

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
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NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
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F000000	<p>This visit was for the Investigation of Complaints IN00152292, IN00151165, and IN00152141.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaints IN00149714 and IN00149804 completed on June 5, 2014.</p> <p>This visit was in conjunction with a PSR to the Recertification and Sate Licensure Survey completed on June 13, 2014.</p> <p>Complaint IN00152292-Substantiated. Federal/state deficiencies related to the allegations are cited at F225 and F226.</p> <p>Complaint IN00151165-Substantiated. Federal/state deficiencies related to the allegations are cited at F353, F465 and F469.</p> <p>Complaint IN00152141-Substantiated. Federal/state deficiencies related to the allegations are cited at F279, F353, F465 and F469.</p> <p>Survey Dates: July 16, 17, 18, 21 & 22, 2014</p> <p>Facility number: 000478 Provider number: 155494</p>	F000000	Preparationand/or execution of this plan of correction in general, or this correctiveaction in particular, does not constitute an admission of agreement by thisfacility of the facts alleged or conclusions set forth in this statement ofdeficiencies. The plan of correction andspecific corrective actions are prepared and/or executed in compliance withState and Federal Laws.	

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

TITLE

(X6) DATE

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

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	<p>AIM number: 100290430</p> <p>Survey team: Gwen Pumphrey, RN-TC Gloria Reisert, MSW (July 17, 21 & 22, 2014) Jennifer Sartell, RN (July 21 & 22, 2014)</p> <p>Census Bed type: SNF/NF: 74 Total: 74</p> <p>Census payor type: Medicare: 10 Medicaid: 60 Other: 4 Total: 74</p> <p>Sample: 9</p> <p>These deficiencies reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on July 30, 2014, by Brenda Meredith, R.N.</p>				

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must</p>			

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	<p>be taken.</p> <p>Based on record review and interview, the facility failed to ensure allegations of physical abuse were thoroughly investigated for 1 of 3 residents reviewed for abuse. (Resident B)</p> <p>Findings include:</p> <p>Resident B's clinical record was reviewed on 7/21/14 at 9:27a.m. The resident had diagnoses, including but not limited to, schizophrenia, dementia, depressive disorder, and muscle weakness. Resident B was in discharged from the facility on 6/11/14.</p> <p>On 7/17/14 at 11:37a.m., a request for investigations related to the reportable's to ISDH were reviewed. An initial report dated 7/6/14 alleged Resident B was a victim of sexual abuse by a male staff while residing in the facility. The initial report indicated the director of nursing (DoN), local police, adult protective services (APS), and physician was notified. The report indicated an investigation was initiated.</p> <p>The follow up report to ISDH dated 7/7/14 indicated the investigation of the allegation included the social worker interviewing the resident, resident's family, and caregiver. The APS</p>	F000225	<p><u>F225-Investigate/Report Allegations/Individuals</u></p> <p><u>It is the practice of this facility to ensure that all allegations of abuse, neglect, or mistreatment are reported immediately to the administrator, thoroughly investigated and documented per facility policy, and notification and proof of notification to all other officials and agencies in accordance with state law.</u></p> <p><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p><u>The details of the investigation have been re-submitted to Adult Protective Services, as well as to the Scottsburg Police department. Confirmation of receipt from these outside agencies has been maintained with the original investigation.</u></p> <p><u>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</u></p> <p>Through review of all reportable allegations in 2014, no other residents were affected by the same alleged deficient practice.</p> <p><u>What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?</u></p> <p>To ensure the notifications are received by the appropriate</p>	08/21/2014	

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	<p>representative was also interviewed as well as all alert and oriented residents in the facility. The report indicated the resident's recount of the event changed multiple times, and the resident's family declined any further investigation. The report also indicated the facility would provide a complete investigation to APS and requested a well check visit by APS for the resident.</p> <p>The report lacked documentation of details of dates, times of interviews, residents interviewed, staff interviewed, or staff suspended pending investigation.</p> <p>On 7/21/14 at 10:42a.m., the Social Services Director (SSD) was interviewed. She indicated when conducting an investigation of an allegation of abuse between a staff person and a resident, the resident should be protected. She indicated the staff involved would be removed from facility until the investigation is complete. She also indicated she would interview the resident and any residents on the unit and nursing would interview other staff for the investigation.</p> <p>When asked how the facility concluded the allegation involving Resident B was unsubstantiated she indicated, "her description of the staff kept changing and</p>		<p>authorities, proof of their submission will be taken to the administrator's office for appropriate filing the next business day. If these notifications are missing the next business day, the administrator or designee will physically collect the notification confirmations from staff, or re-send the information to the appropriate agencies. Future investigations will be comprised of, but not limited to the following: A minimum of 5 staff members interviewed, with dates, times, and signatures. If possible, these statements will be handwritten, signed and dated by each employee. This sample of staff is contingent on how many staff have firsthand knowledge of the alleged event. A minimum of 5 interviewable residents will be sampled, if feasible, with documentation to include each resident's quoted verbiage, date, and time of the interview. This sample of residents is contingent on how many of them have firsthand knowledge of the alleged event. All interview questions will refer to residents and staff by numbers, or letters, to protect the privacy of any and all those involved. Specific names will not be mentioned while conducting the investigation and interviews.</p> <p><i>How the corrective action(s)</i></p>				

