

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  08/07/2012
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NAME OF PROVIDER OR SUPPLIER  WATERS OF SCOTTSBURG II LLC THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
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F0000	<p>This visit was for Investigation of Complaint IN00113000.</p> <p>Complaint IN00113000 - Substantiated. Federal/state deficiencies related to the allegations are cited at F250 and F279.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: 8/2 and 8/7/12</p> <p>Facility number: 000478 Provider number: 155494 AIM number: 100290430</p> <p>Survey team: Jennie Bartelt, RN</p> <p>Census bed type: SNF/NF: 66 Total: 66</p> <p>Census payor type: Medicare: 3 Medicaid: 58 Other: 5 Total: 66</p> <p>Sample: 17</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p><b>Preparation and or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and Federal laws.</b></p>	

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

TITLE

(X6) DATE

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

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	Quality review 8/13/12 by Suzanne Williams, RN			

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician and family were notified timely of a fall. The deficient practice affected 1 of 2 residents reviewed related to falls in a sample of 17</p>	F0157	<b>F 157 Notification of Changes</b> (Injury/Decline/Room, etc)	08/29/2012			

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	<p>residents. (Resident D)</p> <p>Findings include:</p> <p>During confidential interview on 8/2/12, a family member of Resident D indicated the family had not been notified at the time Resident D fell on 7/28/12. The family member indicated learning of the fall from another resident who resided on Resident D's unit.</p> <p>The clinical record for Resident D was reviewed on 8/2/12 at 4:15 p.m.</p> <p>Nurses Notes, dated 7/28/12 at 9:10 p.m., indicated, "Found Resident laying [sic] on back in dining room floor next to table...." Notes indicated the resident was assessed, including vital signs, pain, and range of motion, ambulated to bed, and again assessed. The note was signed by RN #5. Documentation failed to indicate the physician and family were notified of the fall.</p> <p>The next Nurse's Note dated 7/29/12 at 5:00 a.m. was signed by RN #5 and failed to indicate family and physician were notified.</p> <p>The next Nurse's Note (on the reverse side of the Nurse's Notes for 7/28 and 7/29/12) was 7/24/12 (sic) at 12:30 p.m., and</p>		<p>It is the intent of this facility to provide timely notification of all accidents/incidents to the physician and family.</p> <p>1. Actions Taken:</p> <p>a. The family and physician of Resident D were notified of the fall.</p> <p>2. Others Identified:</p> <p>a. 100% audit of all residents records that have fallen since July 1 has been audited to validate appropriate family and MD notification was completed.</p> <p>No other residents were identified.</p> <p>3. Measures Taken:</p> <p>a. All Nurses' have been in-serviced by the DON/Designee on facility policy in regards to notification of physician/family related to a accidents/incidents.</p> <p>4. How Monitored:</p>				

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	<p>indicated, "PT [physical therapy] 5 X's [five times] per week for ambulation...."</p> <p>The next Nurse's Note was 7/31/12 at 11:00 a.m. and indicated, "PT 5 X's per week for ambulation &amp; transfer...."</p> <p>The next Nurse's Note was 8/1/12 at 2:00 a.m. and indicated, "CNA notified this nurse that while giving care to resident, res was grasping L [left] hip, &amp; squinting eyes &amp; lips perced [sic] tightly, upon assessment, res was unable to straighten out both legs, res drew legs up, &amp; showed signs &amp; symptoms of pain, by squeezing face tightly, when res was turned on R [right] side res grabbed L hip, this nurse observed swelling to posterior hip/[arrow pointing up - upper] thigh, res was turned on back &amp; grabbed at coccyx, while squeezing eyes closed tightly, &amp; grimaced [symbol for with] signs &amp; symptoms of pain, PRN [as needed] pain med [medication] given @ this time, will cont [continue] to follow up." Documentation failed to indicate the physician was notified.</p> <p>The next Nurse's Note was 8/2/12 at 11:00 a.m., and indicated, "N.O. [new order] rec'd [received] &amp; noted Xray of R and L hip res holding R hip [symbol for with] facial grimacing...family also request to xray shoulder &amp; R foot.</p>		<p>a. The DON/Designee will review daily, the chart of any resident that has an accident/incident to validate family and MD notification.</p> <p>b. The DON/Designee will review findings with the Quality Assurance Committee daily in the QA Daily Stand-up meeting. The Accident/Incident Analysis Review will be reviewed/discussed in the monthly QA meeting with the IDT; and quarterly at the QA meeting with the Medical Director. This will be an on-going process.</p> <p>5. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 29, 2012.</p>	

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	<p>Family states 'res holds shoulder &amp; foot lays [sic] funny'...Res states 'my hip hurts!....' Notes indicated pain medication was administered.</p> <p>The next Nurse's Note was 8/2/12 at 1:00 p.m., and indicated, "Family called &amp; states want Res [resident] to go to [initials of local hospital] for Xray...."</p> <p>During interview on 8/7/12 at 2:55 p.m., the Director of Nursing (DON) indicated she had fall assessment paperwork related to Resident D's fall. The DON provided the Incident Documentation and Investigation Tool, dated 7/28/12. The document indicated check marks in the boxes for "No" next to the questions "Was the physician notified?" and "Was the family notified?" Next to the question about physician notification was, "Time: 7:00 a.m. Name: [name of Resident D's physician] 7/29/12." Next to the question about family notification was, "Time: 7:15 a.m. Name: dgt [daughter]/husband 7/29/12." The Tool was signed by RN #5 and dated 7/28/12 (prior to the physician and family notification). During interview at this time, the DON indicated the physician and family should be notified immediately of a fall.</p> <p>3.1-5(a)(2)</p>			

