

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155217	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/15/2014
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NAME OF PROVIDER OR SUPPLIER WATERS OF HUNTINGBURG THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 9, 10, 11, 12, and 15, 2014</p> <p>Facility number: 000122 Provider number: 155217 AIM number: 100290560</p> <p>Survey team: Terri Walters RN TC Amy Wininger RN Sylvia Scales RN Debra Holmes RN Dorothy Watts (9/9, 9/10, 9/11, & 9/12/14)</p> <p>Census bed type: SNF/NF: 63 Total: 63</p> <p>Census payor type: Medicare: 7 Medicaid: 37 Other: 19 Total: 63</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on September 19, 2014, by Jodi Meyer, RN</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F000246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview, and record review, the facility failed to ensure services were provided to a resident with a functional disability, in that, a resident who was unable to use a standard call light was provided a call light within her functional ability for 1 of 35 residents who met the criteria for review of call light accessibility. (Resident #100)</p> <p>Findings include:</p> <p>The clinical record of Resident #100 was reviewed on 9/11/14 at 9:31 A.M. Resident #100 was admitted on 8/19/14. The diagnoses of Resident #100 included, but were not limited to, Rheumatoid Arthritis and muscle weakness.</p> <p>The Admission MDS (Minimum Data Set) assessment, dated 08/26/14, documented Resident #100 experienced no cognitive impairment and required the</p>	F000246	<p>Preparation and/or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the facility of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p> <p>F246 –SSD Reasonable accommodation of needs/preferences It is the intent of this facility to ensure that a resident rights to reside and receive services in the facility with reasonable accommodations of needs and preferences.</p> <p>1. Actions Taken: A) Resident #100 was assessed to ensure no negative outcomes. B) As soon as 'squeeze ball' call light was delivered from vendor, which was during survey period, it was installed for resident.</p>	10/03/2014
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	<p>assistance of one staff for transfers, walking, and toileting.</p> <p>A Plan of Care dated 09/02/14 for Resident #100 stated that "Resident requires assistance with ADL's (activities of daily living) r/t (related to) RA, (Rheumatoid Arthritis)...Goal..Resident will have all ADLS met by staff...Keep call light in reach..."</p> <p>A Nurse's note dated 09/02/14 at 14:07 (2:07 P.M.) read as follows, "...Bil (bilateral) hand contractures due to RA. Weakness noted..."</p> <p>A Nurse's note dated 09/05/14 at 14:32 (2:32 P.M.) read as follows, "...has poor dexterity with bilateral hands d/t (due to) rheumatoid arthritis"</p> <p>During an interview on 09/09/14 at 11:10 A.M., Resident #100 indicated she had not received assistance to the bathroom and transferring that she needed. Resident #100 said, "I have very bad arthritis and I have trouble pushing the button (call light button). My thumb just doesn't work very well." At that time, Resident #100 was observed to attempt to push the call light button unsuccessfully. Resident #100 indicated on occasions she thought she had pressed the call light button and waited for assistance but they</p>		<p>2. How other residents have the potential to be affected: A) All residents would have the potential to be affected:</p> <p>3. Measures Taken: A) Resident was trained on 'squeeze ball' call-light with return demonstration to ensure that it would work for her. B) 100% audit/assessment was completed on all residents to determine if they could benefit from this type or any other type of call-light system. Call-light was updated/changed if needed.</p> <p>4. How Monitored: A) All new admits and current residents will be discussed in weekly SWAT meetings for possible at risk diagnosis and/or COC that would warrant call light issues. B) The MDS process will also notify when a resident needs to be assessed for possible issues with call lights due to RA and/or other diagnosis. C) Therapy Director/MDS Director/Designee will review at risk resident charts 5 times a week for 30 days, then once a week for 30 days, then once a month thereafter or more often if needed per IDT and/or SWAT weekly meetings. D) Any inconsistent results will be immediately clarified and corrected appropriately and care plans updated if needed. Results would be monitored and reviewed at the monthly and quarterly QA Meeting for ongoing monitoring and/or</p>	

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	<p>didn't come and she wet on herself. Resident #100 further indicated there had been times when she would see someone passing in the hall and would yell to them and ask for assistance to go to the bathroom. The CNA's would indicate to her the call light had not been activated and was not ringing. Resident #100 said, "They said my light did not go off when I pushed it just this morning." Resident #100 indicated she would go to the bathroom by herself, but they told her it was too dangerous and she needed to wait for a CNA to help her. Resident #100 indicated the staff had given her a flat pad call light to try, but it didn't work. Resident #100 indicated that the flat pad call light went off accidentally all the time, so the staff replaced it with the button call light.</p> <p>During an interview on 09/11/14 at 9:17 A.M., CNA #12 indicated Resident #100 needed the assistance of 1 person with all ADL's and transfers. CNA #12 further indicated Resident #100 was always continent and knew when she needed to use the bathroom.</p> <p>During an interview on 09/11/14 at 8:37 A.M., Occupational Therapy #1 (OT #1) indicated Resident #100 had been provided a special foam handle fork and spoon to use during her meals. OT #1</p>		<p>changes.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is October 3, 2014.</p>	

