

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
--	---

(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
F000000	<p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints IN00149714 and IN00149804 completed on June 5, 2014.</p> <p>This visit was in conjunction with a PSR to the Recertification and Sate Licensure Survey completed on June 13, 2014.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00152292, IN00151165, and IN00152141.</p> <p>Complaint IN00149714 - Not Corrected.</p> <p>Complaint IN00149804 - Not Corrected.</p> <p>Survey Dates: July 16, 17, 18, 21 & 22, 2014</p> <p>Facility number: 000478 Provider number: 155494 AIM number: 100290430</p> <p>Survey team: Gwen Pumphrey, RN-TC Gloria Reisert, MSW (July 17, 21 & 22, 2014) Jennifer Sartell, RN (July 21 & 22, 2014)</p> <p>Census Bed type: SNF/NF: 74</p>	F000000	Preparationand/or execution of this plan of correction in general, or this correctiveaction in particular, does not constitute an admission of agreement by thisfacility of the facts alleged or conclusions set forth in this statement ofdeficiencies. The plan of correction andspecific corrective actions are prepared and/or executed in compliance withState 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: 155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/22/2014
NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170		
(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	
F000353 SS=F	<p>Total: 74</p> <p>Census payor type: Medicare: 10 Medicaid: 60 Other: 4 Total: 74</p> <p>Sample: 6</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on July 30, 2014, by Brenda Meredith, R.N.</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 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>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
--	---

(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>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 observation, interview and record review, the facility failed to ensure sufficient nursing staff were on duty to provide nursing care to residents. This deficient practice affected 4 of 6 sampled residents reviewed for sufficient nursing staffing. (Resident D, E, F, and G)</p> <p>Findings include:</p> <p>On 7/17/14 at 8:15 a.m., Resident D was observed laying in the middle of the hall way fully clothed. There was no staff available to assist Resident D.</p> <p>On 7/21/14 at 12:31p.m. Resident D was observed rolling on the floor out of her room into the hallway. Resident D was dressed in a shirt and was naked from the waist down. Resident D was tangled in stained sheet. Resident D said "Help me, Help me" repeatedly. There was no staff available on the unit to assist Resident D.</p> <p>On 7/21/14 at 8:30a.m., a resident was observed urinating in the doorway of a closet in room 140. Upon notifying the</p>	F000353	<p><u>F353- Nursing Services – Sufficient Staffing -</u></p> <p>The Facility must have sufficient staffing to providenursing and related services to attain or maintain the highest practicablephysical, mental and psychosocial well-being of each resident, as determined byresident assessments and individual plans of care.</p> <p><i>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?</i></p> <p>It is the policy of this facility to provide the servicesrequired to provide the utmost functionality for our residents. The facility will continually recruit staffin an effort to have the personnel available to meet whatever resident needsare presented.</p> <p>A recruiting and retention committee comprised of facilitystaff formed and began monthly meetings.</p> <p>The administrator and regional nursing consultant haveconducted multiple interviews with staff, residents and families to determinewhere to focus new</p>	08/21/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
--	---

(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 #5, she indicated that as soon as another staff member comes back from taking the residents to smoke, she will clean up the urine. CNA #5 indicated she was the only one on the unit at this time and could not let the residents out of her sight.</p> <p>On 7/21/14 at 8:55 a.m., Resident E was observed hanging off of her geri-chair with 1 arm on the seat and her bottom almost to floor. There was no staff available on the unit to assist Resident E. When CNA #2 arrived to assist the resident, CNA #2 looked at the resident and then left the resident to go find additional help for transferring the resident back into her chair.</p> <p>On 7/21/14 at 2:16p.m., Resident F indicated there's not enough staff. The resident indicated, this week has been better than usual.</p> <p>On 7/21/14 at 2:30p.m., Resident G indicated, "at times we have enough and at other times it's not enough."</p> <p>Anonymous interviews with direct care staff including nurses and CNA included the following:</p> <p>Employee #1: When a staff calls in or calls off on vacation, we are working by</p>		<p>efforts and staff.</p> <p>Resident smoking responsibilities have been delegated out, so that the bulk of the labor and time is provided by department heads, or activity staff. This should allow for more focused nursing care without multiple interruptions daily to take residents out to smoke.</p> <p>An increased nursing budget has been approved and implemented. This will be reviewed based on resident need thereafter.</p> <p>An increased nursing and housekeeping pay scale has been approved and implemented. This will be reviewed based on resident need thereafter.</p> <p>We have offered a \$500.00 sign-on bonus for all nursing staff. This information was posted online, as well as in print locally. This will be reviewed based on resident need thereafter.</p> <p>We have implemented a staff referral bonus for referring nursing staff of \$400.00.</p> <p>We have begun to sponsor CNA classes offsite. We have 8 students on our payroll that will begin class on 8/11/2014, with a tentative completion date of 9/1/2014. We will also be paying for each applicant's class and certification, as well as paying their wage while earning this certification. Each applicant has made a commitment of 6 months service with The Waters of Scottsburg in return for us sponsoring their CNA</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
--	---