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F0248 SS=E	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were involved in an activities program designed to meet their interests for 13 of 13 residents reviewed and observed related to activities in a sample of 17. (Residents D, L, K, I, G, F, M, N, O, P, Q, B, and H)</p> <p>Findings include:</p> <p>A brief tour of the facility's four units was made on 8/7/12 from 9:55 a.m. to 10:10 a.m., and the following was observed:</p> <p>On 8/7/12 at 9:55 a.m., Residents D, L, K and I were observed in the activity/dining room on the secured Ruby Bay unit dining and activity room. Resident D was in a wheel chair at a table facing the corner of the room. Resident L was seated in her wheel chair at another table with head down and eyes closed. Resident K was in a reclined geri-chair with her legs swung over the arm rest of the chair. Her eyes were open. Resident I was reclined in a geri-chair with eyes closed. The TV set</p>	F0248	<p><b>F 248 Activities Meet Interests/Needs of Each Res</b></p> <p>It is the intent of this facility to provide an activity program that meets the interests of the residents.</p> <p>1. Actions Taken:</p> <p>a. Each Residents leisure activity preference sheet and care plan has been reviewed and updated.</p> <p>2. Others identified:</p> <p>a. All residents have the potential to be affected by this practice.</p> <p>3. Measures Taken:</p> <p>a. The activity calendar has been revised to incorporate resident</p>	08/29/2012	

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	<p>suspended in the corner of the room (not the corner faced by Resident D) was not on. No staff was in the room. None of the residents were drinking beverages.</p> <p>Resident G entered the room and read from the large activities calendar on the wall that a Yahtzee game was planned for 10:00 a.m. The calendar was observed to have scheduled for Tuesday, August 7, 2012: 9:30 a.m. Coffee/Current Events and 10:00 a.m. Yahtzee. LPN #11 entered the room and told Resident G she didn't know if there would be anyone to do Yahtzee. Resident G indicated residents "don't always do what we're supposed to - they put that sh-t up there [on the calendar], but no one gets to go - it's the truth." LPN #11 asked Resident G not to get upset. LPN #11 indicated the Activity Director had quit and an Activity Aide was filling in for her. LPN #11 indicated the Activity Aide told her the residents on the Ruby Bay unit were not supposed to go out of the secured unit for activities. LPN #11 indicated she and the CNA assigned to the unit are responsible for the activities on the unit. LPN #11 indicated, "We try back here...I've got paperwork...there's not time."</p> <p>The large activities calendar on the wall on the hall of the secured Emerald Brook unit indicated 10:00 a.m. Spill and Spell,</p>		<p>preferences.</p> <p>b. The activity calendar has been revised to focus the activities at the time preferred by the residents.</p> <p>c. A new Activity Director has been appointed and is enrolled in training.</p> <p>d. An Activity Assistant Position has been approved and will be filled as soon as a quality candidate is found.</p> <p>e. The Activity Programming is discussed each morning 5 days a week in the morning IDT meeting to determine issues so they can quickly be resolved.</p> <p>f. The nursing staff has been in-serviced by the DON/Designee on the importance of conducting activities per the schedule.</p> <p>g. The nursing staff has been in-serviced by the Director of Activities/Designee on the importance of filling out the participation records and how to properly complete the forms.</p> <p>h. The facility leadership team has been in-serviced on the importance of activities consistently occurring and has incorporated visual observation to validate they are occurring into their daily routine rounds.</p>				

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	<p>and 11:00 Exercise. No residents were in the two activity/dining rooms on the unit. Resident F was observed pacing up and down the hallway. Resident M was seated in his room in a wheel chair next to his bed with a blanket over his head. Resident N was in the hall requesting to go for smoke break. Other residents were in their rooms. RN #3 was in her office, and CNA #2 was not in sight.</p> <p>The Activity Aide was observed in the hallway of the Sapphire Stream unit, which was not a secured unit. She indicated she was gathering residents to play Bingo in the dining room.</p> <p>The large activities calendar on the wall on the hall of the secured Onyx Cove unit indicated 10:00 a.m. Spill and Spell. As the unit was entered at 10:10 a.m., CNA #4 was observed standing with residents near the doorway. LPN #13 was at the medication cart in her office. CNA #6 was observed to sit down at a table with three residents (Residents O, P, and Q) and pour dice from a container onto the table. CNA #6 indicated she could not find the Spill and Spell game, so the residents would play Yahtzee. CNA #4 indicated to LPN #13 that she was taking seven residents out for smoke break. Resident B was observed with the group of smokers. Resident O interacted with</p>		<p>4. How Monitored:</p> <p>a. The Interdisciplinary Team will discuss the Activity Programming 5 days a week in the morning meeting. Any issues noted will be addressed.</p> <p>b. The Activity Director/Designee will audit the participation logs on a weekly basis to validate compliance and completion. Problems noted will be discussed with the IDT to determine a solution.</p> <p>c. The Activity Director/Designee will provide a summary of the resident participation logs to the Quality Assurance Committee at the monthly meeting. The findings will be discussed with the Medical Director at the quarterly Quality Assurance Meeting.</p> <p>5. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 29, 2012.</p>		

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	<p>CNA #6 to play Yahtzee. Resident P sat a short distance from the table with eyes closed and head tipped back. Resident Q indicated repeatedly, "This chair is killing me." CNA #6 was observed to roll the Yahtzee dice for Residents P and Q and record their scores. When interviewed, Resident Q indicated he wished to go to bed. CNA #6 indicated Resident Q usually remained up out of bed until after lunch.</p> <p>On 8/7/12 at 1:55 p.m., the Activities Aide was observed in the hallway of the secured Emerald Stream unit. During interview at this time, she indicated she was preparing for a party for residents with August birthdays. She indicated not all residents would be coming, but just the residents with August birthdays. She indicated four residents on Emerald Stream unit had birthdays in August, but only three residents would be able to come to the party. She asked CNA #2 to bring the three residents to the main activity/dining room in 10 minutes. She indicated Resident H was a "wanderer," so he would not be able to come to the party. She indicated wandering residents on halls with two CNAs scheduled could come, because the second CNA could accompany the resident, but not on halls with just one CNA scheduled.</p>						

