indicated it took anywhere between 15 minutes to an hour to have the call light answered.</p> <p>Review of the October 2015 physician recap for Resident #19 indicated the resident's diagnoses included, but were not limited to, depression, chronic ischemic heart disease, hypertension, neuropathy, Cerbrovascular accident (stroke), atrial fibrillation, obesity, anxiety, chronic obstructive pulmonary disease, history of right hip fracture, coronary artery disease, dementia with</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>mood behavioral disturbances and vascular dementia.</p> <p>The Annual MDS assessment for Resident #19, dated 8/22/15, indicated the resident sometimes could make himself understood and usually understands others. The resident required extensive assistance of two people for transfers, to walk in his room and use the bathroom. The resident was occasionally incontinent of his bowel and bladder.</p> <p>Interview with Resident #19 on 10/2/15 at 1:10 p.m., indicated there was not enough staff and it took up to an hour for staff to answer a call light. The resident indicated the staff would walk "right by the call light" and not stop. The resident indicated he knew it took up to an hour because he had a cell phone with the time. The resident showed me his cell phone at this time and it had the correct time and date. The resident indicated nothing bad had happened because waiting so long, but it was "annoying" and it would make a "big difference" to have more aides.</p> <p>4.) Interview with Resident #11 and his family member on 9/28/15 at 3:13 p.m., indicated no there was not enough staff available in the facility to make sure that residents got the care and assistance they</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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 without waiting a long time. The resident indicated he would push his call light to go to the bathroom it would take 15 to 20 minutes to answer it and then the staff will have to go get the lift and by that time " I have wet myself". The resident's family member indicated the staff had to transfer him using a lift.</p> <p>Review of the October 2015 physician recap for Resident #11 on 10/1/15 at 11:23 a.m., indicated the resident's diagnoses included, but were not limited to, coronary artery disease, congestive heart failure, peripheral vascular disease, right below the knee amputation, depression, diabetic neuropathy, type two diabetes, chronic kidney disease and peripheral artery disease.</p> <p>Interview with Resident #11 on 10/2/15 at 1:20 p.m., indicated the staff used a stand up lift to take him to the bedside commode. The resident indicated Sometimes he used a urinal. The resident indicated he was not always able to reach his genitals to use the urinal because everything was "all tucked in" his brief and pants and he was unable to get to it. The resident indicated he had waited up to 30 minutes to use the bathroom. The resident indicated knew it was 30 minutes because he timed it with his wrist watch. The resident then indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>what time it was by his watch and it was correct. The resident indicated around meal times seemed to be the worse times. The resident indicated sometimes it caused him to "wet myself". The resident indicated he always knew when he had to go to the bathroom. The resident indicated he had also had been incontinent of his bowels threes times because of having to wait too long. The resident indicated he was not incontinent of his bowels or bladder when he was at home.</p> <p>Review on 10/2/15 at 1:40 p.m., of Resident #11's Bowel and bladder assessment (no date or time) indicated the resident had the perception of the need to void and states bladder feels empty and has the perception of need to defecate.</p> <p>The Admission MDS assessment for Resident #11, dated 8/10/15, indicated the resident was able to make himself understood and he was able to understand others. The resident was cognitively independent with her decisions and was consistent and reasonable. The resident required extensive assistance of two people to transfer, walk in his room and use the toilet. The resident was occasionally incontinent of his bowel and bladder.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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
F 0279 SS=D Bldg. 00	<p>Interview with CNA #3 and CNA #4 on 10/5/15 at 2:45 p.m., indicated they had both cared for Resident #11 since he was admitted to the facility. CNA #3 and CNA #4 indicated the resident was able to tell them when he needed to use the restroom.</p> <p>3.1-3(t)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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 observation, interview and record review the facility failed to</p>	F 0279	F279 Requires the facility to implement a care plan with measurable and individualized interventions.1. Resident #3	10/19/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  10/05/2015
NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353		
(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>implement a care plan with measurable and individualized interventions for 1 of 22 residents reviewed for care plans (Resident #3).</p> <p>Findings include:</p> <p>Review of Resident #3's record on 9/30/15 at 10:45 a.m., indicated diagnoses included but were not limited to hypertension, severe dementia, osteoporosis, depression, kyphosis, arthritis, cardiomegaly, congestive heart failure, peripheral vascular disease and anxiety.</p> <p>Physician's order dated 6/17/14 indicated "Pt to wear full lap tray while in geri chair to support self-feeding, safe geri chair positioning and leisure task participation."</p> <p>Review of Physician's recapitulation orders dated 9/1/15 through 9/30/15 indicated full lap tray to be released every two hours for activities and eating.</p> <p>9/29/15 at 11:50 a.m., observation of Resident #3 indicated the resident was sitting in her room, in a geri chair with a full lap tray in place.