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F000250 SS=D	<p>further indicated that padded utensils were easier to grip for residents with arthritic hands .</p> <p>During an interview on 09/12/14 at 1:36 P.M., the Director of Nursing indicated Resident #100 had not been assessed for a different call light which accommodated the needs of a resident with Rheumatoid Arthritis.</p> <p>During an interview on 09/12/14 at 2:30 P.M., the Assistant Director of Nursing indicated the facility had ordered a modified call light to accommodate Resident #100's needs.</p> <p>3.1-3(v)(1)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview, and record review, the facility failed to address the behavior symptom of yelling for 1 of 1 resident reviewed for the behavior symptom of yelling, in that no</p>	F000250	Preparation and/or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the facility of facts alleged or conclusions set forth in	10/03/2014

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	<p>interventions were initiated to diminish the episodes of the resident's yelling behavior and/or to address the psychosocial needs of Resident #72 or other residents affected by the yelling behavior. (Resident #72)</p> <p>Findings include:</p> <p>On 9/11/14 at 9:15 A.M., an alert and oriented and anonymous resident indicated that Resident #72 has problems now and yells out frequently. The anonymous resident indicated Resident #72 yells out for help and that he wants to die. The anonymous resident indicated Resident #72 started yelling last night at 4:00 A.M.</p> <p>On 9/12/13 at 11:45 A.M., Resident #72 was observed sitting at a table in the main dining room. Resident #72 began yelling out loudly, the yelling continued until 11:48 A.M. The dietary staff were present, they did not intervene.</p> <p>On 9/12/14 at 9:05 A.M., Resident #72's clinical record was reviewed. Diagnoses included but were not limited to, dementia aggressive behavior and delusional thinking, Alzheimer's, hard of hearing, and depression. The current Minimum Data Set (MDS) assessment</p>		<p>the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. F250 – SSD Provision of medically related social service It is the intent of this facility to ensure that it will provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>1. Actions Taken: A) Resident #72 was assessed for any psycho social issues relating to current care plan in place and changes made if warranted. B) Resident #72 was assessed for any possible suicidal ideations.</p> <p>2. How other residents have the potential to be affected: A) All residents have the potential to yell out or to have another resident near them to “yell” out.</p> <p>3. Measures Taken: A) A 100% audit of all behavior management forms, Point Click Care program, Care Plans were updated as needed to reflect resident’s current status. B) Staff was in-serviced concerning Behavior monitoring protocol.</p> <p>4. How Monitored: A) Social Service Director will review all Behavior monitor report in daily clinical Quality Indicator (CQI) meeting to assure each care plan is</p>	

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	<p>dated 7/21/14, indicated a cognitive score for decision making: "2. Moderately impaired-decisions poor, cues/supervision required..." "Physically behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually). Behavior of this type occurred 1 to 3 days."</p> <p>Resident #72's current care plan addressed the behaviors of potential to become combative and resist care (initiated 1/8/14) and aggressive behavior and delusional thinking (initiated 1/8/14). The care plan also included the problem of an elopement risk and wandering behavior which had been initiated on 5/29/14.</p> <p>On 9/12/14 at 10:20 A.M., Resident #72's behavior logs for July, August, and September (9/1- 9/12) 2014 were reviewed. The July 2014 behavior log documented a "Yelling/Screaming behavior had occurred on 7/27/14 at 11:56 A.M., 7/30/14 at 11:47 A.M., and on 7/31/14 at 2:29 A.M. The August behavior log documented the "Yelling/Screaming" behavior had occurred on 8/9/14 at 2:13 A.M., 8/13/14 at 2:07 A.M., 8/24/14 at 2:46 A.M., 8/25/14 at 2:43 A.M., and on 8/26/14 at 2:16 A.M. The September behavior log</p>		<p>accurate, complete and that proper behavior management is in place and up to date and being followed accordingly.</p> <p>B) Social Service and IDT members will complete the weekly behavior meeting per policy and procedure for completeness and monitoring. Any inconsistent results will be immediately clarified and corrected appropriately and care plans updated if needed.</p> <p>C) Any inconsistent results will be immediately clarified and corrected appropriately and care plans updated if needed. Results would be monitored and reviewed at the monthly and quarterly QA Meetings for ongoing monitoring and/or changes.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is October 3, 2014.</p>	

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	<p>documented the "Yelling/Screaming" behavior had occurred on 9/5/14 at 10:56 P.M., and on 9/6/14 at 9:34 A.M.</p> <p>On 9/15/14 at 8:38 A.M., the Social Service Director/ SSD was interviewed regarding Resident #72's behavior logs. She indicated she prints out behavior logs completed by the CNAs every morning except on Monday (prints off 2 for the past weekend) for review at the facility morning department head meeting. She indicated any behavior logged was discussed. The SSD was made aware at that time of the yelling behavior documented in July, August, and September for Resident #72. The SSD was made aware of a resident voicing complaint regarding the yelling behavior of Resident #72. She indicated Resident #72 was hard of hearing and talks loudly. The SSD was also made aware of documentation lacking of a care plan to address the yelling behavior and interventions had not been initiated to diminish the episodes of yelling for Resident # 72 and address his psychosocial needs. The SSD indicated documentation was lacking of a plan and that interventions had not been initiated to address the yelling behavior of Resident #72.</p> <p>On 9/15/14 at 12:12 P.M., during</p>			

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F000279 SS=D	<p>interview with the SSD, she indicated she had interviewed 2 residents on Resident #72's hall. She indicated the two residents had voiced a problem with being awoken from Resident #72's yelling behavior.</p> <p>3.1-34(a)</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</p>			