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	<p>The Daily Hall Assignment was provided on 8/7/12 at 9:40 a.m. The schedule indicated staffing as follows for 8/7/12 from 6:00 a.m. to 6:00 p.m.: Ruby Bay unit: one nurse and one CNA; Emerald Brook unit: one nurse and one CNA; Sapphire Stream: one nurse and two CNAs (one of whom was the facility's Restorative Aide working the floor); and Onyx Cove: one nurse and two CNAs. The line for "Activity Aide" for the three secured units (Ruby Bay, Emerald Brook, and Onyx Cove) was blank. To the side of the schedule was written: "[First name of Activity Aide] Act [activities]."</p> <p>During interview on 8/7/12 at 12 noon, the Administrator indicated the Activities Director left two weeks ago. She indicated the employee gave no notice, placed her keys on the desk, and walked out. She indicated the Activity Aide was filling in for the Activity Director. She indicated the Activity Aide was not yet enrolled in a class to become the Activity Director. She indicated the facility had an agreement with a consulting company but had not yet arranged for consultation related to the Activities Program since the Activity Director left. She indicated it had not been decided if the Activity Aide would be selected for the position of new Activity Director.</p>			

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	<p>The employee files for the Activity Aide and Activity Director were reviewed on 8/7/12 at 12:15 p.m. The file for the Activity Aide included a document entitled "Notice of Unemployment Claim," signed by the Business Office Manager. The document indicated, "Reason for Separation: ...[Name of Activity Aide] was a full-time Activity Aide. On 7/12/12 [name of Activity Aide's] position was eliminated due to budget cuts. She now works as a CNA on a needed basis." The Administrator indicated the positions of Activity Aides on the three secured units had been eliminated on that date, and now nursing staff was responsible for activities on the units. The file for the Activity Director included a termination notice indicating she left employment on 7/30/12 and was not eligible for re-hire.</p> <p>1. The clinical record for Resident G was reviewed on 8/7/12 at 12:30 p.m.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 6/28/12, indicated a Brief Interview for Mental Status score of 12 out of 15 correct responses. The Interview for Activity Preference on the MDS assessment, dated 8/2/11, indicated the following were very important to the resident: being around animals such as pets, keeping up with the news, doing</p>						

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	<p>things with groups of people, and doing favorite activities.</p> <p>The Careplan Worksheet for Activities, originally dated 1/13/12, and most recently updated 6/4/12, with no changes in entries, included, but was not limited to, "... I sometimes lack interest in doing things." The goal was, "I will remain actively involved in group acts [activities] 2 - 3 times wkly [weekly]. I will continue to keep myself active with individual acts daily." Interventions included, but were not limited to, "Review act [activities] calendar with me to assist in finding acts I enjoy. Give me reminders and assist me to and from acts of my choice...Provide me with acts of interest, i.e. music, spiritual , games..."</p> <p>The binder with records of activity participation for residents on the Ruby Bay unit, including Resident G, was reviewed on 8/7/12 at 1:55 p.m. Resident G's participation record for August 2012 failed to indicate participation in any activities. Copies of the records were requested, and the Administrator provided the copies of the blank records. She indicated she also was providing copies of the activity participation records completed by the Activity Aide for Resident G's activities off of her unit. The Administrator indicated Resident G</p>						

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	<p>was "care planned for activities off the unit."</p> <p>2. The clinical record for Resident B was reviewed on 8/2/12 at 1:05 p.m.</p> <p>The quarterly MDS assessment, dated 6/6/12, indicated a Brief Interview for Mental Status score of 15 out of 15 correct responses. The Interview for Activity Preference on the MDS assessment, dated 4/2/12, indicated the following were very important to the resident: listening to music, being around animals such as pets, keeping up with the news, doing favorite activities, going outside to get fresh air when the weather is good, and participating in religious services or practices.</p> <p>The Careplan Worksheet, originally dated 4/2/12 and most recently updated 6/6/12, with no new entries, indicated, "Resident enjoys interacting &amp; socializing with others. Needs to be encouraged &amp; reminded of activities d/t [due to ] dx [diagnosis]: dementia with mood behaviors."</p> <p>On 8/7/12 at 2:10 p.m., the binder with records of activity participation were requested from CNA #8 on the secured Onyx Cove unit where Resident B resided. CNA #8 located the records in</p>						

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	<p>the closet. At this time she indicated the CNAs do not document related to the resident's activities, but the "activities lady" does. Review of Resident B's activities records in the binder indicated no activity participation during the month of August through 8/7/12 at 2:10 p.m.</p> <p>3. The clinical record for Resident F was reviewed on 8/2/12 at 12:20 p.m.</p> <p>The comprehensive MDS assessment, dated 10/4/11, indicated the staff assessed the resident's Activities Preferences as follows for Resident Prefers: snacks between meals, reading books, newspapers, or magazines, listening to music, being around animals such as pets, doing things with groups of people, participating in favorite activities, and participating in religious activities or practices.</p> <p>The Careplan Worksheet for Activities, originally dated 1/13/12, and most recently updated 6/28/12, with no new entries during that period, indicated in Notes: "I enjoy cards, bingo, sports, westerns, gospel music and reading the paper."</p> <p>During interview on 8/7/12 at 2:00 p.m. CNA #2, on the secured Emerald Stream unit, where Resident F lived, indicated the</p>			