</p> <p>Observation on 9/30/15 at 1:40 p.m.,</p>		<p>restraint was discontinued. Resident #3 was placed in a Broda chair per Hospice.2. All residents have the potential to be affected. Residents who currently have restraints, care plan were reviewed to ensure that measureable and individualized interventions are in place. Therapy screens were completed as well to ensure restraints are least restrictive. No concerns were noted. See below for corrective measures.3. The Care Plan Policy and Procedure was reviewed with no changes made. (See attachment C) The staff was inserviced on the on the above procedure.4. The DON or her designee will review restraint care plans daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter to ensure the care plans are measureable and individualized until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted.5. The above corrective measures will be completed on or before October 19, 2015.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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 #3 sitting in the TV area, eating and watching the TV. Appears to be sitting upright in correct positioning.</p> <p>10/5/15 at 8:30 a.m., observation indicated Resident #3 in the TV lounge, sitting in a geri chair with her feet up, in a reclined position.</p> <p>Observation on 10/5/15 at 1:30 p.m., of Resident #3 indicated the resident sitting in a geri chair in the TV lounge area, resident does not appear to have been released and repositioned since 8:30 a.m., appears to be in the same position in the geri chair with legs raised up in a reclined position.</p> <p>10/5/15 at 2:45 p.m., observation of Resident #3 indicated the resident was lying in bed.</p> <p>Interview with Assistant Director of Nursing (ADON) on 10/05/15 at 2:47 p.m., indicated resident #3 was placed in a geri chair with lap tray on 3/18/14 for self feeding, positioning and activities. The geri chair with lap tray order was clarified on 6/17/14. The resident's daughter refuses to allow us to reduce or remove the restraint.</p> <p>10/5/15 at 3:45 p.m., the Director of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>Nursing present 2 forms titled "Restraint Record" dated September 2015 and October 2015 and indicated the CNA's use this form to show when they release the lap tray and reposition resident #3. The form was dated for every day of the month with each hour of the day beginning with 12 midnight through 11 p.m. preprinted on the form. The form indicated in September and October resident #3 was in the geri chair with lap tray every day of each month and is was not documented that it was released or repositioned for several hours ranging from 4 hours to 15 hours.</p> <p>ADON presented a document titled "Restraint Review" on 10/5/15 at 4:00 p.m., the document dated 1/10/15 indicated "type of review: quarterly... date of last attempt at permanent removal of restraint 1/10/15. Explain what occurs when restraint is removed: resident tries to go forward in chair falling unless caught. Explain rational for continued use of this restraint: safety, self feeding, activities..."</p> <p>The next restraint review was completed on 4/3/15 indicated "type of review: quarterly... date of last attempt at permanent removal of restraint 4/3/15. Explain what occurs when restraint is removed: goes forward and would fall. Explain rational for continued use of this</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>restraint: safety, self feeding, activities..."</p> <p>The last restraint review was completed on 7/1/15 indicated "type of review: annual... date of last attempt at permanent removal of restraint 7/1/15. Explain what occurs when restraint is removed: goes forward and will fall unless caught. Explain rational for continued use of this restraint: safety, self feeding, activities..."</p> <p>Review of care plan in place for positioning device dated 7/1/15 indicated "Problem: The resident requires the use of: geri chair with full lap tray due to : self feeding and activities . In an effort to maintain the highest practicable physical, mental and psychosocial well-being for the resident.</p> <p>Goal: The resident will be free from potential negative outcomes and or decline in functioning associated with positioning device use such as: increased incidents of incontinence, declines in functional range of motion, decreased ability to ambulate, loss of muscle tone, the development of skin problems, increased agitation, reduced social interaction, aspiration, ect. Thru next review.</p> <p>Interventions: observe for potential negative outcomes and or functional decline as intervene as needed. Educate the responsible party and or family regarding the reasons for positioning</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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
F 0282 SS=D Bldg. 00	<p>device use and the potential negative outcomes. Head to toe assessment weekly to assess for skin integrity for redness or breakdown. Observe and report changes in mood, behavior, nutritional status, or urinary status. Evaluate device for efficacy and appropriateness. Notify charge nurse of problems for further evaluation and possible physician and responsible party notification. Refer to therapy as needed. Assist resident to activities of interest."</p> <p>10/5/15 at 3:45 p.m., "Care Plan Development and Review" presented by the Administrator indicated Purpose: To ensure an interdisciplinary approach to plan for and meet residents needs. Policy: Facility personnel will ensure development of a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs...</p> <p>3.1-35(a) 3.1-35(b)(1)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  10/05/2015
NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353		