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	<p>§483.10(b)(4). Based on observation, interview, and record review, the facility failed to ensure a care plan was initiated to address the behavior symptom of yelling for 1 of 1 resident reviewed for behaviors. (Resident #72)</p> <p>Findings include:</p> <p>On 9/11/14 at 9:15 A.M., an alert and oriented and anonymous resident initiated an interview with the surveyor. The resident indicated that Resident #72 has problems and yells out frequently. The anonymous resident indicated Resident #72 yells out for help and states that he wants to die. The anonymous resident indicated Resident #72 started yelling last night at 4:00 A.M.</p> <p>On 9/12/13 at 11:45 A.M., Resident #72 was observed sitting at a table in the main dining room. Resident #72 began yelling out loudly, the yelling continued until 11:48 A.M. The dietary staff were present, they did not intervene.</p> <p>On 9/12/14 at 9:05 A.M., Resident #72's clinical record was reviewed. Diagnoses included but were not limited to, dementia aggressive behavior and delusional thinking, Alzheimer's, hard of</p>	F000279	<p>Preparation and/or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the facility of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. F279 SS-D Develop comprehensive care plans It is the intent of this facility to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>1. Actions Taken: A) Resident #72 was assessed for any psycho social issues relating to current care plan in place and changes made if warranted. B) Resident #72 was assessed for any possible suicidal idealizations. C) Other cognitive residents on #72 hall was interviewed for any issues with resident #72 with all having no issues.</p> <p>1. How other residents have the potential to be affected: A) All residents have the potential to yell out or to have another resident near them to "yell" out.</p> <p>2. Measures Taken: A) A 100% audit of all behavior management forms, Point Click Care program, Care Plans were updated</p>	10/03/2014

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	<p>hearing, and depression. The current Minimum Data Set (MDS) assessment dated 7/21/14, indicated a cognitive score for decision making: "2. Moderately impaired-decisions poor, cues/supervision required..." "Physically behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually). Behavior of this type occurred 1 to 3 days."</p> <p>Resident #72's current care plan addressed the behaviors of potential to become combative and resist care (initiated 1/8/14) and aggressive behavior and delusional thinking (initiated 1/8/14). The care plan also included the problem of an elopement risk and wandering behavior which had been initiated on 5/29/14.</p> <p>On 9/12/14 at 10:20 A.M., Resident #72's behavior logs for July, August, and September (9/1- 9/12) 2014 were reviewed.</p> <p>The July 2014 behavior log documented a "Yelling/Screaming behavior had occurred on 7/27/14 at 11:56 A.M., 7/30/14 at 11:47 A.M., and on 7/31/14 at 2:29 A.M.</p> <p>The August behavior log documented the "Yelling/Screaming" behavior had occurred on 8/9/14 at 2:13 A.M., 8/13/14</p>		<p>as needed to reflect resident's current status.</p> <p>B) Staff was in-serviced concerning Behavior monitoring protocol.</p> <p>3. How Monitored: A) Social Service Director will review all Behavior monitor report in daily clinical Quality Indicator (CQI) meeting to assure each care plan is accurate, complete and that proper behavior management is in place and up to date and being followed accordingly.</p> <p>B) Social Service and IDT members will complete the weekly behavior meeting per policy and procedure for completeness and monitoring. Any inconsistent results will be immediately clarified and corrected appropriately and care plans updated if needed. Results would be monitored and reviewed at the monthly and quarterly QA Meetings for ongoing monitoring and/or changes.</p> <p>4. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is October 3, 2014.</p>	

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	<p>at 2:07 A.M., 8/24/14 at 2:46 A.M., 8/25/14 at 2:43 A.M., and on 8/26/14 at 2:16 A.M.</p> <p>The September behavior log documented the "Yelling/Screaming" behavior had occurred on 9/5/14 at 10:56 P.M., and on 9/6/14 at 9:34 A.M.</p> <p>On 9/15/14 at 8:38 A.M., the Social Service Director/ SSD was interviewed regarding Resident #72's behavior logs. She was made aware at that time of the yelling behavior documented in July, August and September for Resident #72. The SSD was also made aware of documentation lacking of a care plan to address the yelling behavior or interventions initiated to diminish the episodes of yelling for Resident # 72 and address his psychosocial needs. The SSD indicated documentation was lacking of a plan and that interventions had not been initiated to address the yelling behavior of Resident #72.</p> <p>On 9/15/14 at 12:12 P.M., the SSD during interview indicated a care plan had been developed to address the problem of Resident #72's yelling behavior.</p> <p>3.1-35(a)</p>			

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F000314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure care was provided, in that, a resident admitted without a pressure ulcer, developed a pressure ulcer for 1 of 3 residents who met the criteria for review of pressure ulcers. This deficient practice resulted in the Resident #27 experiencing a Stage IV pressure wound. (Resident #27)</p> <p>Findings include:</p> <p>During an interview on 09/09/14 at 3:43 P.M., LPN #10 indicated Resident #27 had a facility acquired pressure wound on</p>	F000314	<p>Preparation and/or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the facility of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p> <p>F314 – SSG Treatment/svcs to prevent/heal pressure sores</p> <p>It is the intent of this facility to ensure that a resident who enters the facility without pressure sores does not develop pressure sores.</p> <p>1. Actions Taken:</p>	10/03/2014