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	<p>we didn't have any staff who matched her description. The caregiver indicated the resident had not slept in over 2 weeks and she was not taking her medication. When we spoke to the resident's family, they indicated that Resident B was blowing the thing out of proportion and did not want to investigate it further." When asked which residents and staff were interviewed the SSD indicated, " we spoke to her roommate and asked if the Resident B had ever told her she had been raped."</p> <p>When asked about documentation of interviews conducted in the facility the SSD indicated, "I know I submitted a statement,when I spoke to her (Resident B) and some of the staff submitted statements from talking to the (Resident B's family). I would have to look for the statements from the residents I interviewed."</p> <p>On 7/21/14 at 11:04a.m., the DoN was interviewed. She indicated the facility did not have much information from the resident or the resident's family. She indicated, "I initiated the investigation but I had to have the nurse consultant finished the investigation because I was out sick. When the nurse consultant spoke to Resident B's family and they were informed that we were going to call</p>		<p><i>willbe monitored to ensure the deficient practice will not recur, i.e. what qualityassurance program will be put into place?</i></p> <p>Theadministrator or designee will complete a Reportable Checklist the day aftereach reportable occurrence to ensure that no steps have been missed in theinvestigation process, and that no one's privacy has been compromised. The administrator or designee will completeany actions omitted, or any additional actions needed to ensure the safety andprivacy of all staff and residents. Further, this will also ensure that the investigation of the allegedevent is investigated to the fullest extent possible. These results will be maintained with thedocumentation of the reportable occurrence. Theadministrator will conduct weekly reportable occurrence audits to ensure allapplicable regulations and requirements have been met, and document receipt ofall information sent to outside agencies. Thesemeasures will be reviewed and adjusted accordingly based on monthly andquarterly QA meetings.</p>		

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	<p>the police and APS, they wanted to drop the allegation. I know the SSD spoke with several residents." A second request was made for the details of the investigation. She indicated, "I don't know I would think the [administrator] had that."</p> <p>On 7/21/14 at 11:18a.m., the Administrator was interviewed. He indicated, " We interviewed Resident B's roommate and she stated she had no concerns. We interviewed a few other residents. The destitution of the staff member given we had no one here that matched that description. We interviewed male staff and other staff." He then provided an additional file related to the investigation.</p> <p>The file had the following information: -faxed verification of APS notification -hand written notification to the physician with no evidence of faxed receipt -hand written notification to the local police department with no evidence of faxed receipt -Copy of a time sheet for April 2014 through May 2014 for one male staff -hand written checklist of notes and names -hand written statement from the social services director indicating she spoke to</p>						

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	<p>the resident B's roommate and tablemate's in the cafeteria.</p> <p>-typed statement from staff who was initially notified of the allegation</p> <p>-typed statement from staff who spoke to Resident B's caregiver</p> <p>-Resident B's diagnosis list, nurses notes while in the facility, and care plan</p> <p>On 7/21/14 at 12:06p.m. the administrator provided a copy of a document titled, "Midnight Census" dated 7/7/14. He indicated this document included the resident interviews related to the investigation. On the front page was a list of the residents in the facility on 7/7/14. On the back of the page the following was hand written: "[Resident]-no mention of abuse while here just wanted to go home-prior rmate [roommate] [Resident] and [Resident]-prior tablemates-never mentioned anything to them. usually very quiet and kept to self.</p> <p>On 7/22/14 at 10:30a.m., the DoN provided a copy of 3 staff statements. The statements indicated LPN #1 never entered Resident B's room without RN#2. The statements were dated 7/6/14.</p> <p>On 7/22/14 at 5:00p.m., the Administrator indicated he does not know why the staff statements were not</p>			

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	<p>included with the initial investigation.</p> <p>On 7/22/14 at 5:15p.m., the DoN indicated the staff statements were on her home computer and that is the reason why it was not included with her investigation.</p> <p>On 7/21/14 at 2:40p.m., the APS representative was interviewed. She indicated the facility "sent me the same thing they fax to the state." When asked did she receive any other investigation related to the allegation she indicated no.</p> <p>On 7/22/14 at 1:30p.m., the local police department was contacted. A copy of the police report was unavailable. The officer indicated they have no record of the allegation in question. The officer stated, "I know we get faxes from them [the facility] all the time, usually for small things like someone hitting somebody but something like that we would have investigated. I don't want to say they didn't fax it to us, I just don't have any record of it in the system."</p> <p>A copy of the policy titled, "Abuse Prevention Program" was provided by the DoN on 7/22/14 at 10:07a.m. The policy indicated, ..."The investigator will submit a final report of the conclusion of the investigation in writing within 5 working</p>			