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	<p>activities records binder was missing recently, so she had no time to work in it this month. She located the binder in a closet. Review of the documentation for Resident F indicated on the Independent Activity Tracking Log with a check mark that the resident participated in "TV" on August 1, 2, and 3, 2012. No check-marked activities were indicated for other dates in the month. Also indicated were: August 1: puzzle, chat; August 2: music, outdoors; and August 3, 2012: ROM (range of motion), exercise. On the Activity Calendar for August 2012, in the binder, activities were scheduled daily at 9:30 a.m., 10:00 a.m., 11:00 a.m., 1:30 p.m., 2:30 p.m., 3:00 p.m., 4:00 p.m., 4:30 p.m., and 6:00 p.m. Resident F's calendar was marked with an orange highlighter to indicate passive participation in all activities for August 1 through 3, 2012.</p> <p>4. The clinical record for Resident H was reviewed on 8/2/12 at 11:50 a.m.</p> <p>The quarterly MDS assessment, dated 7/10/12, indicated the resident had long and short term memory problems and was severely impaired for decision making. The assessment indicated the resident wandered daily.</p> <p>The Admission- Face Sheet Information</p>						

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	indicated the resident's birthday was in August.  3.1-33(a)			

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F0249 SS=E	<p>483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL</p> <p>The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State.</p> <p>Based on interview and record review, the facility failed to ensure its activities program was directed by a qualified professional. The deficient practice affected 13 of 13 residents reviewed and observed related to activities in a sample of 17. (Residents D, L, K, I, G, F, M, N, O, P, Q, B, and H)</p> <p>Findings include:</p> <p>During interview on 8/7/12 at 12 noon, the Administrator indicated the Activities Director left two weeks ago. She indicated the employee gave no notice, placed her keys on the desk, and walked out. She indicated the Activity Aide was filling in for the Activity Director. She</p>			F0249	<p><b>F 249 Qualifications of Activity Professional</b></p> <p>It is the intent of this facility to ensure the Activity Program is directed by a qualified professional.</p> <p>1. Actions Taken:</p> <p>a. An Activity Staff person has been promoted to the position of Activity Director.</p> <p>b. Arrangements have been made for her training with the consulting company.</p>		08/29/2012

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	<p>indicated the Activity Aide was not yet enrolled in a class to become the Activity Director. She indicated the facility had an agreement with a consulting company but had not yet arranged for consultation related to the Activities Program since the Activity Director left. She indicated it had not been decided if the Activity Aide would be selected for the position of new Activity Director.</p> <p>The employee files for the Activity Aide and the former Activity Director were reviewed on 8/7/12 at 12:15 p.m.</p> <p>The file for the Activity Director included a termination notice indicating she left employment on 7/30/12 and was not eligible for re-hire. The file included copy of documentation indicating the Activity Director completed required training on 6/25/12. The file failed to include a copy of the Activity Director's signed job description. During interview on 8/7/12 at 2:40 p.m., the Administrator indicated there was no Activity Director's job description in the Activity Director's file.</p> <p>The file for the Activity Aide included a document entitled "Notice of Unemployment Claim," signed by the Business Office Manager. The document indicated, "Reason for Separation: ...</p>		<p>c. She has been enrolled in a ISDH approved Activity Course and will be attending in August and September of 2012</p> <p>2. Others Identified:</p> <p>a. All residents have the potential to be affected by this practice.</p> <p>3. Measures Taken:</p> <p>a. A person has been promoted to the position of Activity Director.</p> <p>b. Arrangements have been made for her training with the consulting company.</p> <p>c. She has been enrolled in an ISDH approved Activity Course and will be attending in August and September of 2012</p> <p>4. How Monitored:</p> <p>a. The Activity Director will present her progress in the ISDH approved Activity Class to the Quality Assurance Committee at the monthly meeting. She will also discuss progress with the Medical</p>				

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	<p>[Name of Activity Aide] was a full-time Activity Aide. On 7/12/12 [name of Activity Aide's] position was eliminated due to budget cuts. She now works as a CNA on a needed basis." The Administrator indicated the positions of the Activity Aides on the three secured units had been eliminated on that date, and now nursing staff was responsible for activities on the units.</p> <p>During interview on 8/7/12 at 2:40 p.m., the Administrator indicated [name of previous Administrator] was at the facility until December 2011, and then she became Administrator. She indicated when she started employment, [name of former employee] was the Program Manager for Dementia Care, and served as Social Services Director and acted as the Interim Activity Director while [name of Activities Director who left without notice] was enrolled in her certification class. The Administrator indicated the Program Manager for Dementia Care "left about February or March [2012]." When interviewed in regard to who provided consultation for the Activities Director prior to her completing her training, after the Program Manager for Dementia Care left, the Administrator named a consultant company, and the consultative reports were requested.</p>		<p>Director at the quarterly Quality Assurance Committee meeting.</p> <p>b. The completion of the class will be noted in her personnel file</p> <p>5. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 29, 2012.</p>				

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	<p>During interview on 8/7/12 at 3:50 p.m., the Administrator provided copy of a consultation report for 4/13/12; however, the report did not indicate consultation was provided related to the activities program. At this time the Administrator indicated, "[Name of former Program Director for Dementia Care] was still overseeing activities in April [2012]."</p> <p>The record of the Program Director for Dementia Care's employment dates was requested. The Administrator provided copy of a print-out indicating [name of former Program Director for Dementia Care] was hired on 1/15/12 and terminated on 7/19/12. The Current Active Status indicated, "Terminated - Disciplinary Action - Thu [Thursday] 19 Jul [July] 2012 Transfer to [name of sister facility in nearby town]." The Administrator indicated the Program Manager had returned to her previous job as the social worker at the sister facility.</p> <p>A brief tour of the facility's four units was made on 8/7/12 from 9:55 a.m. to 10:10 a.m., and the following was observed:</p> <p>On 8/7/12 at 9:55 a.m., Residents D, L, K and I were observed in the activity/dining room on the secured Ruby Bay unit dining and activity room. Resident D was in a wheel chair at a table facing the corner of the room. Resident L was seated in her</p>			

