STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155217		08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF HUNTINGBURG, THE	1712 LELAND DR HUNTINGBURG, IN 47542

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00175692 and Complaint IN00176009 . This visit resulted in a partially extended survey - Immediate Jeopardy. Complaint IN00175692- Unsubstantiated, due to lack of evidence. Complaint IN00176009 - Substantiated, Federal/State deficiency related to the allegation is cited at F353. Unrelated deficiency cited. Survey dates: August 6, 2015 Extended survey dates: August 7, 8, 9, and 10, 2015 Facility number: 000122 Provider number: 155217 AIM number: 100290560 Census bed type: SNF/NF: 69 Total: 69 Census payor type: Medicare: 8	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Medicaid: 39 Other: 22 Total: 69 Sample: 4 Extended sample: 21 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.			
F 0155 SS=K Bldg. 00	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement			

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	advance directives and applicable State law. Based on interview and record review, the facility failed to have a system in place to determine code status and failed to perform Cardiopulmonary Resuscitation (CPR) on a resident who was a full code (Resident E). The facility also failed to ensure advanced directive/code status was clearly and consistently documented for 4 of 6 residents reviewed with advance directives, in a sample of 6. (Resident E, C, B, and F) This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy began on 4/5/15 when the nursing staff failed to provide CPR for a resident who had requested to be a full code. The Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy at 5:45 P.M. on 8/6/15. The Immediate Jeopardy was removed on 8/10/15, but noncompliance remained at the lower level scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: 1. The closed clinical record of Resident	F 0155	F-155 Resident E is deceased. Residents C, B and F and all other residents who reside in the facility have had their CPR/Advanced Directives Code Status desires clearly documented in their clinical record as dictated by the facility's policy as well as the state and federal guidelines/regulations. All residents who reside in the facility have the potential to be affected by the CPR/Advanced Directive Code Status process. A 100% audit of all medical records for all residents was conducted to ensure that their desired CPR/Advanced Directives Code Status was accurate, clearly defined, ordered by their physician, documented, care planned and easily accessible in their medical record. Going forward, as part of the admissions process the resident's CPR/Advanced Directives Code Status will be reviewed, discussed and documented appropriately. Each new admission will be added to the CPR/Advanced Directive Code Status audit tool which will be ongoing and part of the daily CQI meeting agenda. This will ensure that all new admissions or readmissions are addressed as related to their CPR/Advanced Directives Code Status wishes. Additionally, as part of the Medical	08/31/2015

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	E was reviewed on 8/6/15 at 11:30 A.M. Diagnoses included, but were not limited to, end stage renal disease and chronic respiratory failure. "Indiana Physician Orders for Scope of Treatment (POST)," dated 10/13/14, indicated, "A. Cardiopulmonary Resuscitation (CPR): Patient has no pulse AND is not breathing. Attempt Resuscitation/CPR. B. Medical Interventions: If patient has pulse AND is breathing OR has pulse and is NOT breathing. Full Intervention:...use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs...." A Physician's order, initial date unknown and on the April 2015 recertification orders, indicated, "Advanced Directives, Full Code." A Care Plan, undated, indicated, "Code Status: full...Interventions: Wishes will be honored." Nursing Progress Notes, dated 4/5/15 at 7:36 A.M., indicated, "Blood sugar at 4:45 am 130. Resident refused insulin coverage, as she frequently does. Upon entering room at 6:50 am to get resident		Records audit for new admissions and readmissions, the CPR/Advanced Directives Code Status documentation will be reviewed. Any concerns will be addressed daily in the CQI meetings until resolution. Again, the practice will be ongoing. As the care plans are reviewed as well as after a significant change of condition, the CPR/Advanced Directives Code Status will be reviewed by the appropriate legal parties to validate that the CPR/Advanced Directives Code Status is to either remain the same or be amended. Any changes will be documented as dictated by policy. NOTE: Nursing staff (nurses) who are not CPR certified will be trained in CPR to ensure that there is an employee certified in CPR on duty at all times. An inservice for nursing staff, Social Services, Admissions Staff, and Medical Records was/will be held and completed no later than 8-31-15. The following was covered in the inservice: A. CPR/Advanced Directives Code Status Policy B. When to initiate CPR/Advanced Directives C. CPR/Advanced Directives Code Status-Dr. Orders D.	