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F000226 SS=D	<p>days of the incident. The final investigation report shall contain the following: the original allegation(note day, time, location, the specific allegation, by whom, witnesses's to the occurrence, circumstances surrounding the occurrence and any noted injuries; facts determined during the process of the investigation, review of medical record and interview of witnesses; conclusion of the investigation based on known facts; if there is a police report, attach the police report; attach a summary of all interviews conducted...."</p> <p>This Federal tag relates to Complaint IN00152292.</p> <p>3.1-28 (d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview the facility failed to implement their policy and procedure related to investigation of</p>	F000226	<p><u>F226-Develop/Implement Abuse/Neglect, Etc. Policies -</u> It is the policy of this facility to develop and implement written</p>	08/21/2014			

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	<p>abuse allegations. This deficient practice affected 1 of 3 residents reviewed for abuse. (Resident B).</p> <p>Findings include:</p> <p>Resident B's clinical record was reviewed on 7/21/14 at 9:27a.m. The resident had diagnoses, including but not limited to, schizophrenia, dementia, depressive disorder, and muscle weakness. Resident B was in discharged from the facility on 6/11/14.</p> <p>On 7/17/14 at 11:37a.m., a request for investigations related to the reportable's to ISDH were reviewed. An initial report dated 7/6/14 alleged Resident B was a victim of sexual abuse by a male staff while residing in the facility. The initial report indicated the director of nursing (DoN), local police, adult protective services (APS), and physician was notified. The report indicated an investigation was initiated.</p> <p>The follow up report to ISDH dated 7/7/14 indicated the investigation of the allegation included the social worker interviewing the resident, resident's family, and caregiver. The APS representative was also interviewed as well as all alert and oriented residents in the facility. The report indicated the</p>		<p>policies and procedures that prohibit mistreatment, neglect, abuse, and misappropriation of resident's property. Further, it is the policy of this facility to fully document the times, dates, and details of any interviews conducted during the course of investigation of any of the above alleged occurrences, and to suspend any staff that could have potentially been involved in the alleged abusive action. Finally, this facility takes all steps to maintain the utmost privacy possible while conducting investigations and interviews that stem from abuse allegations. <i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i> The details of the investigation have been re-submitted to Adult Protective Services, as well as to the Scottsburg Police department. Confirmation of receipt from these outside agencies has been maintained with the original investigation. <i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i> Through review of all reportable allegations in 2014, no other residents were affected by the same alleged deficient practice. <i>What measures or what systemic changes will be made to</i></p>		

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	<p>resident's recount of the event changed multiple times, and the resident's family declined any further investigation. The report also indicated the facility would provide a complete investigation to APS and requested a well check visit by APS for the resident.</p> <p>The report lacked documentation of details of dates, times of interviews, residents interviewed, staff interviewed, or staff suspended pending investigation.</p> <p>On 7/21/14 at 10:42a.m., the Social Services Director (SSD) was interviewed. She indicated when conducting an investigation of an allegation of abuse between a staff person and a resident, the resident should be protected. She indicated the staff involved would be removed from facility until the investigation is complete. She also indicated she would interview the resident and any residents on the unit and nursing would interview other staff for the investigation.</p> <p>When asked how the facility concluded the allegation involving Resident B was unsubstantiated she indicated, "her description of the staff kept changing and we didn't have any staff who matched her description. The caregiver indicated the resident had not slept in over 2 weeks and</p>		<p><i>ensure that the deficient practice does notreoccur?</i></p> <p>Toensure the notifications are received by the appropriate authorities, proof oftheir submission will be taken to the administrator's office for appropriatefiling the next business day. If thesenotifications are missing the next business day, the administrator or designee willphysically collect the notification confirmations from staff, or re-send theinformation to the appropriate agencies. Futureinvestigations will be comprised of, but not limited to the following: Aminimum of 5 staff members interviewed, with dates, times, and signatures. If possible, these statements will be handwritten, signed and dated by each employee. This sample of staff is contingent on how many staff have firsthandknowledge of the alleged event. Aminimum of 5 interviewable residents will be sampled, if feasible, withdocumentation to include each resident's quoted verbiage, date, and time of theinterview. This sample of residents iscontingent on how many of them have firsthand knowledge of the alleged event. All interviewquestions will refer to residents and staff by numbers, or letters, to protectthe privacy of any and all those involved. Specific names will not</p>	

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	<p>she was not taking her medication. When we spoke to the resident's family, they indicated that Resident B was blowing the thing out of proportion and did not want to investigate it further." When asked which residents and staff were interviewed the SSD indicated, " we spoke to her roommate and asked if the Resident B had ever told her she had been raped."</p> <p>On 7/21/14 at 11:04a.m., the DoN was interviewed. She indicated the facility did not have much information from the resident or the resident's family. She indicated, "I initiated the investigation but I had to have the nurse consultant finished the investigation because I was out sick. When the nurse consultant spoke to Resident B's family and they were informed that we were going to call the police and APS, they wanted to drop the allegation. I know the SSD spoke with several residents." A second request was made for the details of the investigation. She indicated, "I don't know I would think the [administrator] had that."</p> <p>On 7/21/14 at 12:06p.m. the administrator provided a copy of a document titled, "Midnight Census" dated 7/7/14. He indicated this document included the resident interviews related to</p>		<p>be mentioned while conducting the investigation and interviews.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</i></p> <p>The administrator or designee will complete a Reportable Checklist the day after each reportable occurrence to ensure that no steps have been missed in the investigation process, and that no one's privacy has been compromised. The administrator or designee will complete any actions omitted, or any additional actions needed to ensure the safety and privacy of all staff and residents. Further, this will also ensure that the investigation of the alleged event is investigated to the fullest extent possible. These results will be maintained with the documentation of the reportable occurrence.</p> <p>The administrator will conduct weekly reportable occurrence audits to ensure all applicable regulations and requirements have been met, and document receipt of all information sent to outside agencies.</p> <p>These measures will be reviewed and adjusted accordingly based on monthly and quarterly QA meetings.</p>				