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	<p>wheel chair at another table with head down and eyes closed. Resident K was in a reclined geri-chair with her legs swung over the arm rest of the chair. Her eyes were open. Resident I was reclined in a geri-chair with eyes closed. The TV set suspended in the corner of the room (not the corner faced by Resident D) was not on. No staff was in the room. None of the residents were drinking beverages.</p> <p>Resident G entered the room and read from the large activities calendar on the wall that a Yahtzee game was planned for 10:00 a.m. The calendar was observed to have scheduled for Tuesday, August 7, 2012: 9:30 a.m. Coffee/Current Events and 10:00 a.m. Yahtzee. LPN #11 entered the room and told Resident G she didn't know if there would be anyone to do Yahtzee. Resident G indicated residents "don't always do what we're supposed to - they put that sh-t up there [on the calendar], but no one gets to go - it's the truth." LPN #11 asked Resident G not to get upset. LPN #11 indicated the Activity Director had quit and an Activity Aide was filling in for her. LPN #11 indicated the Activity Aide told her the residents on the Ruby Bay unit were not supposed to go out of the secured unit for activities. LPN #11 indicated she and the CNA assigned to the unit are responsible for the activities on the unit. LPN #11</p>				

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	<p>indicated, "We try back here...I've got paperwork...there's not time."</p> <p>The large activities calendar on the wall on the hall of the secured Emerald Brook unit indicated 10:00 a.m. Spill and Spell, and 11:00 Exercise. No residents were in the two activity/dining rooms on the unit. Resident F was observed pacing up and down the hallway. Resident M was seated in his room in a wheel chair next to his bed with a blanket over his head. Resident N was in the hall requesting to go for smoke break. Other residents were in their rooms. RN #3 was in her office, and CNA #2 was not in sight.</p> <p>The Activity Aide was observed in the hallway of the Sapphire Stream unit, which was not a secured unit. She indicated she was gathering residents to play Bingo in the dining room.</p> <p>The large activities calendar on the wall on the hall of the secured Onyx Cove unit indicated 10:00 a.m. Spill and Spell. As the unit was entered at 10:10 a.m., CNA #4 was observed standing with residents near the doorway. LPN #13 was at the medication cart in her office. CNA #6 was observed to sit down at a table with three residents (Residents O, P, and Q) and pour dice from a container onto the table. CNA #6 indicated she could not</p>			

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	<p>find the Spill and Spell game, so the residents would play Yahtzee. CNA #4 indicated to LPN #13 that she was taking seven residents out for smoke break. Resident B was observed with the group of smokers. Resident O interacted with CNA #6 to play Yahtzee. Resident P sat a short distance from the table with eyes closed and head tipped back. Resident Q indicated repeatedly, "This chair is killing me." CNA #6 was observed to roll the Yahtzee dice for Residents P and Q and record their scores. When interviewed, Resident Q indicated he wished to go to bed. CNA #6 indicated Resident Q usually remained up out of bed until after lunch.</p> <p>On 8/7/12 at 1:55 p.m., the Activities Aide was observed in the hallway of the secured Emerald Stream unit. During interview at this time, she indicated she was preparing for a party for residents with August birthdays. She indicated not all residents would be coming, but just the residents with August birthdays. She indicated four residents on Emerald Stream unit had birthdays in August, but only three residents would be able to come to the party. She asked CNA #2 to bring the three residents to the main activity/dining room in 10 minutes. She indicated Resident H was a "wanderer," so he would not be able to come to the</p>			

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	<p>party. She indicated wandering residents on halls with two CNAs scheduled could come, because the second CNA could accompany the resident, but not on halls with just one CNA scheduled.</p> <p>The Daily Hall Assignment was provided on 8/7/12 at 9:40 a.m. The schedule indicated staffing as follows for 8/7/12 from 6:00 a.m. to 6:00 p.m.: Ruby Bay unit: one nurse and one CNA; Emerald Brook unit: one nurse and one CNA; Sapphire Stream: one nurse and two CNAs (one of whom was the facility's Restorative Aide working the floor); and Onyx Cove: one nurse and two CNAs. The line for "Activity Aide" for the three secured units (Ruby Bay, Emerald Brook, and Onyx Cove) was blank. To the side of the schedule was written: "[First name of Activity Aide] Act [activities]."</p> <p>3.1-33(e)(4) 3.1-33(f)(1) 3.1-33(f)(2) 3.1-33(f)(3)</p>				

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F0250 SS=D	<p><b>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</b></p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review, and interview, the facility failed to ensure social services assisted the care team to develop interventions related to management of behaviors for a resident with two recent hospitalizations related to sexual behaviors. The deficient practice affected 1 of 4 residents reviewed related to behaviors in a sample of 17. (Resident C)</p> <p>Findings include:</p> <p>On 8/2/12 at 12:30 p.m., Resident C was observed lying in bed in his room. The resident's roommate was in the room and indicated he had transferred to that room "Sunday a week ago."</p> <p>On 8/7/12 at 1:30 p.m., Resident C was observed lying in bed in his room. The MDS Coordinator was observed seated in a chair at the open doorway to the resident's room. During interview at this time, the MDS (Minimum Data Set) Coordinator indicated she had been asked to provide one to one supervision for Resident C and indicated, "He's been as</p>	F0250	<p><b>F 250 Provision of Medically Related Social Service</b></p> <p>It is the intent of this facility to ensure social services assists the care team in developing interventions related to management of behaviors.</p> <p>1. Actions Taken:</p> <p>a. The care plan for Resident C was reviewed and updated per the IDT and the SSD.</p> <p>2. Others Identified:</p> <p>a. A 100% audit of all residents' care plans was completed to identify any other residents at risk; any identified were reviewed/revise and updated per the IDT and the SSD.</p> <p>3. Measures Taken:</p>	08/29/2012			