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	<p>the left heel.</p> <p>The clinical record of Resident #27 was reviewed on 09/15/14 at 9:13 A.M. The record indicated Resident #27 was admitted on 06/25/14 with diagnoses including, but not limited to, major depressive disorder.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 07/02/14, indicated Resident #27 experienced moderate cognitive impairment, no pressure wounds, and required the extensive assistance of two staff for bed mobility.</p> <p>The Physician's Admission Orders included, but was not limited to, an order for, "...skin check wkly (weekly)..."</p> <p>An Interim Care Plan dated 06/25/14 lacked any identified problem related to Resident #27 being at risk for skin impairment.</p> <p>A Care Plan dated 06/30/14 for, "potential for pressure ulcer development r/t (related to) immobility" included, but was not limited to, an intervention for "The resident requires Pressure relieving/reducing device on bed/chair..."</p> <p>A Care Plan dated 07/04/14 for "Skin integrity impaired r/t area to left heel"</p>		<p>A) Resident #27 is receiving Physical Therapy with controlled Electrical Stimulation and skilled nursing. His wound has improved and he is improving physically to the point that resident will be able to go home in 2 weeks or less.</p> <p>2. How other residents would have the potential to be affected:</p> <p>A) All residents would have the potential to be affected.</p> <p>B) 100% audit completed for risk of pressure sores and/or need for treatment changes. No treatment changes needed.</p> <p>3. Measures Taken:</p> <p>A) All nursing staff will be in-serviced on Policy & Procedure relating to skin issue identification and the reporting measures on all new admits, readmits and current residents.</p> <p>B) DON/Designee will review all new admission records in the following CQI meeting ongoing.</p> <p>C) DON/Designee will review weekly skin checks in CQI meeting.</p> <p>4. How Monitored:</p> <p>A) DON/Designee to discuss residents at risk in weekly SWAT meeting.</p> <p>B) DON/Designee to complete a weekly skin/wound round.</p> <p>C) Any inconsistent results will be immediately clarified and corrected appropriately and care plans updated if needed. Results would be monitored and reviewed at the monthly and quarterly QA Meetings for ongoing monitoring and/or</p>	

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	<p>identified interventions of, "Notify MD (Medical Doctor) and family of change in condition, observe for s/s/ (signs/symptoms) of increase in size of area, observe VS (vital signs) as indicated, treatment per order" The care plan lacked any interventions related to pressure relief to the left heel.</p> <p>The Admission Braden Scale Assessment dated 06/26/14 indicated Resident #27 was at risk for the development of pressure related skin impairment.</p> <p>The Admission Nursing Assessment dated 06/25/14 indicated Resident #27 experienced no skin impairment to the left heel.</p> <p>A Nursing note dated 07/04/14 at 2:54 P.M., indicated, "...Area noted to left heel..."</p> <p>A Nursing note dated 07/06/14 at 6:02 P.M., indicated, "...Wound on left heel is weeping an raw. Boot to foot..."</p> <p>A Nursing note dated 07/07/14 at 4:05 A.M. indicated, "...WOUND ON LEFT HEEL WEEPING AND RAW. PRESSURE RELIEF BOOT TO LEFT FOOT..."</p> <p>The Nursing notes from 07/04/14 through</p>		<p>changes.</p> <p>D) The criteria/threshold for QA committee will be audit – identify-rectify.</p> <p>E) All shifts will be included in the monitoring process.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is October 3, 2014.</p>	

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	<p>07/11/14 lacked any documentation related to the size and/or characteristics of the left heel wound.</p> <p>A Weekly Skin Sheet Dated 07/05/14 indicated Resident #27 experienced, "left heel opened blister that has peeled off. Area is red and raw..."</p> <p>A Weekly Skin Assessment dated 07/11/14 indicated Resident #27 experienced, "...Left heel...Stage IV...5.0 X 5.5 with black area 3 X 1.5...Pink 70%...Black/Eschar 30%...Worsening..." The Assessment further indicated, "...4. Stage IV-Full thickness tissue loss...Slough or eschar may be present on some parts of the wound bed..."</p> <p>A Physical Therapy Progress note dated 07/17/14 indicated, "...E-stim (Electrical stimulation) to LLE (left lower extremity) heel for wound healing...selective debridement for removal of necrotic tissue to promote wound healing.."</p> <p>During an interview on 09/09/14 at 2:15 P.M. the DON (Director of Nursing) indicated Resident #27 had developed the Stage IV wound after admission to the facility and no documentation could be provided to indicate services had been provided to relieve pressure to the left heel.</p>			

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F000353 SS=E	<p>The Policy and Procedure for Pressure Ulcer Assessment and Staging provided by RN #10 on 09/15/14 at 12:44 P.M., indicated, "...Stage IV Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures..."</p> <p>3.1-40(a)(1)</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>			

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	<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 adequate nursing staff for timely call light response on 3 of 3 nursing units, in that, lack of sufficient staff was verbalized during 3 of 3 family interviews (D, E, F) and 3 of 21 resident interviews (A, B, C) and documented in resident council meetings. (Unit 1, Unit 2, and Alzheimer's unit)</p> <p>Findings include:</p> <p>1. On 9/9/14 at 12:16 P.M., RN #5 was observed in the Alzheimer's unit dining room preparing meal trays for service for 3 residents who resided on the unit. Resident #36 and Resident #48 were observed, at that time, sitting at a dining room table in the dining room conversing with each other. On 9/9/14 at 12:17 P.M., RN #5 was observed to leave the dining room to answer a safety alarm. The Director of Nursing (DON) was observed to enter the dining room at 12:23 P.M. The dining room was observed to be unattended for 6 minutes.</p>	F000353	<p>Preparation and/or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the facility of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p> <p>F353 – SSE Sufficient 24-HR nursing staff per care plans</p> <p>It is the intent of this facility to 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>1. Actions Taken: A) It is the policy of this facility to provide the services needed to give the utmost functionality for our residents. The facility will continually recruit staff in an effort to have the appropriate personnel available to meet whatever resident</p>	10/03/2014