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	up for breakfast, CNAs found resident deceased. Resp [respirations] ceased, no heartbeat, skin cold and mottled. CPR not initiated, deemed ineffective. Husband, Dr., ED [Executive Director], and DON [Director of Nursing] notified." On 8/6/15 at 4:00 P.M., during an interview with RN # 1, she indicated she was working on the morning of 4/5/15. She indicated it was "right at change of shift" when a CNA went in the room to get the resident up for breakfast. RN # 1 indicated the CNA, "came and got me, and when I went into the room [Resident E] was cold, stiff, and mottled half way up." RN # 1 indicated she thought, "This just didn't happen. CPR is not going to bring this woman back." RN # 1 indicated she was so shocked, and had thought about calling the ambulance, but she thought "the EMTs would just tell me to call the coroner." RN # 1 indicated the resident had no pulse, no respirations, and no blood pressure. On 8/6/15 at 4:20 P.M., during an interview with the DON, she indicated she did find notes that she had written regarding the incident. The DON indicated she had inserviced RN # 1, and told her, "You can't do that." The DON indicated she inserviced her that if a resident is a full code, she needed to		CPR/Advanced Directives Code Status-Care Planned E. Where in the medical record CPR/Advanced Directives can be easily located behind the advance Directive (tab) Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. At the monthly Quality Assurance meetings the results of the ongoing CPR/Advanced Directives Code Status monitoring tool for new admissions and readmissions will be reviewed. Additionally, at these meetings the ongoing Medical Records monitoring tool for new admissions and readmissions will be reviewed. Any patterns will be identified and an Action Plan will be written by the committee if needed. This plan will be monitored weekly by the Administrator until resolution. NOTE: Concerns will be addressed and corrected as found on the audit tools.	

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	perform CPR. The DON indicated that since that incident, if staff called her regarding a resident, she always asked, "What's their code status?" On 8/7/15 at 1:50 P.M., during an interview with CNA # 2, she indicated she was working on the morning of 4/5/15. She indicated she and CNA # 1 had just started getting residents up, when CNA # 1 went into Resident E's room. She indicated CNA # 1 came out of the room and told CNA # 2, "I think [Resident E] has passed away." CNA # 2 indicated she went into the room and found the resident was not breathing. CNA # 2 indicated they then both went and informed RN # 1. 2. On 8/6/15 at 10:30 A.M., the Assistant Director of Nursing (ADON) provided a CNA assignment sheet. The assignment sheet indicated Resident C was a "Full Code." The clinical record of Resident C was reviewed on 8/6/15 at 1:55 P.M. Diagnoses included, but were not limited to, dementia with Lewy Bodies. An "Indiana Physician Orders For Scope of Treatment," dated 6/8/15, indicated, "A. Cardiopulmonary Resuscitation (CPR): Patient has no pulse AND is not			

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	breathing. Attempt Resuscitation/CPR...." A "Resident Information Sheet, " dated 6/11/15, included: "Code Status, FULL." There was no sticker on the face sheet which indicated the resident's code status. A Social Service Note, dated 6/16/15 at 8:51 A.M., indicated, "...Resident is DNR [Do Not Resuscitate]...." A Care Plan, dated 6/16/15, indicated, "The resident's code status is DNR...Interventions, Respect resident and family choices, Review code status at care plan meetings." A Social Service Note, dated 6/19/15 at 5:09 P.M., indicated, "...Resident is FULL code - reviewed with no changes...." The current Physician orders, dated August 2015, indicated, "Advanced Directives" and was left blank. On 8/6/15 at 3:15 P.M., during an interview with RN # 2, she indicated that if she found a resident without a pulse, and was not breathing, she would check the resident's chart for the code status. She indicated she would first look for the sticker on the face sheet, which indicated			

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	if the resident was a "DNR" or "Full Code." She indicated if the sticker was not there, she would either check the Advanced Directive, or "POST," sheet or would check the Physician orders. On 8/6/15 at 3:35 P.M., during an interview with LPN # 1, she indicated that if she found a resident without a pulse or respirations, she would check the resident's chart for the code status. She indicated she would check the sticker on the face sheet, or check the Physician's orders. 3. On 8/6/15 at 10:30 A.M., the Assistant Director of Nursing (ADON) provided a CNA assignment sheet. The assignment sheet indicated Resident B's code status was "DNR." The clinical record of Resident B was reviewed on 8/6/15 at 3:10 P.M. Diagnoses included, but were not limited to, dementia. A Resident Information Document, or face sheet, dated 3/12/15, indicated, "Code Status, DNR." A sticker was on the sheet which indicated, "Code Status, DNR." An "Indiana Physician Orders for Scope of Treatment," dated 12/19/2014,			

