STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155238	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF YORKTOWN THE	2000 S ANDREWS RD YORKTOWN, IN 47396

(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
F0000	This visit was for the Investigation of Complaint #IN00123434. Complaint #IN00123434-Substantiated. Federal deficiencies related to the allegation are cited at F157 and F323. Survey dates: 2/5-2/6/13 Facility number: 000143 Provider number: 155238 AIM number: 100283890 Survey team: Shelley Reed, RN Census bed type: SNF/NF 84 Total: 84 Census payor type: Medicare: 8 Medicaid: 61 Other: 15 Total: 84 Sample: 6 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2	F0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions 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.	

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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F0157 SS=D	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). 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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on interview and record review, the facility failed to notify a resident's physician related to an accident for 1 of 3 residents reviewed for accidents. (Resident A).	F0157	It is the intent of this facility to notify the physician and family and or legal representative of all accidents and incidents. 1. All accidents and incidents have been and will continue to be	02/26/2013

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	Findings include: The clinical record of Resident A was reviewed from 2/5/13 thru 2/6/13. The clinical record indicated Resident A had diagnoses that included, but were not limited to; diabetes mellitus, chronic obstructive pulmonary disease, rehabilitation, hypertension, right above the knee amputation and protein malnutrition. During an interview on 2/6/13 at 8:50 a.m., Resident A indicated his care was really good in the facility, but hoped to return home soon. He indicated he recently fell while in the therapy room. He indicated he was wearing his new prosthetic leg during therapy and was walking between the parallel bars with the assistance from the representatives of the therapy company when he fell. He indicated his back hurt a little bit, but his back was hurting prior to the fall. Resident A voiced no other concerns related to the fall. During record review on 2/6/13 at 10:15 a.m., the Minimum Data Set assessment (MDS), dated 1/2/13, indicated Resident A scored a 15 of 15 for the Brief Interview Mental Status (BIMS). A BIMS score of 15		reviewed in daily clinical meeting Monday through Friday for physician and family and or legal representative notifications by DON/designee. In-services were conducted on 2/6/13 pertaining to notification of physician and family and or legal representative. 2._ Accidents and Incidents that have occurred between the dates of 2/4/13 through 2/17/13 were audited for physician and family and or legal representative notifications. 3._ Nurses will mark on the 24 hour report in regards to, accidents and incidents, that the physician and family and or legal representative was notified. Each accident and incident report along with the medical record, will be brought to daily clinical meeting Monday through Friday and reviewed by DON/designee, to validate that notification of physician and family and or legal representative has occurred. 4._ a. DON/designee during daily clinical meeting Monday through Friday will review and audit every accident and incident, chart, and 24 hour reports to assure that physician and family and or legal representative have been notified for compliance. b. DON/designee will review trends pertaining to notification of Accident and Incident reports weekly for 4 weeks, then monthly for three months, and then quarterly thereafter with the Medical Director. 5. This plan of	

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	indicated the resident was cognitively intact. During an interview on 2/6/13 at 8:55 a.m., the Health Facility Administrator, Director of Nursing, and Physical Therapy Assistant #5 indicated Resident A did fall in the therapy room on 1/31/13. The DoN indicated 2 employees from Prevail Prosthetics were assisting Resident A between the parallel bars when his right prosthetic knee buckled while pivoting. The DoN indicated PTA #2 was also in the therapy room during the fall. The DoN indicated PTA #2 took Resident A back to his room and reported to LPN #1 that the resident fell while in the therapy room. The DoN indicated LPN #1 failed to follow facility policy and did not report the fall to the DoN or HFA. She indicated LPN #1 also failed to notify the physician or POA for Resident A. During an interview on 2/6/13 at 9:55 a.m., LPN #1 indicated she was told Resident A fell during therapy on 1/31/13. She indicated she did a full assessment of Resident A on 1/31/13. She indicated Resident A had full range of motion, denied any pain and no redness or swelling was		correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 2/26/13.	