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	<p>2. During 3 of 3 confidential resident interviews on the 100 unit and 200 units, residents indicated they frequently had to wait extended periods of time for call lights to be answered. They indicated frequently their call lights were turned off and staff indicated they would return.</p> <p>Their comments included:</p> <p>During a confidential interview with Resident A, on the 100 unit, they indicated they required assistance of two people to use the restroom. They indicated they often experience call light wait times of 30 or more minutes around meal times and in the mornings.</p> <p>During a confidential interview and observation on 9/9/14 at 9:00 A.M., Resident B indicated the resident's roommate needed assistance and would sometimes have to wait a long time to go to bed or the bathroom. The resident pointed to the roommate (who was sitting in a wheelchair next to the bed with head hanging down and eyes closed). The resident said, "My roommate wants to go to bed, but has to wait until they finish bringing everyone back from the dining room then the CNA's will take people to the bathroom and put them to bed. Many times my roommate has to wait longer</p>		<p>needs are presented.</p> <p>2. How other residents would have the potential to be affected: A) All residents would have the potential to be affected.</p> <p>3. Measures Taken: A) A recruiting and retention committee comprised of QA/IDT will meet monthly to discuss new ideas or any concerns that need addressing. B) An increased pay scale has been implemented. This will be reviewed based on resident need thereafter. C) We have offered a \$400 sign-on bonus for all nursing staff. This will be reviewed based on resident need thereafter. D) We have implemented a staff referral bonus for referring nursing staff of \$400. E) We have begun to sponsor a CNA class's offsite. We will also be paying for each applicant's class and certification. Additional classes will be scheduled until the CNA staffing needs have been met. F) 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>4. How Monitored: A) Resident council will be attended by the administrator monthly, by invitation, to get feedback from the residents first</p>	

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	<p>that 15 minutes. They just need more help."</p> <p>During a confidential interview on 9/12/14 at 9:15 A.M., Resident C residing on the 200 hall indicated the facility was short on staff, especially when they were putting people to bed. The resident indicated that they would have to wait for CNA assistance because CNA's were putting residents to bed and the CNA's couldn't stop what they were doing. Since the resident had to wait for the CNA to complete the task at hand, the resident indicated one would often have to wait for quite awhile until the CNA's finished their task. The resident indicated the big problem was new staff members who answered the call light, shut it off and said they would return soon. The resident in the confidential interview said, "You just sit there and wait and wait and nobody knows." The resident in the confidential interview further indicated that other residents were informed to tell the CNA's to not turn the call light off if they couldn't help right then, because another CNA who came onto the floor would then answer it.</p> <p>3. During 3 of 3 family confidential family interviews on the 100 unit, family members indicated there were frequently not enough nursing staff to answer call</p>		<p>hand. This will also give leadership the opportunity to communicate the improvements that are currently being completed.</p> <p>B) 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.</p> <p>C) The Administrator will speak to at least one resident and/or their family per week, until there have been 4 weeks with zero negative staffing concerns.</p> <p>D) Any inconsistent results will be immediately clarified and corrected appropriately and care plans updated if needed. Results would be monitored and reviewed at the monthly and quarterly QA Meetings for determination of ongoing monitoring and/or changes.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is October 3, 2014.</p>	

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	<p>lights promptly.</p> <p>Their comments included:</p> <p>"Weekends staffing shorter." Family member D explained facility managers come in and serve meals on weekends. Also indicated facility managers come in on weekend days and help serve meals but not the same as regular nursing staff assisting with care.</p> <p>"CNAs busy only 2 working floor." Short of staff noted for over 6 months and generally occurred all the time. Family member E indicated had turned on call light and no staff answered for 20 minutes. When CNAs didn't answer family member called out CNA's name. CNA explained that staff had to get all residents out of the dining room before providing care on the halls. Family member indicated resident had needed changing (incontinent care).</p> <p>During a confidential family F interview on 9/10/14 at 8:44 A.M., the family indicated call light wait times were often 40 minutes. They further indicated when the staff did answer the call light they would tell them they would have to come back and they would not return for 30 minutes.</p>						

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	<p>4. Resident Council Minutes documentation for the past 7 months were received and reviewed on 9/11/14 at 3:42 P.M.</p> <p>Resident Council Minutes dated 3/6/14, indicated, "... Turning off Call Lights and Not Coming back to Answer Them..."</p> <p>Two residents had voiced.</p> <p>The Resident Council Minutes dated 7/2/14, indicated, "... No problems with Call Lights on Unit 1. Unit 2 Residents stated they have to Wait for longer Periods..."</p> <p>On 9/15/14 at 9:00 A.M., the Activity Director who documented the Resident Council Minutes indicated there was a problem with staff turning off call lights and not coming back to answer them in March 2014. The Activity director also indicated there was a problem with residents waiting longer periods for call lights to be answered in July 2014.</p> <p>On 9/15/14 at 3:00 P.M., the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were interviewed regarding facility nursing schedule and staffing. The DON indicated at that time all staff including department heads had been inserviced on answering call lights in regard to not turning off call lights until providing the</p>			

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F000431 SS=D	<p>nursing service needed.</p> <p>3.1-17(a)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p>			