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	indicated, "Do Not Attempt Resuscitation (DNR)." The form was not signed by the physician. Current Physician orders did not include an order for the DNR status. 4. On 8/6/15 at 10:30 A.M., the Assistant Director of Nursing (ADON) provided a CNA assignment sheet. The assignment sheet indicated Resident F's code status was "Full Code." The clinical record of Resident F was reviewed on 8/7/15 at 9:30 A.M. Diagnoses included, but were not limited to, dementia. An "Admission Record" face sheet, dated 12/16/13, indicated, "Advanced Directives" and was left blank. A sticker on the document indicated, "Code Status DNR." An "Indiana Physician Orders for Scope of Treatment," dated 3/17/15, indicated, "Do Not Attempt Resuscitation...." A computerized "Profile" indicated Resident F was a "Full Code." On 8/7/15 at 10:20 A.M., the DON indicated the facility was auditing the clinical records regarding consistent CPR			

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	status, but had not yet audited the CNA assignment sheets or the Profiles/Face sheets. 5. On 8/6/15 at 4:20 P.M., during an interview with the DON, she indicated when a resident chooses his code status, a sticker regarding that information is placed on the resident's face sheet, the POST paper regarding the Advance Directive is completed, and a physician's order is obtained. On 8/6/15 at 5:15 P.M., the DON provided the current facility policy on "Cardio-Pulmonary Resuscitation," dated 7/11. The policy included: "It is the intent if the facility to ensure that all residents suffering a cardiac or respiratory arrest will receive the treatment of CPR unless the resident has a Do Not Resuscitate Order. Defined: Basic CPR is defined as artificial respiration accompanied by external cardiac compressions. Responsibility:...1. CPR will be performed by licensed nursing or staff trained in CPR. 2. Residents who request FULL CODE STATUS will receive CPR if they arrest... Procedure: 1. Check chart for code status. 2. Assess resident to determine respirations have ceased, palpate or auscultate for absence of			

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	pulse/heartbeat...4. If the resident has a cessation of heartbeat or cessation of respiration and if the resident wished to be resuscitated delegate a person to page for assistance, call 911...." On 8/7/15 at 10:20 A.M., during an interview with the DON, she indicated she was unable to locate a facility policy regarding Advanced Directives, but that the facility was going to "do away with the stickers on the face sheets, " and utilize purple DNR Post Sheets if the resident requested DNR status. At that time, the DON provided a list of staff who were CPR certified. The list indicated 12 staff members were CPR certified, and 10 staff members who did not have proof of CPR certification. RN # 1 was documented as not having proof of CPR documentation. The DON indicated at that time that she had scheduled a CPR certification class for the next week. The immediate jeopardy that began on 4/5/15 was removed on 8/10/15 when the facility began inservicing staff on performing CPR and how to determine a resident's code status, and auditing clinical records, but the noncompliance remained at the lower scope and severity level of pattern, no actual harm with			

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	potential for more than minimal harm that is not immediate jeopardy, because not all of the employees had been inserviced . 3.1-4(f)(5)			
F 0353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER			

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Bldg. 00	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. 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: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. 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.			
	Based on observation, interview, and record review, the facility failed to ensure staffing was sufficient on the locked Alzheimer's Unit to provide ADL (activities of daily living) care, activities, and personal hygiene, for 15 of 15 residents residing on the Alzheimer's Unit, for 1 of 3 units reviewed. Findings include: On 8/6/15 at 10:15 A.M., during the initial tour, the Assistant Director of Nursing (ADON) indicated there were 15	F 0353	F-353 Residents who reside on the Alzheimer's Unit receive all necessary care as related to activities of daily living as well as any needed personal hygiene. Residents who reside on the Alzheimer's Unit have the potential to be affected by this finding. Residents on the Alzheimer's Unit have had their personal care needs reassessed. Their care plans have been reviewed and updated to reflect their needs and how these	08/31/2015

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	residents who resided on the locked Alzheimer's Unit. The ADON indicated the Social Services Director (SSD) was also the Alzheimer Unit Director. Six (6) residents were observed sitting in the lounge area with an activity aide. Two (2) of the residents were observed to have their eyes closed. Other residents were observed sitting in their rooms. Activity aide # 1 indicated she worked on the Alzheimer's Unit at times, and also throughout the rest of the facility. On 8/6/15 at 12:05 P.M., residents were observed to be eating in the dining room. CNA # 3 indicated CNA # 4 had come in that day at 11:00 A.M. CNA # 1 and CNA # 2 were observed feeding residents. CNA # 1 indicated all residents except 1 were in the dining room. Resident C was observed sitting in the dining room, with his hair uncombed, and he was unshaven. On 8/6/15 at 2:55 P.M.-3:35 P.M., during observation of the Alzheimer's Unit, 1 resident was up in the lounge area. Other residents were sitting or lying in their rooms. On 8/7/15 at 9:00 A.M., the Director of Nursing provided the previous 1 week schedule. The Alzheimer's Unit schedule indicated 1 nurse and 1 CNA worked on		needs will be met. Since the survey there has been the addition of a full time staff member on the Alzheimer's Unit who will function in the capacity of engaging the residents in appropriate, beneficial activities as well as assisting with any care needs. Organized programming will be conducted on the unit daily. The DON/Designee or SSD (Social Service Designee) will tour the Alzheimer's Unit 3 days weekly on various shifts to monitor and ensure that ADLs. Including personal hygiene needs are being met for the residents. Additionally, the Activity Programs and resident participation will be assessed. Any concerns will be immediately addressed and corrected as discovered. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, the monitoring will continue at least weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur. An inservice will be held/completed for all appropriate staff who work on the Alzheimer's Unit the following was covered: A. Criteria for admission to the Alzheimer's Unit B. ADLs-Personal Hygiene- Best Approaches C. Activities-How To Best Encourage Participation	