(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 observation, interview and record review the facility failed to follow a care plan to do provide active range of motion with the resident's bath upon rising and failed to follow the careplan for a pad chair alarm to prevent accidents for 2 of 22 residents reviewed for care plans (Resident #14 and Resident #4).</p> <p>Findings include:</p> <p>1.) Review of the September 2015 physician recapitulation (recap) orders for Resident #14 on 9/30/15 at 10:08 a.m., indicated the resident's diagnoses included, but were not limited to, progressive multiple sclerosis (MS), anxiety, muscle spasm, major depressive disorder, osteoporosis, acute respiratory failure, degenerative joint disease, paresis of the bilateral lower extremities, right foot drop, chronic pain and weakness.</p> <p>The Quarterly Minimum Data Set (MDS) for Resident #14, dated 8/19/15, indicated the resident was able to make himself understood and he was able to understand others. The resident was cognitively independent with his decisions and was consistent and reasonable. The resident was totally dependent of two staff for his bed mobility, transfers and using the toilet. The resident was unable to walk in his</p>	F 0282	<p>F282 Requires the facility to follow a care plan to provide active range of motion and to follow the care plan to prevent accidents.1. Resident #14 fall care plan was reviewed to ensure interventions are being followed. Resident #4 active range of motion care plan was reviewed to ensure interventions are being followed. 2. All residents have the potential to be affected. Residents care plan regarding fall risk care plans and range of motion care plans were reviewed to ensure interventions are being followed. No concerns were noted. See below for corrective measures.3. The Care Plan Policy and Procedure was reviewed with no changes made. (See attachment C) The staff was inserviced on the on the above procedure.4. The DON or her designee will review care plans daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter to ensure the care plans interventions are being followed 100% compliance is obtained and maintained. The DON or her designee will conduct 2 observations of staff providing active range of motion and conduct 2 observations to ensure fall interventions are in place as care planned. (See attachment B) The audits will be reviewed</p>	10/19/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/05/2015	
NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353			
(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 or corridor. The resident had limitations in range of motion of his bilateral upper and lower extremities.</p> <p>The careplan for Resident #14, dated 9/2/15, indicated the resident had multiple health conditions including, but not limited to, muscle spasms. The intervention included, but were not limited to, active range of motion with the resident's bath upon rising in the a.m.</p> <p>Interview with Resident #14 on 9/30/15 at 11:03 a.m., indicated the aides did not do range of motion with his hands, fingers, arms, legs or feet. The resident indicated when CNA #5 worked she would stretch out his fingers on his right hand before applying his splint and other than that he did not receive any other range of motion. The resident indicated the aides did not do any type of exercise with him when he received his bath or during care.</p> <p>During observation on 10/1/15 at 9:10 a.m., CNA #1 and CNA #2 provided a bath for Resident #14 and got him dressed. During his care there were no range of motion exercises provided.</p> <p>Interview with CNA #1 and CNA #2 on 10/1/15 at 9:50 a.m., indicated there was not a restorative program at the facility</p>		<p>during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted.5. The above corrective measures will be completed on or before October 19, 2015.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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 the CNA's took over doing range of motion for residents. CNA #1 indicated no they did not do range of motion for Resident #14 with his bath. CNA #1 indicated range of motion was done for the resident on night shift. 2. Resident #4's record was reviewed on 9/30/15 at 2:36 p.m. Her diagnoses on her September 2015 physician recapitulation orders included but were not limited to, Alzheimer's dementia, history of left pelvic fracture, history of left hip fracture with compression screw, history of left humerus fracture, history of closed mid-shaft fracture of left femur, history of spiral fracture of distal femoral shaft, right total hip arthroplasty, and osteoarthritis.</p> <p>Resident #4's quarterly Minimum Data Set (MDS) assessment dated 7/12/15, indicated she was understood and usually understood others. She required limited assistance of 1 person for bed mobility. She required extensive assistance of 1 person for transfers and toileting. She did not walk. She was severely impaired in her daily cognitive decision making skills.</p> <p>Resident #4's physician recapitulation orders for September 2015, indicated an order initiated 2/24/15, Resident #4 would be provided an alarm pad to her</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>bed and chair. Placement and function of the alarm pad would be checked every day.</p> <p>A plan of care for Resident #4 initiated 7/11/14, and updated 7/24/15, indicated she had multiple risk factors for falls and would utilize an alarm pad in her bed and chair.</p> <p>On 9/30/15 at 11:42 a.m., Resident #4 was observed sitting in her wheelchair in her bedroom. She had a pad alarm on the seat of her wheelchair but the alarm pad was not connected to an alarm box. At that time, Resident #4 indicated she had transferred herself to her wheelchair.</p> <p>On 9/30/15 at 11:58 a.m., the Director of Nursing (DON) moved the alarm box from Resident #4's bed and attached it to the alarm pad on Resident #4's wheelchair. The DON indicated Resident #4 must have transferred herself from her bed to her wheelchair.</p> <p>On 9/30/15 at 1:25 p.m., Resident #4 was observed seated in her recliner in her bedroom. She did not have an alarm pad on her recliner seat.