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	<p>good as gold" with no behaviors.</p> <p>The clinical record for Resident C was reviewed on 8/2/12 at 12:40 p.m. The record indicated the resident was admitted 5/25/12.</p> <p>The Minimum Data Set assessment, dated 7/31/12, indicated the resident scored 12 of 15 correct responses on the Brief Interview for Mental Status. The Behavior section of the MDS indicated the resident had no behaviors exhibited during the assessment period.</p> <p>The Care Plan, originally dated 5/29/12, and most recently updated 6/4/12, with no revised problem, goals, or interventions since 6/4/12, indicated, "Resident at risk for behavioral disturbances R/T [related to] DX [diagnosis]: Dementia with Behavioral Disturbance and TX [history] of inappropriate sexual behaviors/yelling out. Resident on antipsychotic med [medication] R/T DX inappro [inappropriate] [sic]." Interventions indicated to observe for behaviors, approach the resident calmly and quietly, let resident know what you are doing during care, offer activity of choice, 1 on 1 prn [as needed] notify MD, family &amp; IDT of change in behaviors, medications and observe for adverse reactions to medication, gradual dose reduction per</p>		<p>a. Training sessions have been arranged with the consultant company for the new Social Service Director.</p> <p>4. How Monitored:</p> <p>a. All records will be reviewed by the IDT and the SSD during the quarterly review to validate current care plans are in place. This will be an on-going process.</p> <p>b. The Director of Social Services will complete a 100% audit of all records to validate care plans and interventions are current and appropriate. All records for each unit will be reviewed/revise and upon completion reported to the IDT at the daily QA stand-up meeting.</p> <p>c. The audits will be reviewed at the monthly QA meeting with the QA Committee; and reviewed/discussed with the Medical Director during the quarterly Quality Assurance meeting.</p> <p>5. This Plan of Correction constitutes our credible allegation of</p>		

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	<p>guidelines, psychiatric consult as ordered, social services as needed, monitor of effectiveness of medication and interventions, explain inappropriate behaviors, Alora (hormone medication) as ordered, and Seroquel (psychiatric medication) as ordered.</p> <p>The Careplan Worksheet for Activities, dated 5/28/12, and without updates, indicated, the resident was at risk for decreased activity due to dementia with behavior disturbance, and "Res [resident] may make sexually inappropriate comments." Interventions indicated, "Res will be provided an activity calendar. Res will be reminded &amp; encourage to attend. Res. will be reminded of courtesy &amp; praised for acting appropriately."</p> <p>Social Services Notes, dated 6/7/12 (untimed), indicated, "Res reviewed by PAR [person at risk] by IDT [interdisciplinary team] due to new admit. Hx [history] of sexual bx [behaviors], presently no bx. Will cont. to monitor."</p> <p>Nurses Notes indicated on 6/23/12 at 10:00 p.m., the resident was resting in bed without distress, was cooperative and had no complaints.</p> <p>The next Nurses Note was for 6/29/12 at 12:10 p.m., and indicated, "[Name of</p>		<p>compliance with all regulatory requirements. Our date of compliance is August 29, 2012.</p>	

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	<p>behavior center] contacted per signer @ this X [time] regarding [arrow pointing up] sexual behavior...." The notes indicated the resident was placed on one on one supervision until transferred to the behavior unit at 6:15 p.m.</p> <p>The behavior unit Discharge Summary, dated 7/10/12, indicated, "History of Present Illness: This patient is...admitted to our unit from The Waters of Scottsburg, who reported the patient had been exhibiting escalating behaviors i.e. sexually acting out, inappropriate gestures, rubbing his groin against a male peer, then masturbating, very agitated, difficult to redirect, and was admitted for behavioral/medication stabilization." The "Recommendations" section indicated, "Patient...is to be re-admitted to the Waters of Scottsburg on this date. He would benefit from structured activity groups within your facility. He has exhibited increased socialization with an improvement in his mood and affect...."</p> <p>Social Services Notes for 7/10/12 (untimed) indicated, "Spoke with [name] from [name of behavior center]. Res to return to facility. Res has had no bx [behaviors] while @ hospital. Res was mixed in w/ [with] women. She stated if res returns &amp; has bx to send him back out &amp; she will assist in finding a new facility.</p>			

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	<p>Another Social Services Note for 7/10/12 (untimed) indicated, "Res moved into [room number] from [room number]. It may be better for Res to have no rm [sic - roommate] due to bx...."</p> <p>Social Services Notes for 7/13/12 (untimed) indicated, " Resident adjusting well to return. No behaviors noted...."</p> <p>Nurses Notes for 7/13/12 at 11:15 p.m. was a Monthly Summary which did not address behaviors.</p> <p>The next Nurses Notes were 7/16/12 at 12:30 p.m. and indicated the resident had "mania-like behavior noted to start early AM [morning] [symbol for with] breakfast. Res. [illegible word] non-stop [symbol for with] peers, laughing, cursing, making inappropriate sexual comment about staff members...." Notes indicated the physician was contacted, and the resident was placed on every 15 minute checks. Notes indicated the physician ordered an injection of Depo-Provera (hormone medication), which was administered on 7/17/12.</p> <p>Nurses Notes for 7/19/12 at 5:30 p.m., indicated the resident was having increased sexual behaviors, the physician was contacted, and the resident was</p>			