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	<p>the investigation. On the front page was a list of the residents in the facility on 7/7/14. On the back of the page the following was hand written:</p> <p>"[Resident]-no mention of abuse while here just wanted to go home-prior rmate [roommate]</p> <p>[Resident] and [Resident]-prior tablemates-never mentioned anything to them. usually very quiet and kept to self.</p> <p>On 7/21/14 at 2:40p.m., the APS representative was interviewed. She indicated the facility "sent me the same thing they fax to the state." When asked did she receive any other investigation related to the allegation she indicated no.</p> <p>On 7/22/14 at 1:30p.m., the local police department was contacted. A copy of the police report was unavailable. The officer indicated they have no record of the allegation in question. The officer stated, "I know we get faxes from them [the facility] all the time, usually for small things like someone hitting somebody but something like that we would have investigated. I don't want to say they didn't fax it to us, I just don't have any record of it in the system."</p> <p>A copy of the policy titled, "Abuse Prevention Program" was provided by the DoN on 7/22/14 at 10:07a.m. The policy</p>			

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F000279 SS=D	<p>indicated, ..."The investigator will submit a final report of the conclusion of the investigation in writing within 5 working days of the incident. The final investigation report shall contain the following: the original allegation(note day, time, location, the specific allegation, by whom, witnesses's to the occurrence, circumstances surrounding the occurrence and any noted injuries; facts determined during the process of the investigation, review of medical record and interview of witnesses; conclusion of the investigation based on known facts; if there is a police report, attach the police report; attach a summary of all interviews conducted..., "The investigator shall do as much as possible to protect the identities of any employee and residents involved in the investigation."</p> <p>The Federal Tag relates to Complaint IN00152292.</p> <p>3.1-28(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes</p>			

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	<p>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 record review and interview, the facility failed to develop care plans which addressed care of a resident's surgical wounds to leg and non-compliance with dressing changes and keeping legs wrapped. This deficient practice affected 1 of 2 residents reviewed for surgical wounds. (Resident #C).</p> <p>Findings included:</p> <p>Review of the clinical record for Resident #C on 7/17/14 at 12:35 p.m., indicated the resident had had 2 re-admissions from the hospital on 6/30/14 and 7/12/14 due to vascular wounds on legs which required surgical intervention. Diagnoses included, but were not limited to Left femoral/popiteal bypass, diabetes mellitus and dementia.</p>	F000279	<p><u>F279-Develop Comprehensive Care Plans</u></p> <p>It is the policy of this facility to be constantly and consistently utilizing the results of our assessments to develop, review and revise each resident's individual care needs, so that their plan of care can be adjusted accordingly to promote the highest functional status possible.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #3 had his care plan immediately corrected and updated to reflect and address this resident's non-compliance with his wound treatments and staple placement.</p> <p>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</p>	08/21/2014

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	<p>Hospital records indicated the resident was sent to the hospital on 6/19/14 for a Left femoral/popiteal bypass surgery due to worsening vascular wounds and returned on 7/12/14.</p> <p>The records also indicated the resident again was sent to the hospital on 7/8/14 due to an infection in his groin surgical site and subsequently returned back to the facility on 7/12/14.</p> <p>Nursing and Social Service Notes between 6/30/14 and 7/17/14 indicated the following entries:</p> <p>- "7/1/14 7:37 a.m. - upon entering room to give resident his HS [evening] meds, observed resident picking at legs and removing dressing. There were dressings thrown on the floor by resident, staples in left LE [lower extremity] were however intact...Applied new dressings to cover staples only to have observed resident removing it shortly afterwards."</p> <p>- "7/5/14 3:08 a.m. - ...Staples intact to left surgical area is red with swelling noted and some drainage noted. Resident does pick at areas and surgical incision."</p> <p>- "7/5/14 1:18 p.m. - ...Res [Resident] cont [continues] to pick at staple area as well as other leg.."</p>		<p>Anyresident receiving a surgical procedure outside of the facility has thepotential to be affected. A 100% auditwas performed of all surgical wound patients. No other resident was found to be affected by this deficientpractice.</p> <p>Allresidents receiving a surgical procedure outside of the facility will havetheir orders reviewed and new orders updated by the charge nurse re-admittingthe resident. The IDT and clinical teamwill review the discharge orders, in addition to the admission record enteredby the charge nurse to ensure all careplans are updated and as accurate as possible based on review of their surgicalassessment 5 times per week.</p> <p>Whatmeasures or what systemic changes will be made to ensure that the deficientpractice does not reoccur?</p> <p>The DONwill ensure that these results are tracked, monitored and maintained wheneverthere is an outside procedure performed through review in weekly skinmeetings.</p> <p>The DONwill review these results weekly with the IDT team, as well as theadministrator to ensure all care plans are up to date.</p> <p>How thecorrective action(s) will be monitored to ensure the deficient practice willnot recur, i.e. what quality assurance program will be put into place?</p> <p>The DONwill review these results</p>	