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	<p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure expired medications were discarded for 1 of 3 medication rooms reviewed. (Resident # 47)</p> <p>Findings include:</p> <p>On 9/15/14 at 11:38 A.M., the 200 hall medication room was toured with the Director of Nursing (DON). Two 100 cc Intravenous (IV) tobramycin (antibiotic) solution bags were observed in the medication refrigerator.</p> <p>The label of one 100 cc IV solution indicated medication for Resident #47, tobramycin (an antibiotic) 480 mg/100 ml (normal saline) had a discard date of 9/11/14. The other tobramycin IV</p>	F000431	<p>Preparation and/or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the facility of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p> <p>F431 – SSD Drug records, label/store drugs & biological</p> <p>It is the intent of this facility to ensure that expired medications are discarded.</p> <p>1. Actions Taken: A) Out dated product identified was discarded immediately after it was identified.</p>	10/03/2014

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	<p>solution 400 mg/100 ml was for Resident #47 also and had a discard date of 7/26/14.</p> <p>The DON at that time indicated she would destroy the antibiotic solutions due to expired discard dates.</p> <p>The Director of Nursing (DON) on 9/15/14 at 12:00 P.M., provided a copy of a physician's telephone order for Resident #47 dated 9/10/14 that indicated, "...D/C (discontinue) tobramycin..." Another physician order was dated 7/23/14, indicated, "...tobramycin 400 mg IVPB (Intravenously piggy back) x i (one time only)."</p> <p>A facility policy entitled "7.3: Discontinued Medications" (updated 2/6/14), indicated but was not limited to, "All non-scheduled medications discontinued by the physician will be returned to the (name of pharmacy) for credit or will be destroyed in accordance with local, state, and federal regulations..."</p> <p>3.1-25(o) 3.1-25(r)</p>		<p>2. How other residents have the potential to be affected: A) All residents have the potential to be affected.</p> <p>3. Measures Taken: A) A 100% audit was completed to identify and discard expired medications.</p> <p>4. How Monitored. A) DON/Consulting Pharmacist/Designee will audit three times a week for four weeks, than as needed thereafter. B) Any inconsistent results will be immediately clarified and corrected appropriately and care plans updated if needed. Results would be monitored and reviewed at the monthly and quarterly QA Meetings on-going monitoring and/or changes. C) The criteria will be to audit – identify – rectify. D) All shifts will be involved in the monitoring process.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is October 3, 2014.</p>	

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p>			

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	<p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper hand washing and/or glove use was performed, in that, proper hand washing and/or glove use were not performed during 1 of 2 observations of Stage IV wound dressing changes. (Resident #62)</p> <p>Findings include:</p> <p>During an observation of care on 09/11/14 at 11:15 A.M., RN #4 was observed to apply gloves and indicated during an interview, at that time, she was preparing to change the dressing of a Stage 4 coccyx wound for Resident #62. RN #4 was then observed to, remove the dressing and cleanse the wound with gloved hands. RN #4 was observed, at that time, to not remove the gloves or perform hand washing and/or hand hygiene. RN #4 was then observed to place packing inside the wound using a cotton applicator and her fingers.</p> <p>The Policy and Procedure for Standard Precautions provided on 09/15/14 at 2:45 P.M. indicated, "Wash hands after touching...body fluids, secretions,</p>	F000441	<p>Preparation and/or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the facility of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. F441 – SSD Infection control, prevent spread, linens. It is the intent of this facility to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>1. Actions Taken: A) Resident #62 was assessed and monitored with no negative outcomes.</p> <p>2. How other residents have the potential to be affected: A) All residents have the potential to be affected.</p> <p>3. Measures Taken: A) All nursing staff will be in-serviced on proper hand washing and glove use.</p> <p>4. How Monitored: A) Don/Designee will monitor</p>	10/03/2014

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F000465 SS=E	<p>excretions, and contaminated items...Wash hands between tasks and procedures on the same patient..."</p> <p>3.1-18(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. A. Based on observation, interview and record review, the facility failed to ensure</p>	F000465	<p>and/or audit staff for proper infection control measures.</p> <p>B) Prior to next dressing change DON/Designee will observe, with one-to-one demonstration, dressing changes.</p> <p>C) DON/Designee will train all new hires relating to infection control and proper dressing change procedures.</p> <p>D) Monitoring by DON/Designee will be completed three times a week for four weeks, then as needed thereafter.</p> <p>E) Any inconsistent results will be immediately clarified and corrected appropriately and care plans updated if needed. Results would be monitored and reviewed at the monthly and quarterly QA meeting for ongoing monitoring and/or changes.</p> <p>F) All shifts are involved in the monitoring process.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is October 3, 2104.</p> <p>Preparation and/or execution of the</p>	10/03/2014	