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	<p>discharged to the behavior unit.</p> <p>Nurses Notes for 7/26/12 at 5:00 p.m., indicated the resident was readmitted to the facility. Notes through 8/1/12 at 9:00 p.m., did not indicate behavior issues.</p> <p>The next Social Services Note after the 7/13/12 entry was 8/1/12 and indicated, "Bx Management Note: IDT [interdisciplinary team] reviewed res bx's and care plan. [Symbol for No changes] in res bx's @ this time. IDT will continue to review res bx's &amp; cp [care plans] as needed."</p> <p>The next Social Services Note was 8/3/12 [untimed] and indicated, "DC [discharge] Planning note - SW [social worker] left a message [symbol for with] res daughter [name] to inquire is she had any specific facilities she would like res med rec [medical record] faxed to in an effort to assist [symbol for with] alternate placement for res [resident] d/t [due to] current facility attempting to dc res @ this time. SW spoke [symbol for with] res RE: facility attempting to find alternate placement for res. Res said, 'Whatever you wanna do.' SW will continue to assist [symbol for with] discharge planning for res as needed."</p> <p>The next Social Services Note was 8/7/12</p>			

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	<p>[untimed] and indicated, "D/C planning note: SW contacted res daughter, [name of daughter] via telephone &amp; discussed finding alternate placement for res. Daughter agreed to transferring res to another facility preferably not further north but closer toward [name of near-by town]. SW will assist res [symbol for with] finding another facility to transfer to as needed. [Name of another local facility] came out to review res &amp; res med [medical] record, will let Waters know if res will be accepted for admission. SW will continue to assist res [symbol for with] discharge plans as needed."</p> <p>During interview on 8/7/12 at 2:55 p.m., the Director of Nursing indicated the Social Services Director should be interviewed related to the resident's behavior care planning. She indicated the Nursing Department was not responsible for the behavior plans.</p> <p>On 8/7/12 at 2:20 p.m., the Nurse Consultant, Director of Nursing (DON), and Assistant Director of Nursing were interviewed in regard to the behavior management and one on one supervision for Resident C. The Nurse Consultant indicated, "I don't want to speak [for them] - it's their building." The Director of Nursing indicated one on one supervision started on Friday, 8/3/12, as</p>			

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	<p>determined by the IDT meeting. The DON indicated the resident had had no behaviors since the most recent return from the hospital. She indicated he had been hospitalized twice and "needs alternate placement." The DON indicated he "would be a better fit somewhere else than at this facility." Documentation related to the IDT decision regarding the resident's behavior management was requested.</p> <p>On 8/7/12 at 2:55 p.m., the DON provided copy of a document typed on a plain piece of white paper, with signatures of the Nurse Consultant, DON, and Social Services Director. The document indicated, "A PAR [person at risk] meeting related to [name of Resident C] was recommended by the Regional QA [Quality Assurance] nurse during a routine visit on Friday, August 3, 2012. She felt that his needs would be better met in a different environment and recommended to start the search for a different facility. It was recommended that he be placed on 1:1 supervision until the IDT either determined to reduce the focus of the supervision or he was transferred to another facility." When interviewed at this time related to the origin of the document, the DON indicated, "You need to talk to [name of Administrator]."</p>			

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	<p>During interview on 8/7/12 at 3:10 p.m., the Administrator indicated she did not attend the meeting where Resident C's care was planned, but she had typed the information today related to the PAR meeting, when the Nurse Consultant told her what happened at the meeting. She indicated the document was not part of the resident's clinical record. The Administrator indicated the care decisions were based on the recommendation of the Nurse Consultant.</p> <p>During interview on 8/7/12 at 3:30 p.m., the Social Services Director indicated the resident's behavior plan had not been updated since she started her job with the facility, because the resident had had no behaviors since she got here. She indicated, "Corporate met on Friday," and Resident C was placed on one to one supervision. She indicated she had talked with the family about better environment for Resident C at another facility. She indicated the resident had resided at another long term care facility before coming to this facility.</p> <p>This federal tag relates to Complaint IN00113000.</p> <p>3.1-34(a)</p>			

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review and interview, the facility failed to ensure the care plans were updated with revised interventions related to sexual behaviors for 1 of 4 residents reviewed related to behavior care plans in a sample of 17 residents. (Resident C)</p> <p>Findings include:</p> <p>On 8/2/12 at 12:30 p.m., Resident C was observed lying in bed in his room. The resident's roommate was in the room and indicated he had transferred to that room "Sunday a week ago."</p>	F0279	<p><b>F 279 Develop Comprehensive Care Plans</b> It is the intent of this facility to update care plans to reflect revised interventions addressing the needs of residents. 1. Actions Taken: a. The care plan for Resident C was reviewed and updated. 2. Others Identified: a. A 100% audit of all residents care plans was completed to identify any other residents at risk; any identified were reviewed and updated with appropriate interventions. 3. Measures Taken: a. Training has been arranged with the consultant company for the new Social</p>	08/29/2012	

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	<p>The clinical record for Resident C was reviewed on 8/2/12 at 12:40 p.m. The record indicated the resident was admitted 5/25/12.</p> <p>The Minimum Data Set assessment, dated 7/31/12, indicated the resident scored 12 of 15 correct responses on the Brief Interview for Mental Status. The Behavior section of the MDS indicated the resident had no behaviors exhibited during the assessment period.</p> <p>The Care Plan, originally dated 5/29/12, and most recently updated 6/4/12, with no revised problem, goals, or interventions since 6/4/12, indicated, "Resident at risk for behavioral disturbances R/T [related to] DX [diagnosis]: Dementia with Behavioral Disturbance and TX [history] of inappropriate sexual behaviors/yelling out. Resident on antipsychotic med [medication] R/T DX inappro [inappropriate] [sic]." Interventions indicated to observe for behaviors, approach the resident calmly and quietly, let resident know what you are doing during care, offer activity of choice, 1 on 1 prn [as needed] notify MD, family &amp; IDT of change in behaviors, medications and observe for adverse reactions to medication, gradual dose reduction per guidelines, psychiatric consult as ordered,</p>		<p>Service Director. b. Care Plans will be reviewed and updated on a quarterly basis, and prn with any updated interventions. This is an on-going process. 4. How Monitored: a. Charts will be reviewed by the IDT during the quarterly review to validate current care plans are in place and to revise/update as necessary. This is an on-going process. b. The Director of Social Services will audit interventions for all behaviors to ensure they are current quarterly and prn as changes are made. This will be an on-going process. c. The Quality Assurance Committee will review any identified concerns at the monthly meeting and discussed with the Medical Director during the quarterly Quality Assurance meeting. 5. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 29, 2012.</p>		