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	<p>- "7/5/14 5:54 p.m. - resident pulled drsg [dressing] off of left leg where staples are from surgery. Res picked at staple area to the left upper thigh, area had a steady stream of blood coming from area. Leg was re-wrapped..."</p> <p>- "7/7/14 10:16 a.m. - ...resident has been having behaviors and picking at legs and refusing to elevate them."</p> <p>- "7/14/14 2:19 a.m. - Attempted to do skin assessment resident refused kept yelling to leave him alone. resident had all his bandages off and had picked areas on his legs open."</p> <p>- "7/14/14 2:30 a.m. - Resident pulled off dressings picking at skin..."</p> <p>- "7/14/14 2:06 p.m.- ...Cont to pick at skin, dsg [dressing] intact at this time..."</p> <p>- "7/15/14 10:28 a.m. - Psych [psychiatric] eval [evaluation] 7/14/14 new orders to increase klonopin [an anti-anxiety medication] due to anxiety and picking at skin. care plan and log updated."</p> <p>- "7/17/14 4:40 a.m. - Resident is NPO [nothing by mouth] due to fem pop [femoral popiteal] in a.m., dressings changed x 2 resident keeps picking and</p>		<p>weekly with the IDT team, as well as the administrator to ensure all care plans are up to date and any concerns or complications are immediately addressed. The administrator will monitor this along with the IDT team, and will audit results monthly. The results of these audits will be submitted to the monthly and quarterly QA & A committee for further review and reassessment for further ongoing monitoring.</p>				

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	<p>pulling them off..."</p> <p>Review of the current care plans as presented by the Medical Records Clerk on 7/21/14 at 2:00 p.m. included an Interdisciplinary care plan for at risk for increased anxiousness related to anxiety and picks skin dated 5/7/14. A 7/15/14 additional approach to reflect the new order for Klonopin was listed, but the care plan failed to address the resident's picking at his skin, and especially at his surgical incisions and refusal to keep legs bandaged.</p> <p>A care plan which addressed the resident's new surgical sites and care related to these wounds was also lacking.</p> <p>During an interview with the MDS (Minimum Data Set) Coordinator on 7/22/14 at 10:30 a.m. indicated that some issues with residents, such as new wounds should be care planned right away.</p> <p>On 7/22/14 at 11:00 a.m., the Director of Nursing presented a copy of the facility's current policy titled "Care Plans". Review of this policy at this time included, but was not limited to: "Guidelines: It is the intent pf the facility that each resident will have a plan of care to identify problems, needs and strengths that will</p>						

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F000353 SS=F	<p>identify how the interdisciplinary team will provide care. Responsibility: All members of the interdisciplinary team. Coordinated by the MDS Coordinator...Procedure:...3. The Initial Care Plan will be completed as soon as possible after admission...."</p> <p>This Federal tag relates to Complaint IN00152141.</p> <p>3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of</p>			

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	<p>this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview and record review, the facility failed to ensure sufficient nursing staff were on duty to provide nursing care to residents. This deficient practice affected 4 of 6 sampled residents reviewed for sufficient nursing staffing. (Resident D, E, F, and G)</p> <p>Findings include:</p> <p>On 7/17/14 at 8:15 a.m., Resident D was observed laying in the middle of the hall way fully clothed. There was no staff available to assist Resident D.</p> <p>On 7/21/14 at 12:31p.m. Resident D was observed rolling on the floor out of her room into the hallway. Resident D was dressed in a shirt and was naked from the waist down. Resident D was tangled in stained sheet. Resident D said "Help me, Help me" repeatedly. There was no staff available on the unit to assist Resident D.</p> <p>On 7/21/14 at 8:30a.m., a resident was observed urinating in the doorway of a closet in room 140. Upon notifying the CNA #5, she indicated that as soon as</p>	F000353	<p>F353- <u>Nursing Services – Sufficient Staffing -</u> <u>The Facility must have sufficient staffing to providenursing and related services to attain or maintain the highest practicablephysical, mental and psychosocial well-being of each resident, as determined byresident assessments and individual plans of care.</u> <u>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?</u> <u>It is the policy of this facility to provide the servicesrequired to provide the utmost functionality for our residents. The facility will continually recruit staffin an effort to have the personnel available to meet whatever resident needsare presented.</u> <u>A recruiting and retention committee comprised of facilitystaff formed and began monthly meetings.</u> <u>The administrator and regional nursing consultant haveconducted multiple interviews with staff, residents and families to determinewhere to focus new efforts and staff.</u> <u>Resident smoking responsibilities have been delegated out,so that</u></p>	08/21/2014