</p> <p>On 9/30/15 at 1:32 p.m., CNA #1 indicated Resident #4 was supposed to have an alarm pad on her recliner seat.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>CNA #1 placed an alarm pad from Resident #4's wheelchair seat to Resident #4's recliner seat. CNA #1 observed the clip that attached to the alarm box on the alarm pad was broken and she got a new alarm pad and placed on Resident #4's recliner seat.</p> <p>On 10/1/15 at 9:28 a.m., Resident #4 was observed seated in her wheelchair in the hallway near the nurses station. Resident #4 did not have an alarm pad in her wheelchair seat.</p> <p>On 10/1/15 at 9:34 a.m., the DON placed an alarm pad in Resident #4's wheelchair seat.</p> <p>On 10/1/15 at 9:35 a.m., CNA #6 indicated she had assisted Resident #4 out of bed and Resident #4 had not had an alarm pad on her wheelchair seat. CNA #6 indicated she usually remembered which residents had alarms. CNA #6 indicated she could also review the Activities of Daily Living sheet to know what residents utilized alarms but she was working as Activity staff and wasn't carrying one.</p> <p>The Care Plan Development and Review procedure provided by the DON on 10/5/15 at 5:30 p.m., indicated the following: "Purpose: To ensure an</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>interdisciplinary approach to plan for and meet resident's needs. Policy: Facility personnel will ensure development of a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs. Procedure:... 4. The comprehensive care plan is designed to: Address the needs, strengths and preferences identified in the comprehensive resident assessment. Be oriented toward preventing avoidable declines in functioning or functional levels. Reflect standards of current professional practice. Incorporate risk factors associated with identified problems and ways to manage said risk factors. Reflect treatment goals and objectives in measurable outcomes. Identify the professional services that are responsible for each element of care. Enhance the optimal functioning of resident by focusing on a rehab program... Communication to Personnel:</p> <ol style="list-style-type: none"> <li>Care plans will be available to all personnel providing care to the residents.</li> <li>Care plan interventions specific to direct care personnel will be included on the direct caregiver's assignment sheet, or similar tool in use."</li> </ol> <p>3.1-35(g)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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
F 0312 SS=D Bldg. 00	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on interview and record review, the facility failed to provide a resident with bathing according to her preference and bathing schedule for 1 of 3 residents reviewed for Activities of Daily Living (ADL), of 14 who met the criteria for ADL's. (Resident #24)</p> <p>Findings include:</p> <p>Resident #24's record was reviewed on 10/1/15 at 10:45 a.m. Her diagnoses on her September 2015 physician recapitulation orders included but were not limited to, osteoarthritis and chronic kidney disease.</p> <p>Resident #24's annual Minimum Data Set (MDS) assessment dated 7/24/15, indicated she was understood and had the ability to understand others. She was cognitively intact in her daily decision making skills. It was very important for her to choose what type of bathing she received. She required limited assistance of 1 person for personal hygiene.</p>	F 0312	<p>F282 Requires the facility to provide a resident with bathing according to her preference and bathing schedule.1. Resident #24 preference was reviewed to ensure bathing preference were accurate with resident's wishes. no changes were needed.2. All residents have the potential to be affected. Resident's bathing preferences were reviewed. No concerns were noted. See below for corrective measures.3. The staff was inserviced regarding the need to follow the resident's preference regarding bathing. If the resident refuses, a behavior memo will be completed. The staff was inserviced on the above procedure.4. The DON or her designee will review bathing preferences to ensure their preferences are being followed daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance</p>	10/19/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/05/2015	
NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353			
(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 plan of care for Resident #24 initiated 1/28/15, and updated 7/25/15, indicated it was very important for her to choose what type of bathing she preferred and she preferred a bed bath. She would be assisted to bathe according to her preference.</p> <p>Resident #24's Resident Care Records indicated she had only received partial bathing from September 2nd through September 8th. No refusals were documented. She was scheduled for a bath on September 5th, and 8th. She had only received partial bathing from September 24th through October 2nd. No refusals were documented. She was scheduled for a bath on September 26th, and 29th.</p> <p>An interview on 9/29/15 at 10:30 a.m., Resident #24 indicated she was not bathed often enough.</p> <p>An interview on 9/30/15 at 9:42 a.m., Resident #24 indicated she usually had to ask staff to bathe and she wasn't bathed often enough. She indicated she would like to bathe 2 to 3 times a week.</p> <p>On 10/5/15 at 10:24 a.m., CNA #1 indicated the resident's bathing schedule was posted on the wall at the nurses station and was also documented on the</p>		meetings and the plan of correction will be adjusted accordingly if warranted.5. The above corrective measures will be completed on or before October 19, 2015.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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