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	<p>social services as needed, monitor of effectiveness of medication and interventions, explain inappropriate behaviors, Alora (hormone medication) as ordered, and Seroquel (psychiatric medication) as ordered.</p> <p>The Careplan Worksheet for Activities, dated 5/28/12, and without updates, indicated, the resident was at risk for decreased activity due to dementia with behavior disturbance, and "Res [resident] may make sexually inappropriate comments." Interventions indicated, "Res will be provided an activity calendar. Res will be reminded &amp; encourage to attend. Res. will be reminded of courtesy &amp; praised for acting appropriately."</p> <p>The Nurses Note for 6/29/12 at 12:10 p.m., indicated, "[Name of behavior center] contacted per signer @ this X [time regarding [arrow pointing up] sexual behavior...." The notes indicated the resident was placed on one on one supervision until transferred to the behavior unit at 6:15 p.m.</p> <p>The behavior unit Discharge Summary, dated 7/10/12, indicated, "History of Present Illness: This patient is...admitted to our unit from The Waters of Scottsburg, who reported the patient had been exhibiting escalating behaviors i.e.</p>			

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	<p>sexually acting out, inappropriate gestures, rubbing his groin against a male peer, then masturbating, very agitated, difficult to redirect, and was admitted for behavioral/medication stabilization." The "Recommendations" section indicated, "Patient...is to be re-admitted to the Waters of Scottsburg on this date. He would benefit from structured activity groups within your facility. He has exhibited increased socialization with an improvement in his mood and affect...."</p> <p>Social Services Notes for 7/10/12 (untimed) indicated, "Spoke with [name] from [name of behavior center]. Res to return to facility. Res has had no bx [behaviors] while @ hospital. Res was mixed in w/ [with] women. She stated if res returns &amp; has bx to send him back out &amp; she will assist in finding a new facility."</p> <p>Another Social Services Note for 7/10/12 (untimed) indicated, "Res moved into [room number] from [room number]. It may be better for Res to have no rm [sic - roommate] due to bx...."</p> <p>Documentation failed to indicate the care plans related to behaviors and activities, including the recommended structured activities and plan for no roommate, were updated with new interventions after the</p>						

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	<p>hospitalization.</p> <p>Nurses Notes for 7/16/12 at 12:30 p.m., indicated the resident had "mania-like behavior noted to start early AM [morning] [symbol for with] breakfast. Res. [illegible word] non-stop [symbol for with] peers, laughing, cursing, making inappropriate sexual comment about staff members...." Notes indicated the physician was contacted, and the resident was placed on every 15 minute checks. Notes indicated the physician ordered an injection of Depo-Provera (hormone medication), which was administered on 7/17/12.</p> <p>Nurses Notes for 7/19/12 at 5:30 p.m., indicated the resident was having increased sexual behaviors, the physician was contacted, and the resident was discharged to the behavior unit.</p> <p>Nurses Notes for 7/26/12 at 5:00 p.m., indicated the resident was readmitted to the facility. Notes through 8/1/12 at 9:00 p.m., did not indicate behavior issues.</p> <p>Documentation failed to indicate the resident's care plans were updated following the second hospitalization.</p> <p>The next Social Services Note after the second hospitalization was an entry on</p>			

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	<p>8/1/12 and indicated, "Bx Management Note: IDT [interdisciplinary team] reviewed res bx's and care plan. [Symbol for No changes] in res bx's @ this time. IDT will continue to review res bx's &amp; cp [care plans] as needed."</p> <p>The next Social Services Note was 8/3/12 [untimed] and indicated, "DC [discharge] Planning note - SW [social worker] left a message [symbol for with] res daughter [name] to inquire is she had any specific facilities she would like res med rec [medical record] faxed to in an effort to assist [symbol for with] alternate placement for res [resident] d/t [due to] current facility attempting to dc res @ this time. SW spoke [symbol for with] res RE: facility attempting to find alternate placement for res. Res said, "Whatever you wanna do." SW will continue to assist [symbol for with] discharge planning for res as needed."</p> <p>The next Social Services Note was 8/7/12 [untimed] and indicated, "D/C planning note: SW contacted res daughter, [name of daughter] via telephone &amp; discussed finding alternate placement for res. Daughter agreed to transferring res to another facility preferably not further north but closer toward [name of near-by town]. SW will assist res [symbol for with] finding another facility to transfer to</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  08/07/2012
NAME OF PROVIDER OR SUPPLIER  WATERS OF SCOTTSBURG II LLC THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170		
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	<p>as needed. [Name of another local facility] came out to review res &amp; res med [medical] record, will let Waters know if res will be accepted for admission. SW will continue to assist res [symbol for with] discharge plans as needed."</p> <p>During interview on 8/7/12 at 2:55 p.m., the Director of Nursing indicated the Social Services Director should be interviewed related to the resident's behavior care planning. She indicated the Nursing Department was not responsible for the behavior plans.</p> <p>During interview on 8/7/12 at 3:30 p.m., the Social Services Director indicated the resident's behavior plan had not been updated since she started her job on 7/22/12 with the facility, because the resident had had no behaviors since she got here. She indicated, "Corporate met on Friday," and Resident C was placed on one to one supervision. She indicated she had talked with the family about better environment for Resident C at another facility. She indicated the resident had resided at another long term care facility before coming to this facility.</p> <p>This federal tag relates to Complaint IN00113000.</p> <p>3.1-35(a)</p>				

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