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	the day and evening shifts. One (1) QMA and 1 CNA worked on the night shift. On 8/10/15 at 10:20 A.M., the current CNA assignment sheets were provided by the Director of Nursing (DON). The sheets indicated 15 residents resided on the Alzheimer's Unit: Five (5) residents required 1 assist with transfers, 1 required 2 assist, and 4 residents required a hoyer or alpine (mechanical) lifts. Three (3) residents needed assistance with feeding. Regarding toileting, 10 residents were documented as requiring "T-time," 1 resident toileted himself, and 2 residents required "pull-ups." "T-Time Guidelines" indicated: "1. can not turn self. 2. restraint 3. alarm 4. pressure sore/area 5. Toileting program 6. incont. [incontinent] epis. [episodes] +/or receives incont. care." On 8/10/15 at 1:50 P.M., during an interview with the SSD, she indicated she was the Alzheimer's Director, and also the SSD for the entire facility. She indicated that the facility would like to make the staffing assignments more consistent, and would like to have an activity assistant back on the unit at all times. She indicated that there was no "daily programming" for the residents on		D. Quality of Life-Some things to say and/or do to enhance the lives of residents on the unit E. Q & A Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. At the monthly Quality Assurance meetings the results of the ADL, personal hygiene and Activity Program monitoring will be reviewed. Any patterns will be identified and if necessary, an Action Plan will be written by the committee to address the concerns. The plan will be reviewed by the Administrator until resolved. Note: Any concerns noted during the monitoring will have been addressed and corrected as discovered.	

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 08/10/2015
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	the Alzheimer's Unit, but that there were activities planned. She indicated the residents on the Alzheimer's Unit required a lot of care at that time. She indicated she was not responsible for staffing the Unit, but that the DON and scheduling coordinator scheduled the number of staff. The SSD indicated the Activities Director was responsible for the activity program on the Alzheimer's Unit. On 8/10/15 at 2:50 P.M., during an interview with the DON, she indicated she and the schedule coordinator scheduled staff for the Alzheimer's Unit. She indicated she had just increased staff this week to have 2 CNAs, due to the acuity of the residents. She indicated several of the residents required the assistance of 2 staff, and 2 of the newer residents exhibited behaviors. The DON indicated the facility had tried to increase the Activity program on the unit, but that it did not involve any daily programming. The DON indicated there were at least 2 residents who needed to be transferred off of the unit, due to the level of care. During a confidential family interview #1, he/she indicated their family member was frequently found without the teeth brushed or the hair combed. The family member indicated, "There's no activities			

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	here. Everyone sleeps." The family member indicated he/she had found the resident dirty and smelling of BM. During a confidential family interview #2, he/she indicated, "I just feel like they are understaffed." He/She indicated there were times when there were no staff to be found. He/She indicated, "Hygiene-wise could be better." On 8/10/15 at 11:30 A.M., the SSD provided the current "Admission/Discharge Criteria" for the Alzheimer's Unit, undated. The document included: "Admission guidelines to Hope Springs (Alzheimer's Unit) include: a) Diagnosis of Alzheimer's disease and/or a type of dementia diagnosis. b) The resident is in need of a structured, routine environment. c) The resident is in need of specialized dementia programming...f) Wheelchair residents will be allowed as long as resident meets the criteria above. g) Geri-chairs and total assist resident [sic] will not be permitted on Hope Springs. 3) Social Services and the nursing staff will continue to observe all residents for Appropriate placement on Hope Springs. This will foster further assessment opportunities to ensure placement is appropriate and continue to protect the controlled environment of the unit...Discharge Critereria...When a			

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	resident's physical/cognitive condition has so declined from activity focused programming, does not need a secured unit, the interdisciplinary team will evaluate to determine if other placement is appropriate...Geri-chairs and residents that require maximum assist with ADL's will be transferred to another unit in facility." This Federal tag relates to Complaint IN00176009. 3.1-17(a)			

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