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	noted. She indicated she did not report the fall to the DoN or HFA. During an interview on 2/6/13 at 11:40 a.m., PTA #2 indicated Resident A did fall in the therapy room on 1/31/13. She indicated he was between the parallel bars with his new prosthetic leg and while he was turning, his right knee buckled and he was lowered to the ground with assistance from the prosthetic company representatives. She indicated the resident did have a gait belt on at the time of the fall. She indicated she was on the outside of the parallel bars because there was not enough room on the inside of the bars. She indicated he denied any pain after the fall. She indicated she took the resident back to his room and reported to LPN #1 that he fell while in therapy room. Review of a current facility policy, dated 11/05, titled "Incident Documentation and Investigation," which was provided by the Director of Nursing on 2/6/13 at 11:20 a.m., indicated the following; "Procedure: 1. Completing the Incident Documentation and Investigation Form:			

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	a. The Charge Nurse at the time of the resident care incident is responsible for conducting an investigation of the circumstances surrounding the incident, and for notifying the Director of Nursing and/ or Administrator. b. The Charge Nurse at the time of the incident is responsible to complete the Incident Documentation and Investigation Tool (example attached), ensuring that all items identified on that form have been completed as applicable to the incident. c. The Charge Nurse at the time of the incident is responsible for documenting the incident in the resident's medical record...tool. 2. Notifications...Medical Record. a. The Charge Nurse shall put the resident on the 24 Hour Report, documenting the incident, and notify the Director of Nursing for follow through as needed. 5. any contacts made or attempted with the resident's physician, family, legal representative...care."			

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	During an interview on 2/6/13 at 2:00 p.m., the ADoN indicated LPN #1 did not complete the Incident Documentation and Investigation Tool, chart the incident into his medical record or place the resident on the 24 Hour Report at the time of the incident. No additional documentation was provided. This Federal tag relates to Complaint #IN00123434. 3.1-5(a)(1)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on interview and record review, the facility failed to ensure a resident was provided with the necessary care following a fall for 1 of 3 residents who were reviewed for accidents. (Resident A) Findings include: The clinical record of Resident A was reviewed from 2/5/13 thru 2/6/13. The clinical record indicated Resident A had diagnoses that included, but were not limited to; diabetes mellitus, chronic obstructive pulmonary disease, rehabilitation, hypertension, right above the knee amputation and protein malnutrition. During an interview on 2/6/13 at 8:50 a.m., Resident A indicated his care was really good in the facility, but hoped to return home soon. He indicated he recently fell while in the therapy room. He indicated he was wearing his new prosthetic leg during therapy and was walking between the parallel bars with the assistance from	F0323	It is the intent of this facility to ensure that a resident receives necessary care following an accident. 1.Nurses and therapy staff were in serviced on 2/6/13 and educated on what constitutes an accident and the steps to take after the incident occurs. 2.During the nursing and therapy in services:staff members were asked to identify or report any other possible accidents that may have occurred and were not reported.24 hour reports from 2/4/13 through 2/17/13 were reviewed for any other possible occurrences that were not reported per policy. No other residents were identified at this time. 3.Nurses were in serviced on 2/6/13 and educated on the need to complete an Accident and Incident form for all occurrences.Nurses were educated that they are to report the accident and incident to the DON/ designee. Nurses were educated when therapy reports an incident, they are to go to the resident and complete a head-to-toe assessment immediately. Nurses and therapy staff were educated on what constitutes a fall. Therapy was	02/26/2013