F 0318 SS=D Bldg. 00	<p>CNA Assignment Sheet. Resident #24's bathing schedule and CNA Assignment Sheet indicated she would be bathed weekly on evening shift, Tuesday and Saturday. Resident's bathing was documented daily on their Resident Care Record including what type of bathing they received. If a resident didn't bathe on their assigned day, a notation was made on the Resident Care Record as to why they didn't.</p> <p>3.1-38(a)(2)(A)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview and record review the facility failed to provide range of motion exercises for a resident who had limited range for 1 of 6 residents who met the criteria for range of motion of 3 residents reviewed for contractures (Resident #14).</p> <p>Finding include:</p> <p>During observation on 9/28/15 at 2:41 p.m., Resident #14 had right hand</p>	F 0318	F318 Requires the facility to provide range of motion exercises for residents with limited range. 1. Resident #14 nursing measure for passive range of motion was reviewed with no changes. 2. All residents have the potential to be affected. Resident's range of motion nursing measures were reviewed. No concerns were noted. See below for corrective measures. 3. The Passive Range of Motion policy and procedure was reviewed with no	10/19/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  10/05/2015
NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353		
(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>contractures with a splint device in place.</p> <p>Review of the September 2015 physician recapitulation (recap) orders for Resident #14 on 9/30/15 at 10:08 a.m., indicated the resident's diagnoses included, but were not limited to, progressive multiple sclerosis (MS), anxiety, muscle spasm, major depressive disorder, osteoporosis, acute respiratory failure, degenerative joint disease, paresis of the bilateral lower extremities, right foot drop, chronic pain and weakness.</p> <p>The Quarterly Minimum Data Set (MDS) for Resident #14, dated 8/19/15, indicated the resident was able to make himself understood and he was able to understand others. The resident was cognitively independent with his decisions and was consistent and reasonable. The resident was totally dependent of two staff for his bed mobility, transfers and using the toilet. The resident was unable to walk in his room or corridor. The resident had limitations in range of motion of his bilateral upper and lower extremities.</p> <p>The physician order for Resident #14, dated 8/27/15, indicated the resident was to wear a left upper extremity splint per resident's request as tolerated and a right upper extremity splint to be worn at all</p>		<p>changes made. (See attachment D) The staff was inserviced on the on the above procedure.</p> <p>4. The DON or her designee will conduct 2 observations of staff providing passive range of motion and documenting the procedure daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. 5. The above corrective measures will be completed on or before October 19, 2015.</p> <p style="padding-left: 40px;">IDR Rational F-318- Increase/Prevent Decrease in Range of Motion</p> <p>Per the 2567, the facility "failed to provide range of motion exercises for a resident who had limited range for 1 of 6 residents who met the criteria for range of motion of 3 residents reviewed for contractures"</p> <p>The facility respectfully requests that the following information be reviewed relative to the aforementioned alleged deficient practice.</p> <p>Upon review of the PROM documentation sheets dated July 2015, August 2015 and September 2015 documentation is present to indicate the resident did in fact receive ROM. During the survey the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>times as tolerated except for personal care.</p> <p>The careplan for Resident #14, dated 9/2/15, indicated the resident had multiple health conditions including, but not limited to, muscle spasms. The intervention included, but were not limited to, active range of motion with the resident's bath upon rising in the a.m.</p> <p>The joint mobility assessment screen for Resident #14, dated 9/16/15, indicated the resident had deteriorated joint mobility due to MS.</p> <p>The physician progress note, dated 9/25/15, indicated the resident complained of numbness and tingling of the left hand and worsening pain in the legs and increased spasticity (tightness, stiffness or pull of muscles). The resident's Baclofen pump (treatment for spasticity) was increased.</p> <p>Interview with Resident #14 on 9/30/15 at 11:03 a.m., indicated he use to be in a restorative program for range of motion and the facility no longer had a restorative program. The resident indicated the aides did not do range of motion with his hands, fingers, arms, legs or feet. The resident indicated when CNA #5 worked she would stretch out his</p>		<p>State Surveyor requested copies of July 2015 and August 2015 which are the same copies being presented for review one again. The surveyor did not request nor receive a copy of the September 2015 PROM documentation.</p> <p>Per the 2567 "Review of the passive range of motion (PROM) documentation for resident #14 indicated in July he received PROM with PM care 7 times, August he received PROM with PM care 31 times and September he received PROM with PM care 29 times." The documentation respectfully being submitted contends he received PROM.(See Attachment A)</p> <p>Per the 2567, "on 10-1-15 at 9:10am CNA #1 and CNA #2 provided a bath for resident #14 and dressed him. During his care there were no range of motion exercises provided."</p> <p>Interview with CNA #1 on 10-1-15 at 9:50am states, "CNA #1 indicated range of motion was done for the resident on night shift". The staff interviewed during the survey process were day shift CNA's. (See Attachment B)</p> <p>One should note that Mr. Antrobus was receiving inpatient treatment at Reid Hospital in Richmond Indiana for an exacerbation of his Multiple Sclerosis from July 6, 2015 to July 11, 2015. He returned to the facility on July 11,2015 was evaluated by physical therapy and per the physician order dated July 12, 2015 "physical therapy not indicated at</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>fingers on his right hand before applying his splint and other than that he did not receive any other range of motion. The resident indicated the aides did not do any type of exercise with him when he received his bath or during care. The resident indicated he would like to be in a range of motion program as he was unable to do it himself.