(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>alone. We can not get everything done that we are supposed to. It is difficult to watch residents with behaviors and do all your other care. Some times shaving, showers and 2 hour checks are not getting done because its not enough time. You do incontinence care and making sure they are clean and dry and that's about all you can do.</p> <p>Employee #2: We are short but not too bad today. We were short last week and the State knew it. If we don't get to all the showers we are supposed to do today, then we make sure to do them the next day with the other people due a shower. We try to do showers, incontinence care and making sure the resident is clean and dry. Its hard to get everything done."</p> <p>Employee #3: I have worked by myself before and there is always supposed to be 2 staff on this unit. On days when I work by myself I don't get a lunch. The nurse will try to help if we are short but they have their own tasks to do to.</p> <p>Employee #4: When we have to watch the meals, sometimes the residents get upset when their medications are not given exactly when they want them, they are not late but we aren't able to honor their choices.</p>		<p>certification. Additional classes will be scheduled until the CNA staffing needs havebeen met.</p> <p>Our Weekend Manager On Duty tasks have been altered untilstaffing stabilizes. The adjustmentsdouble management's presence on the weekends, giving extra hands to assist.</p> <p>Help wanted advertising will continue until the staffingneeds are met.</p> <p>Resident council will be attended by the administratormonthly, by invitation, to get feedback from the residents first hand. This will also give leadership theopportunity to communicate the improvements that are currently being completed.</p> <p>A Family Night has been scheduled, with invitations mailed,to give families the opportunity to express concerns and get communicationabout physical plant and care improvements. This will also give families an opportunity to help direct where theyfeel attention is needed to better care for their loved ones. Family Night will be held quarterly movingforward, unless the attendance and concerns dictate a change in frequency.</p> <p><i>How will otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective actions will be taken?</i></p> <p>All residents could be affected by the same allegeddeficient practice. A recruiting and retention</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/22/2014
NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170		
(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>Employee #5: When we are short, they will pull an aide from another unit. When we have 2 aides and the activity assistant, I feel this is when we have optimal staffing on this unit.</p> <p>On 7/22/14 at 10:29a.m., the document titled, "Resident Council Report Communication," dated 7/9/14, was reviewed. The report indicated, "still having issues of untimeliness with aides." The response, dated 7/11/14, indicated, "staff reinserviced, please let management know right away when this happens so we can address the specific staff and issue."</p> <p>This deficiency was cited on June 5, 2014. The facility failed to implement a systematic plan of correction to prevent recurrence.</p> <p>3.1-17(a)</p>		<p>committee comprised of facility staff formed and began monthly meetings.</p> <p>The administrator and regional nursing consultant have conducted multiple interviews with staff, residents and families to determine where to focus new efforts and staff.</p> <p>Resident smoking responsibilities have been delegated out, so that the bulk of the labor and time is provided by department heads, or activity staff. This should allow for more focused nursing care without multiple interruptions daily to take residents out to smoke.</p> <p>An increased nursing budget has been approved and implemented. This will be reviewed based on resident need thereafter.</p> <p>An increased nursing and housekeeping pay scale has been approved and implemented. This will be reviewed based on resident need thereafter.</p> <p>We have offered a \$500.00 sign-on bonus for all nursing staff. This information was posted online, as well as in print locally. This will be reviewed based on resident need thereafter.</p> <p>We have implemented a staff referral bonus for referring nursing staff of \$400.00.</p> <p>We have begun to sponsor CNA classes offsite. We have 8 students on our payroll that will begin class on 8/11/2014, with a tentative completion date of 9/1/2014. We</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
--	---

(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>will also be paying for each applicant's class and certification, as well as paying their wage while earning this certification. Each applicant has made a commitment of 6 months service with The Waters of Scottsburg in return for us sponsoring their CNA certification. Additional classes will be scheduled until the CNA staffing needs have been met.</p> <p>Our Weekend Manager On Duty tasks have been altered until staffing stabilizes. The adjustments double management's presence on the weekends, giving extra hands to assist.</p> <p>Help wanted advertising will continue until the staffing needs are met.</p> <p><i>What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?</i></p> <p>The DON, or her designee, will monitor the staffing needs daily to determine if adequate staff is available to meet the needs of our facility. This monitoring will be ongoing.</p> <p>Resident council will be attended by the administrator monthly, by invitation, to get feedback from the residents first hand. This will also give leadership the opportunity to communicate the improvements that are currently being completed.</p> <p>A Family Night has been scheduled, with invitations mailed, to give families the opportunity to express</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
--	---

(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>concerns and get communication about physical plant and care improvements. This will also give families an opportunity to help direct where they feel attention is needed to better care for their loved ones. Family Night will be held quarterly moving forward, unless the attendance and concerns dictate a change in frequency.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</i></p> <p>Any staffing needs identified by the DON, or her designee, will be discussed with the Administrator. Through their joint discussion, it will be determined if additional or altered recruiting efforts need to be put into action. An audit will be performed by the SSD weekly, with a sample of 5 residents until there has been 4 consecutive weeks with zero negative staffing concerns. The administrator will speak to at least one resident family per week, until there have been 4 weeks with zero negative staffing concerns. Resident council will be attended by the administrator monthly, by invitation, to get feedback from the residents first hand. This will also give leadership the opportunity to communicate the improvements that are currently being completed. A Family Night has been scheduled, with invitations mailed, to give</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/22/2014
NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170		
(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	
			families the opportunity to express concerns and get communication about physical plant and care improvements. This will also give families an opportunity to help direct where they feel attention is needed to better care for their loved ones. Family Night will be held quarterly moving forward, unless the attendance and concerns dictate a greater frequency. These measures will be reviewed and adjusted accordingly based on monthly and quarterly QA meetings.		