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

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	<p>that we are supposed to. It is difficult to watch residents with behaviors and do all your other care. Some times shaving, showers and 2 hour checks are not getting done because its not enough time. You do incontinence care and making sure they are clean and dry and that's about all you can do.</p> <p>Employee #2: We are short but not too bad today. We were short last week and the State knew it. If we don't get to all the showers we are supposed to do today, then we make sure to do them the next day with the other people due a shower. We try to do showers, incontinence care and making sure the resident is clean and dry. Its hard to get everything done."</p> <p>Employee #3: I have worked by myself before and there is always supposed to be 2 staff on this unit. On days when I work by myself I don't get a lunch. The nurse will try to help if we are short but they have their own tasks to do to.</p> <p>Employee #4: When we have to watch the meals, sometimes the residents get upset when their medications are not given exactly when they want them, they are not late but we aren't able to honor their choices.</p> <p>Employee #5: When we are short, they</p>		<p><u>Our Weekend Manager On Duty tasks have been altered until staffing stabilizes. The adjustments double management's presence on the weekends, giving extra hands to assist.</u></p> <p><u>Help wanted advertising will continue until the staffing needs are met.</u></p> <p><u>Resident council will be attended by the administrator monthly, by invitation, to get feedback from the residents first hand. This will also give leadership the opportunity to communicate the improvements that are currently being completed.</u></p> <p><u>A Family Night has been scheduled, with invitations mailed, to give families the opportunity to express concerns and get communication about physical plant and care improvements. This will also give families an opportunity to help direct where they feel attention is needed to better care for their loved ones. Family Night will be held quarterly moving forward, unless the attendance and concerns dictate a change in frequency.</u></p> <p><u>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</u></p> <p><u>All residents could be affected by the same alleged deficient practice.</u></p> <p><u>A recruiting and retention</u></p>	

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	<p>will pull an aide from another unit. When we have 2 aides and the activity assistant, I feel this is when we have optimal staffing on this unit.</p> <p>On 7/22/14 at 10:29a.m., the document titled, "Resident Council Report Communication" dated 7/9/14 was reviewed. The report indicated, "still having issues of untimeliness with aides." The response dated 7/11/14 indicated, "staff reinserviced, please let management know right away when this happens so we can address the specific staff and issue."</p> <p>This Federal tag relates to Complaint IN00151165 and Complaint IN00152141.</p> <p>3.1-17(a)</p>		<p><u>committee comprised of facility staff formed and began monthly meetings.</u></p> <p><u>The administrator and regional nursing consultant have conducted multiple interviews with staff, residents and families to determine where to focus new efforts and staff.</u></p> <p><u>Resident smoking responsibilities have been delegated out, so that the bulk of the labor and time is provided by department heads, or activity staff. This should allow for more focused nursing care without multiple interruptions daily to take residents out to smoke.</u></p> <p><u>An increased nursing budget has been approved and implemented. This will be reviewed based on resident need thereafter.</u></p> <p><u>An increased nursing and housekeeping pay scale has been approved and implemented. This will be reviewed based on resident need thereafter.</u></p> <p><u>We have offered a \$500.00 sign-on bonus for all nursing staff. This information was posted online, as well as in print locally. This will be reviewed based on resident need thereafter.</u></p> <p><u>We have implemented a staff referral bonus for referring nursing staff of \$400.00.</u></p> <p><u>We have begun to sponsor CNA classes offsite. We have 8 students on our payroll that will begin class on 8/11/2014, with a tentative completion date of 9/1/2014. We will also be paying</u></p>		

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

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

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on record review, observation and interviews, the facility failed to ensure a clean and functional environment was maintained for residents on 4 of 4 halls and 1 of 1 Main Dining rooms in that dead flies were on windowsills and in light coverings, chandelier and fluorescent light bulbs were missing and/or burned out; flooring and resident bedside mats had food and stains on them, light coverings were cracked/dirty, and door frames to resident rooms were marred with chipped paint. (Sapphire Stream, Onyx, Emerald Brook and Ruby</p>	F000465	<p><u>scheduled, with invitations mailed to give families the opportunity to express concerns and get communication about physical plant and care improvements. This will also give families an opportunity to help direct where they feel attention is needed to better care for their loved ones. Family Night will be held quarterly moving forward, unless the attendance and concerns dictate a greater frequency. These measures will be reviewed and adjusted accordingly based on monthly and quarterly QA meetings.</u></p> <p><u>465-Safe/Functional/Comfortable Environment</u> It is the policy of this facility to provide the safest, most comfortable, functional, homelike environment possible. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The flooring in room 115 was cleaned. The food observed from breakfast on the floor of room 111 was swept up and disposed of. All light bulbs have been replaced by the maintenance supervisor.</p>	08/21/2014