</p> <p>During observation on 10/1/15 at 9:10 a.m., CNA #1 and CNA #2 provided a bath for Resident #14 and dressed him. During his care there were no range of motion exercises provided.</p> <p>Interview with CNA #1 and CNA #2 on 10/1/15 at 9:50 a.m., indicated there was not a restorative program at the facility and the CNA's took over doing range of motion for residents. CNA #1 indicated they did not do range of motion for Resident #14 with his bath. CNA #1 indicated range of motion was done for the resident on night shift.</p> <p>Interview with the Director of Nursing (DON) on 10/1/15 at 10:47 a.m., indicated the CNA's were responsible to do range of motion exercises with the residents. When queried why range of motion was not being provided for Resident #14, the DON indicated the CNA's were signing that they were doing</p>		<p>this time". (See Attachment C) He was also evaluated by occupational therapy and determination was made that he could potentially benefit from occupational therapy services. He received occupational therapy from July 12, 2015 until his discharge from therapy on 8-27-15. The facility is now respectfully submitting the physicians order dated 7-12-15 for occupational therapy for "OT to treat 5 times a week times 30 days addressing w/c positioning, ther (therapeutic) exercise self feeding and pt/caregiver training".(See Attachment D) He received occupational therapy from July 12, 2015 until his discharge from therapy on 8-27-15. During his participation with occupational therapy he received the following services ; therapeutic exercises in bilateral upper extremities to increase strength, treatment for positioning in electric wheel chair, treatment for self feeding and tolerance of splint.(See Attachment E)</p> <p>Per the facility policy as cited in the 2567 "Range of motion exercises are provided to assist residents to reach and maintain highest level of ROM possible and prevent avoidable decline". The facility is respectfully submitting a letter from Amy Spivey MD who is Mr. Antrobus' primary care physician. Dr. Spivey states that "It is virtually unavoidable for a person with this diagnosis to not</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/05/2015	
NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353			
(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			
F 0323 SS=D Bldg. 00	<p>range of motion.</p> <p>Review of the passive range of motion (PROM) documentation for Resident #14 indicated in July 2015 he received PROM with p.m. care 7 times, August 2015 he received PROM with p.m. care 31 times and September 2015 he received PROM with p.m. care 29 times.</p> <p>The range of motion policy provided by the DON on 10/1/15 at 11:00 a.m., indicated the range of motion exercises are indicated for resident with temporary or permanent loss of mobility, sensation, or consciousness, and as a restorative measure to prevent loss of function, muscle contractures and/or deformity. "Range of motion exercises are provided to assist residents to reach and maintain highest level of ROM possible and prevent avoidable decline."</p> <p>3.1-42(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to implement new</p>	F 0323	<p>have some form of spasticity or contracture" and "PROM performed by staff will hopefully help, but will but no means prevent further spasticity and/or contractures". (See Attachment F)</p> <p>The facility respectfully disagrees with the allegation that the facility "failed to provide range of motion exercises for a resident who had limited range for 1 of 6 residents who met the criteria for range of motion of 3 residents reviewed for contractures".</p> <p>Given the information supplied, the facility requests F318 be deleted as a citation.</p> <p>F323 Requires the facility to implement new interventions</p>	10/19/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>interventions and provide supervision for a resident who continued to fall out of bed for 1 of 3 resident reviewed for accidents, of 4 who met the criteria for accidents. (Resident #21)</p> <p>Findings include:</p> <p>An interview with Resident #21's son on 9/30/15 at 1:47 p.m., indicated he felt most of his mother's falls were a result of her trying to get out of bed. His mother was on Hospice and she suffered with agitation at times and "she thinks she can get up on her own."</p> <p>Resident #21's record was reviewed on 10/2/15 at 9:53 a.m. Diagnoses on her September 2015 physician recapitulation orders indicated but were not limited to, dementia, anxiety, and a history of radius fracture.</p> <p>Resident #21's significant change Minimum Data Set (MDS) assessment dated 9/4/15, indicated she was sometimes understood and she sometimes understood others. She was severely impaired in her cognitive daily decision making skills. She required total assistance of 2 persons for bed mobility and toileting. She required extensive assistance of 2 persons for transfer. She had functional limitation in</p>		<p>and provide supervision for a resident who continued to fall. 1. Resident #21 is in a low bed with a mat next to the bed. The half side rail was discontinued. 2. All residents have the potential to be affected. All falls in the last 30 days were reviewed to ensure new interventions were implemented. No concerns were noted. See below for corrective measures. 3. The Fall Prevention Program policy and procedure was reviewed with no changes made. (See attachment E) The staff was inserviced on the on the above procedure. 4. The DON or her designee will review all new falls in the morning meeting and ensure new fall interventions are in place immediately. The audits will be conducted daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. 5. The above corrective measures will be completed on or before October 19, 2015. IDR Rational F323 Free of Accident Hazards/Supervision/Devices Per the 2567 the facility <i>failed to implement new interventions and provide supervision for a resident</i></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  10/05/2015	
NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353			
(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>her range of motion to both lower extremities.</p> <p>Resident #21's most recent Fall Risk Assessment dated 7/20/15, indicated she was a high risk for falls.</p> <p>An Accident and Incident Report and Investigation for Resident #21 dated 4/22/15 at 2:20 a.m., indicated she had an unwitnessed fall in her bedroom. She had attempted to get out of bed and had slipped down on her bottom onto a mat next to her bed. She was unable to provide any information as to what she was trying to do when she fell. The immediate action or intervention implemented to prevent any recurrence indicated her bed had been in low position, her pad alarm had been sounding, a mat had been on the floor next to her bed. All interventions had been in place and had kept her free of injury. Staff would complete a fall assessment and do a bed check at 1:00 a.m., to ensure she was resting quietly.</p> <p>An Accident and Incident Report and Investigation for Resident #21 dated 5/3/15 at 3:00 a.m., indicated she had an unwitnessed fall in her bedroom. She was found on a mat beside her bed. She had stated she did not know why she was out of bed. The immediate action or</p>		<p><i>who continued to fall out of bed for 1 of 3 residents reviewed for accidents, of 4 who met the criteria for accidents". The facility respectfully requests that the following information be reviewed relative to the aforementioned alleged deficient practice. Per the 2567 the following falls were reviewed; "An accident and incident report and investigation for resident # 21 dated 4/22/15 at 2:20am, indicated she had an unwitnessed fall in her bedroom. She had attempted to get out of bed and had slipped down on her bottom onto a mat next to her bed. She was unable to provide any information as to what she was trying to do when she fell. The immediate action or intervention implemented to prevent any recurrence indicated her bed had been in the lowest position, her pad alarm had been sounding, and a mat had been on the floor next to her bed. All interventions had been in place and kept her free of injury; Staff would complete a fall assessment and do a bed check at 1:00am, to ensure she was resting quietly".</i></p> <p>The new intervention for the fall on 4-22-15, as documented on her fall care plan was "staff will do bed check at 1am to ensure she is resting quietly" (See Attachment A) "An accident and Incident report and investigation for Resident #21 dated 5/3/15 at 3:00am indicated she had an unwitnessed fall in her bedroom.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  10/05/2015
NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353		
(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>intervention implemented to prevent any recurrence indicated she had a bed mat on the floor and her pad alarm had been sounding. All interventions had been in place and had kept her safe and free of injury.</p> <p>An Accident and Incident Report and Investigation for Resident #21 dated 7/19/15 at 12:30 a.m., indicated a CNA had heard her pad alarm sounding and when they walked into the bedroom, Resident #21 was observed sliding out of bed onto a mat on the floor and landing on her buttock. She had a red area on her right elbow that had disappeared after 2-3 minutes. Resident #21 had stated she thought she had been on the toilet. The immediate action or intervention implemented to prevent any recurrence indicated staff would continue to do bed checks every 2 hours. She had been care planned for trying to get up without assistance. Her bed alarm had been on and functioning. A mat had been in place on the floor next to her bed. The bed had been in low position.</p> <p>An Accident and Incident Report and Investigation for Resident #21 dated 8/2/15 at 4:20 p.m., indicated she had an unwitnessed fall in her bedroom. A CNA had heard her pad alarm sounding and when they walked into the bedroom,</p>		<p><i>She was found on the mat beside her bed. She didn't know why she was out of bed. The immediate action or intervention implemented to prevent any recurrence indicated she had a bed mat on the floor and her pad alarm had been sounding. All interventions had been in place and kept her free of injury". The new intervention for fall on 5/3/15, as documented on her fall care plan was "UA-urinary symptoms". (See Attachment A) "An Accident and Incident Report and Investigation for Resident #21 dated 7/19/15 at 12:30am, indicated a CNA had heard her pad alarm sounding and when they walked into the bedroom, Resident#21 was observed sliding out of bed onto a mat on the floor and landing on her buttock. She had a red area on her right elbow that had disappeared after 2-3 minutes. Resident #21 had stated she thought she had been o the toilet. The immediate action or intervention implemented to prevent any recurrence indicated staff would continue to do bed checks every 2 hours. She had been care planned for trying to get up without assistance. Her bed alarm had been on and functioning. A mat had been in place on the floor next to her bed. The bed had been in the lowest position" The new intervention for fall on 7/19/15, as documented on the fall care plan was "bed in</i></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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 #21 was observed lying on a mat on the floor on her right side. She had a skin tear on her right elbow. The immediate action or intervention implemented to prevent any recurrence indicated all fall precautions had been in place. A Therapy Fall Screen would be completed. If the resident appeared restless, staff would get her up in a chair.