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	<p>the kitchen floors, dining room floors and resident room floors were maintained in a sanitary manner, and that plaster was not repaired after a leaking roof in resident room, in that, debris was observed around tables and floor in kitchen on 3 of 3 kitchen observations and a dark gritty line of debris surrounded the perimeter of the dining room, resident rooms and bathrooms during 3 of 3 observations. (Room #102,103, 104, 105, 112, 113, 115, Resident #70)</p> <p>B. Based on observation, interview and record review the facility failed to ensure Residents whose rooms were located next to or close in proximity to a door leading outside to the inner court yard were protected from exposure to the odor of cigarette smoke. (Resident #69)</p> <p>Findings Include:</p> <p>A .1. The kitchen floors were observed on 9/9/14 at 9:15 A.M., 9/12/14 at 11:50 A.M., During both observations the floor was covered with loose food around food prep areas and a sticky layer of debris, was observed around table legs and equipment legs in the entire kitchen including.</p> <p>On 9/15/14 at 9:30 A.M., the dietary manager was made aware of the concerns</p>		<p>plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the facility of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p> <p>F465 – SSE Safe/functional/sanitary/comfortabl e environment</p> <p>It is the intent of this facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>1. Actions Taken:</p> <p>A) The Housekeeping Director and her staff deep cleaned all areas of concern as well as other areas.</p> <p>B) The Plant Operations Director repaired walls, ceiling, and discolored tile in kitchen.</p> <p>C) Smoking area was moved to avoid any possible smell or other issues related to residents smoking.</p> <p>2. How other residents have the potential to be affected:</p> <p>A) All residents would have the potential to be affected.</p> <p>3. Measures Taken:</p> <p>A) 100% audit of all resident rooms was completed to identify and rectify any issues.</p> <p>4. How Monitored:</p> <p>A) Monthly wall/ceiling checks were placed on Plant Operations Director Preventative Maintenance program.</p>	

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	<p>she indicated, kitchen staff swept and mopped the floors every night. She further indicated they did not have a specific policy on scarping floors but that it would be done as needed and indicated extra cleaning would just be added on bottom of the cleaning schedule documentation after it was completed.</p> <p>A. 2. The main dining room was observed on 9/9/15 at 12:30 P.M., 9/12/14 at 12:15 P.M., and 9/15/14 at 9:40 A.M., The entire perimeter of the dining room had dark, gritty debris. In the back right corner of the room was a pile of loose debris containing hair, debris, a fly and a white button.</p> <p>9/15/14 at 10:55 A.M., the Dietary Manager provided a document titled "DAILY CLEANING SCHEDULE" for September 2014 the document included "PM (evening) SPRAYER" "MOP ANS SWEEP FLOORS" staff initials were present in all boxed from September 1st through the 15th. The documentation lacked any written comments about scraping debris from kitchen floors. She also provided a log titled "Kitchen Floors" indicating on 8/15/15 "BUFFED FRONT/REAR" no signature.</p> <p>Observations for 100 unit rooms:</p>		<p>B) Resident and common area floors was placed on all housekeepers daily check-off sheets.</p> <p>C) Kitchen floor was placed on check-off list for Dietary Manager/Designee to complete and monitor for compliance.</p> <p>D) Administrator/Designee will complete audits three times a week for four weeks, than as needed thereafter.</p> <p>E) Any inconsistent results will be immediately clarified and corrected appropriately and care plans updated if needed. Results would be monitored and reviewed at the monthly and quarterly QA Meetings for ongoing monitoring and/or changes.</p> <p>F) All shifts will be included in the monitoring process.</p> <p>5) This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is October 3, 2014.</p>	

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	<p>A. 3. On 9/9/14 at 10:45 A.M., and on 9/15/14 at 10:40 A. M, on the 100 unit, the bathroom of Resident room 115 had rusted areas on the metal handles on the commode. The handles of the commode were loosely attached. The wall paint was marred on the wall area behind the head of the bed.</p> <p>On 9/9/14 at 4:21 P.M., and 9/15/14 at 10:45 A.M., in room 113, the seams of the vinyl bathroom floor tile around the base of the commode had brown soiling and were stained.</p> <p>During observations on 9/9/14 at 11:15 A.M., 9/12/14 at 10:00 A.M. and 9/15/14 at 9:30 A.M. the floors in rooms #102 were observed to have a layer of dark, gritty, debris present in the perimeter of the room and behind the door.</p> <p>During observations on 9/9/14 at 11:20 A.M., 9/12/14 at 10:06 A.M. and 9/15/14 at 9:34 A.M. the floors in rooms #103 were observed to have a layer of dark, gritty, debris present in the perimeter of the room and behind the door.</p> <p>During observations on 9/9/14 at 11:25 A.M., 9/12/14 at 10:15 A.M. and 9/15/14 at 9:22 A.M. the floors in rooms</p>			

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	<p>#104 were observed to have a layer of dark, gritty, debris present in the perimeter of the room and behind the door.</p> <p>During observations on 9/9/14 at 11:35 A. M., 9/12/14 at 10:20 A.M. and 9/15/14 at 9:13 A.M. the floors in rooms #105 were observed to have a layer of dark, gritty, debris present in the perimeter of the room and behind the door.</p> <p>During observations on 9/9/14 at 11:40 A.M., 9/12/14 at 10:00 A.M. and 9/15/14 at 9:30 A.M. the floors in rooms #112 were observed to have a layer of dark, gritty, debris present in the perimeter of the room and behind the door.112</p> <p>The main dining room was observed on 9/9/15 at 12:30 P.M., 9/12/14 at 12:15 P.M., and 9/15/14 at 9:40 A.M., The entire perimeter of the dining room had dark, gritty debris. In the back right corner of the room was a pile of loose debris containing hair, debris, a fly and a white button.</p> <p>A walk through was conducted on 9/15/14 at 10:10 A.M., He was made aware of the floor conditions in rooms 102,103, 104, 105, 112, 113 and 115. He</p>			