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	<p>Bay).</p> <p>Findings included:</p> <p>1. During a tour of the halls on 7/17/14, the following was observed between 8:10 a.m. and 9:30 a.m.:</p> <ul style="list-style-type: none"> - The mat on the right side of Resident #A's bed in Room 126 was observed to have numerous dried yellow and white splatters on it. - The floor in Room 115 was observed to have multiple brown and red dried spots on it. - The floor in Room 111 was observed to have multiple pieces of brown food-like chunks on the floor underneath the overbed table where the resident was sitting in his wheelchair. - Lounge on Ruby Bay - the room appeared very dark with little lighting. Upon observation, 2 of 2 chandeliers had missing and/or burned out light bulbs - 1 had only 1 of 8 lit bulbs; the other only had 2 of 8 light bulbs. In an interview with Activities #2 at this time, she indicated the room was going to be turned into a mini theater but agreed that the room was very dark. A resident deemed alert and oriented by Activities #2, was observed in the room trying to 		<p>While replacing light bulbs, the maintenancedirector also cleaned the fixtures. These are to be inspected weekly moving forward. 10 of 10resident room door frames on Ruby hall were either sanded down, resurfaced andscheduled to be replaced by 2/1/2015. 1of 1 linen closet door frames was repaired. 1 of 1 old dining room door frame repaired. 4ceiling tiles leading into Onyx hall were replaced. All stained ceiling tiles that could not becleaned appropriately were replaced.</p> <p>The 2hoyer lifts mentioned at the end of Sapphire Hall were cleaned and storedappropriately. Newscale was purchased to replace the worn and dirty scale. Rooms146, 148, 150, and 151 on Onyx hall were in the process of having their calllights replaced. This project wascompleted, and all wires were back in place once the new call lights wereinstalled. The covebase outside of rooms 137 and 138 was installed. Thebutter packet was picked up and disposed of in room 113. Alloverhead fluorescent ceiling lights on Emerald Brook were replaced with newfixtures. Alloverhead fluorescent ceiling lights on Ruby Bay were replaced with newfixtures. Allwindow sills are checked daily to ensure no dead insects are found. ResidentA and resident #41 had their bedside mats deep cleaned.</p>	

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	<p>read his bible. She indicated the resident came into this room every day after breakfast to read and that other residents came in to watch tv. She was unable to account for how long the bulbs in the chandeliers had been missing or burned out.</p> <p>- Ruby Bay hall - 10 of 10 resident room door frames to the hall, 1 of 1 linen closet door frames and 1 of 1 to the locked old dining room door had marred and chipped paint door frames extending up half way from the floor.</p> <p>- 4 ceiling tiles to the left corner of the hall entrance to Onyx hall were observed to be bulging with brown stains and were cracking. 2 ceiling tiles between the nursing station and the entrance to Onxy hall had brown stains on them - 1 was the size of a serving plate and was by the light and the 3 others surrounding this tile had multiple brown stains ranging in dime size to quarter size.</p> <p>2. During random observations on 7/17/14 between 11:15 a.m. and 1:25 p.m., the following was observed:</p> <p>- At the end of Sapphire hall, the weight scale's entire frame had a heavy accumulation of black/brown dirt on it; the black mat at the base had several worn areas which exposed the frame</p>		<p>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>All window sills were immediately checked and cleaned.</p> <p>All light bulbs have been replaced by the maintenance supervisor. While replacing light bulbs, the maintenance director also cleaned the fixtures.</p> <p>What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>A new housekeeping supervisor was recruited and hired.</p> <p>A new, increased housekeeping budget was implemented, and staff has been hired to fill these extra shifts.</p> <p>We have had outside housekeeping department heads conducting orientation for the new housekeeping supervisor and their staff. This includes, but is not limited to: A deep cleaning schedule, a regular cleaning schedule, daily cleanliness checklist, and cleanliness standards.</p> <p>New housekeeping team receiving ongoing, thorough in service training.</p> <p>The main dining hall flooring was replaced.</p> <p>Quote to repair the drywall throughout the facility have been</p>	

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	<p>beneath; the mat was also heavily soiled with dirt particles. 2 of 2 hoyer lifts also located here had a moderate accumulation of dust and brown spots on the metal frame.</p> <p>- The Main Dining Room floor had numerous black scuff marks and appeared dirty and dull.</p> <p>- Room 111 - floor remained the same as previously observed at 8:30 a.m.</p> <p>3. During an environmental observation on 7/21/14 between 8:50 a.m. and 10:00 a.m., the following was observed:</p> <p>- Rooms 146, 148, 150 and 151 on Onyx hall was observed to have the hall cover and call light system wires hanging down from the wall. Several residents were observed wandering around - these residents on the unit were identified by the Administrator on 7/22/14 at 4:00 p.m. as being confused.</p> <p>During an interview with the Director of Maintenance at 11:40 a.m., he indicated that he had run out of screws and had to go buy some more before he could hang up and secure the call lights hanging out from the wall.</p> <p>- the weight scale and 2 hoyer lifts previously identified on 7/17/14 at 11:15</p>		<p>secured, and we have atentative completion date of 10/1/2014. GuardianAngel rounds. These rounds/audits areconducted 5 times per week, and reviewed 5 times per week by the management team, and theadministrator. Thus, any negativeobservations can be addressed.</p> <p>How thecorrective action(s) will be monitored to ensure the deficient practice willnot recur, i.e. what quality assurance program will be put into place?</p> <p>Sanitation/Cleanlinessrounds/aud its will be conducted by the New Housekeeping Supervisor 5 days aweek for 4 weeks, then 3 days per week for 4 weeks, then weeklythereafter. The results of theseinspections will be provided to the administrator daily, and audited a minimumof one time weekly.</p> <p>Theadministrator or designee will monitor these audits. The results of these audits will be submittedto the monthly and quarterly QA & A committee for further review andreassessment for further ongoing monitoring.</p>		