</p> <p>An Accident and Incident Report and Investigation for Resident #21 dated 9/2/15 at 2:00 p.m., indicated her pad alarm sounded. A staff member walked into her bedroom and observed her sitting on the side of the bed and slide to the mat on her floor on her knees. She had a skin tear on her right middle finger. The immediate action or keep safe intervention implemented to prevent any recurrence indicated if she was anxious in bed, staff would get her back up in a chair.</p> <p>An Accident and Incident Report and Investigation for Resident #21 dated 9/25/15 at 11:45 p.m., indicated staff responded to her bed pad alarm and yells for help. She was observed on her mat by her bed. Her right hand had been bleeding and a bruise was observed on her right hand and elbow. She had been unable to tell staff how she cut her 4th finger on her right hand. She had been</p>		<p>lowest position". (See Attachment A) "An accident and Incident Report and Investigation for Resident #21 dated 8/2/15 at 4:20 pm, indicated she had an unwitnessed fall in her bedroom. A CNA had heard her pad alarm sounding and when they walked into the bedroom, Resident #21 was observed lying on a mat on the floor on her right side. She had a skin tear on her right elbow. The immediate action or intervention implemented to prevent any recurrence indicated all fall precautions had been in place. A therapy fall screen would be completed. If resident appeared restless, staff would get her up in a chair." The new intervention for the fall on 8/2/15, as documented on the fall care plan was "therapy fall screen". (See Attachment A) An Accident and Incident Report and Investigation for Resident #21 dated 9/2/15 at 2:00pm indicated her pad alarm sounded. A staff member walked into her bedroom and observed her sitting on the side of the bed and slide to the mat on her floor on her knees. She had a skin tear on her right middle finger. The immediate action or keep safe intervention implemented to prevent recurrence indicated if she was anxious in bed, staff would get her back up in a chair". The New intervention for the fall on 9/2/15, as documented on the fall care plan was "watch resident when</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>yelling out "it hurts." The immediate action or keep safe intervention implemented to prevent any recurrence indicated a bed pad alarm, low bed, mat on the floor, and non-skid socks were already in place.</p> <p>The Fall Prevention Program provided by the Administrator on 10/5/15 at 5:21 p.m., indicated the following: "Purpose: To identify residents who are at risk for falls and subsequently implement appropriate, individualized fall prevention interventions. Policy: It is the policy of this facility to identify any resident who is at increased risk for falls. Identified residents shall be monitored by the Interdisciplinary team (IDT) in an effort to implement fall prevention interventions that minimize occurrence of falls thereby minimizing residents risk of injury. The IDT shall review those residents identified as being at risk for falls or those residents who have sustained falls and are at risk for recurrent falls... Procedure:... 3. IDT meetings will be held daily, Monday thru Friday, as warranted. 4. During the meetings, IDT members will review and discuss applicable residents addressing any falls which have occurred since the last meeting; enter said fall(s) on the Individual Fall Monitoring Log; address current intervention(s) for each resident</p>		<p>anxious and get up in chair". (See Attachment A) <i>An Accident and Incident Report and Investigation for Resident #21 date 9/25/15 at 11:45pm, indicated staff responded to her bed pad alarm and yells for help. She was observed on her mat by her bed. Her right hand had been bleeding and a bruise on her right hand and elbow. She had been unable to tell staff how she had cut her 4th finger on her right hand. She had been yelling out "it hurts". The immediate action or keep safe intervention implemented to prevent any recurrence indicated a bed pad alarm, low bed, mat on the floor, and non-skid socks were already in place".</i> The new intervention for the fall on 9/25/15, as documented on the fall care plan was "wear non skid socks to bed". (See Attachment A) The facility contends that there is documentation on the fall care plan for Resident #21 related to each fall and a new intervention was implemented. The facility feels as the confusion as to whether there were interventions put in place may have been a result of this surveyor requesting to look at the Accident and Incident Report and Investigation. These are merely internal investigation forms utilized by the facility to ensure the incident or accident was thoroughly investigated. The information from this form is then entered into the resident medical</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/05/2015
NAME OF PROVIDER OR SUPPLIER  WHITEWATER COMMONS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353		
(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	
	being reviewed and efficacy thereof; and determine if other/additional interventions are warranted at the time of review... 8. Should a resident incur multiple falls, the facility shall continue to document prevention interventions attempted. The IDT may reference the Fall Prevention Intervention Resource Guide for potential interventions that may applicable...."  3.1-45(a)(2)		record and resident care plans are then updated. The facility respectfully disagrees with the allegation that the facility "failed to implement new interventions and provide supervision for a resident who continued to fall out of bed for 1 of 3 residents reviewed for accidents, of 4 who met the criteria for accidents. (Resident #21)		