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	the representatives from the prosthetic company when he fell. He indicated his back hurt a little bit, but his back was hurting prior to the fall. Resident A voiced no other concerns related to the fall. During record review, on 2/6/13 at 10:15 a.m., the Minimum Data Set assessment (MDS), dated 1/2/13, indicated Resident A scored a 15 of 15 for the Brief Interview Mental Status (BIMS). A BIMS score of 15 indicated the resident was cognitively intact. During an interview on 2/6/13 at 8:55 a.m., the Health Facility Administrator, Director of Nursing and Physical Therapy Assistant #5 indicated Resident A did fall in the therapy room on 1/31/13. The DoN indicated 2 employees from the prosthetics company were assisting Resident A between the parallel bars when his right prosthetic knee buckled while pivoting. The DoN indicated PTA #2 was also in the therapy room during the fall. The DoN indicated PTA #2 took Resident A back to his room and reported to LPN #1 the resident fell while in the therapy room. The DoN indicated LPN #1 failed to follow		instructed that in addition to notifying the resident's nurse immediately they needed to inform the DON/designee when an incident occurs. 4. a.DON/designee will monitor 24 hour sheets daily during clinical meeting Monday through Friday to identify any possible incidents that have not been reported and processed correctly for compliance. b. DON/designee will review trends pertaining to notification of Accident and Incident reports weekly for 4 weeks, then monthly for three months, and then quarterly thereafter with the Medical Director. 5.This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 2/26/13.	

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	facility policy and did not report the fall to the DoN or HFA. She indicated LPN #1 also failed to notify the physician or POA for Resident A. During an interview on 2/6/13 at 9:55 a.m., LPN #1 indicated she was told Resident A fell during therapy on 1/31/13. She indicated she did a full assessment on Resident A on 1/31/13. She indicated Resident A had full range of motion, denied any pain and no redness or swelling was noted. No additional documentation was provided related to assessment, vital signs or monitoring for pain. She indicated she did not report the fall to the DoN or HFA. During an interview on 2/6/13 at 11:40 a.m., PTA #2 indicated Resident A did fall in the therapy room on 1/31/13. She indicated he was between the parallel bars with his new prosthetic leg and while he was turning, his right knee buckled and he was lowered to the ground with assistance from the prosthetic company representatives. She indicated the resident did have a gait belt on at the time of the fall. She indicated she was on the outside of the parallel bars because there was not enough room on the inside of the bars. She indicated he denied any			

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	pain after the fall. She indicated she took the resident back to his room and reported to LPN #1 that he fell while in therapy room. Review of a current care plan, updated 2/6/13, provided by the DoN on 2/6/13 at 11:20 a.m., indicated no changes were made to Resident A's care plan prior to 2/6/13. A care plan, dated 2/6/13, indicated the following; "therapy to have a therapist / or PTA in parallel bars with resident and prosthetist when training with prosthetic." Review of a current facility policy, dated 11/05, titled "Incident Documentation and Investigation," which was provided by the Director of Nursing on 2/6/13 at 11:20 a.m., indicated the following; "Procedure: 1. Completing the Incident Documentation and Investigation Form: a. The Charge Nurse at the time of the resident care incident is responsible for conducting an investigation of the circumstances surrounding the incident, and for notifying the Director of Nursing and/ or Administrator.			

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	b. The Charge Nurse at the time of the incident is responsible to complete the Incident Documentation and Investigation Tool (example attached), ensuring that all items identified on that form have been completed as applicable to the incident. c. The Charge Nurse at the time of the incident is responsible for documenting the incident in the resident's medical record...tool. a. The Charge Nurse shall put the resident on the 24 Hour Report, documenting the incident, and notify the Director of Nursing for follow through as needed. 2. A thorough assessment of the resident's condition at the time of the incident (this assessment should include a description of the resident's vital signs and other physical characteristics apparent as a result of the incident.) During an interview on 2/6/13 at 2:00 p.m., the ADoN indicated LPN #1 did not complete the Incident Documentation and Investigation Tool, chart the incident into his medical record or place the resident			

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	on the 24 Hour Report at the time of the incident. No additional documentation was provided. This Federal tag relates to Complaint #IN00123434. 3.1-45(a)(2)			