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	<p>was also shown the dining room floors and the debris in the back right corner still containing a button and dead fly. He indicated he would have housekeeping address the concerns.</p> <p>During an interview with the Housekeeping supervisor on 9/15/14 at 10:23 A.M., she indicated that housekeepers used a daily checklist that was supposed to be completed on every room. She further indicated it had in-services staff about cleaning the parameter of the room in the past. She indicated they used a cleaning list, but did not know if there was a specific policy regarding the cleaning of floors.</p> <p>The Housekeeping supervisor provided an undated document titled "Daily Unit Clean Sheet" on 9/15/14 at 10:23 A.M., it included "11. Check/Clean perimeter of bathroom/bedroom floor.</p> <p>A. 4. During an interview and observation on 9/9/14 at 9:00 A.M., Resident #70 indicated she was in her room about a month ago eating an orange when she felt something drop on her head. Resident #70 then indicated she felt something drop on her head again. Resident #70 said, " There was a leak in</p>			

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	<p>the roof and the rain had come through the plaster on my ceiling. They fixed the roof, but they need to fix the plaster above my bed." Resident #70 pointed to the area on the ceiling. Located above the head of the bed was an 8 inch diameter area of peeling paint and plaster.</p> <p>B. The clinical record of Resident #69 was reviewed on 9/12/14 at 9:53 A.M. Resident #69 was admitted on 9/11/12. The diagnoses of Resident #69 included, but were not limited to, breast cancer, bone cancer, fatigue and hypertension.</p> <p>The Admission MDS (Minimum Data Set) assessment, dated 08/6/14, documented Resident #69 experienced no cognitive impairment.</p> <p>A smoke Risk Assessment, completed on 8/6/14 documented; Resident #69 was a non-smoker.</p> <p>During an interview on 9/12/14 at 9:34 A.M., Resident #69 said, "I smell smoke lots of times. They smoke right under that sheltered area next to the door. I just shut my door to keep it out." Resident #69 further indicated that her daughter sometimes comes in to visit and would say, "I've just got to go. I can't stand that smell, it makes me sick." Resident #69 indicated residents can go out and smoke</p>			

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	<p>after each meal.</p> <p>During a confidential interview on 09/10/2014 at 08:49 A.M., a resident's family member indicated that residents often sat immediately outside the door and smoked cigarettes whenever the weather was cold or rainy. The resident's family member indicated that, at such times, the smell of cigarette smoke entered the building whenever the door was opened, traversed throughout the hallways, and entered the residents' rooms. The resident's family member indicated that the staff would use an aerosol air freshener whenever they complained about the cigarette odor issue.</p> <p>During an observation on 9/12/14 at 8:35 A.M., 2 residents were observed sitting in their wheelchairs on the porch under the awning where they were smoking cigarettes. One resident's wheelchair was within 5 feet of the door entrance. The residents were accompanied by one staff member.</p> <p>Durning an interview on 9/12/14 at 8:37 A.M. on the 100 hall, near Resident #69's door, LPN# 16 indicated she smelled cigarette smoke. LPN #16 further indicated that whenever the door to the courtyard was opened the cigarette smoke</p>			

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F000514 SS=D	<p>entered the building.</p> <p>During an interview and observation on 9/12/14 1:34 P.M., the Heath Care Administrator (HCA) indicated he had smelled cigarette smoke in the hall in the past and that he would look into relocating the smoking area away from the court yard door.</p> <p>3.1-19(f)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview, and record review. The facility failed to ensure, the clinical record for a resident</p>	F000514	Preparation and/or execution of the plan of correction in general, or this corrective action in particular does	10/03/2014

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	<p>was complete, in that, Physicians order recaps for a resident were not signed in a timely manner for 1 of 1 resident reviewed for clinical records. (Resident #29)</p> <p>Findings Include:</p> <p>The Clinical Record for Resident #29 was reviewed on 9/12/14 at 10:00 A.M., The current signed rewrites (physician order recap) were unavailable. The most recent signed rewrites were for June 1, 2014 and signed August 22, 2014.</p> <p>During an interview on 9/12/14 at 10:20 A.M., The Medical Records Supervisor indicated the most current signed rewrites available for Resident #29 were dated 6/1/14 - 6/30/14 and were not signed until August 22,2014 (83 days after orders started). She indicated rewrites (physicians order recaps) were to be signed every 60 days by the physician during their required visits with residents.</p> <p>On 9/15/14 at 9:00 A.M., The DON (Director of Nursing) provided a current rewrite for September 2014 dated September 12, 2014. 3.1-50(a)</p>		<p>not constitute an admission agreement by the facility of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. F514 – SSD Records-complete/accurate/accessible It is the intent of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete.</p> <p>1. Actions Taken: A) Resident #29 was assessed to ensure no negative outcomes. 2. How other residents have the potential to be affected: A) All residents would have the potential to be affected. 3. Measures Taken: A) A 100% audit was completed on all residents to ensure that all rewrites were signed and completed in a timely manner. 4. How Monitored: A) Medical Records Director/DON/Designee will audit rewrites and results will be discussed in the daily CQI meeting and monthly QA meeting for accurate documentation. B) Any inconsistent results will be immediately clarified and corrected appropriately and care plans updated if needed. Results would be monitored and reviewed at the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155217	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/15/2014
NAME OF PROVIDER OR SUPPLIER WATERS OF HUNTINGBURG THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542		
(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>monthly and quarterly QA Meetings ongoing monitoring and/or changes.</p> <p>C) All shifts will be included in the monitoring process.</p> <p>5. This plan of correction constitutes our allegation of compliance with all regulatory requirements. Our date of compliance is October 3, 2014.</p> <p>Preparation and/or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the facility of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p>		