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	<p>a.m. remained with the same dirt and worn places.</p> <ul style="list-style-type: none"> - The hall cove baseboard was missing outside Rooms 137 and 138. - Room 113 - a butter packet was on the floor by the resident's wheelchair. - Emerald Brook hall: the last 3 ceiling lights at the end of the hall were missing a light bulb and/or had dead bugs inside and were cracked with brown splatters on them. - Ruby Bay hall - the ceiling light cover at the entrance had a 6 inch crack in it with dead bugs inside. The first light cover upon entering the unit had a 4 inch crack in it with multiple areas of chipping plaster around it. This same crack was again observed on 7/22/14 at 4:15 p.m. during the environmental tour with the Administrator and the Director of Maintenance. The next 8 ceiling light covers had cracks and dead bugs in them. The 8th light was burned out. The 10th light was missing the bulbs and the light cover. - During an observation on 7/21/14 at 2:10 p.m., the covering to Resident #41's bedside floor mat had multiple brownish spots on it ranging from 1/2 dollar size to 			

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F000469 SS=F	<p>dime size. Area surrounding the spots had a moisture appearance. Room 130 was observed to have dead flies on the window sill. These same flies were again observed at 4:10 p.m. on 7/22/14 during the environmental tour with the Administrator and the Director of Maintenance.</p> <p>This Federal tag relates to Complaint IN00151165 and Complaint IN00152141.</p> <p>3.1-19(f)</p> <p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. Based on record review, observation and interviews, the facility failed to maintain an effective pest control program on 2 of 4 halls, 1 of 1 Main Dining room, and 6 of 51 resident rooms in that flies were observed on residents' bodies, linens and tables and flying around the facility during 3 of 5 survey days. (Onyx and Sapphire Stream halls and Rooms 111, 113, 115, 119, 126 and 130)</p>	F000469	<p>F469-Maintains Effective Pest Control Program It is the policy of this facility to maintain an environment that is free and clear of pests and insects. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A new Pest Control company has been contracted as our vendor for</p>	08/21/2014

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	<p>Findings included:</p> <p>1. During lunch meal observation on 7/16/14 between 11:50 a.m. and 12:30 p.m., the following was observed:</p> <ul style="list-style-type: none"> - 11:55 a.m. - a fly was observed flying around the man dining room tables while residents were in the dining room. - 12:27 p.m. - 1 fly was observed flying around the Sapphire Stream hall. <p>2. During the medication pass observation on 7/17/14 between 8:15 a.m. and 9:30 a.m., the following was observed:</p> <ul style="list-style-type: none"> - 8:22 a.m. - several flies were observed in the dayroom either flying around or sitting on the furniture. - 8:46 a.m. - 2 flies were observed in Room 119 - on the bedside table and 1 on the overbed table. - 9:04 a.m. - 1 fly was observed flying around Emerald Brooks hall and 5 flies were observed in Room 111 on the resident's pillow, bedding and his body. <p>3. During tour on 7/17/14 between 8:10 a.m. and 9:30 a.m., the following was observed:</p> <ul style="list-style-type: none"> - 8:10 a.m. -Resident #A was observed in 		<p>our pest and insectremediation and control.</p> <p>NewVendor made initial visit with treatment for flies specifically, on 7/25/2014.</p> <p>9 Flylights have been placed throughout the facility in strategic areas.</p> <p>An aircurtain and a mesh screen were added to the highest traffic door as well as amesh screen added to the service entrance.</p> <p>How will other residents having the potential to be affected by the same deficientpractice will be identified and what corrective actions will be taken?</p> <p>Allresidents could be affected by the alleged deficient practice.</p> <p>A newPest Control company has been contracted as our vendor for our pest and insectremediation and control.</p> <p>Newvendor made initial visit with treatment for flies, specifically, on 7/25/2014.</p> <p>9 Flylights have been placed throughout the facility in strategic areas.</p> <p>An aircurtain and a mesh screen was added to the highest traffic door as well as amesh screen added to the service entrance.</p> <p>Whatmeasures or what systemic changes will be made to ensure that the deficientpractice does not reoccur?</p> <p>A newPest Control company has been contracted as our vendor for our pest control.</p> <p>Pestcontrol reports will be generated from each vendor</p>	

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	<p>bed in his room #126 swiping at a fly. He was also observed to have 2 fly swatters on his bed with 2 additional flies observed flying around him. In an interview with the resident at this time, he indicated that the flies were always in his room bothering him keeping him awake, especially at night and that was why he had a fly swatter.</p> <p>An interview with CNA #1 at 8:20 a.m. indicated that she did not think the flies were too bad.</p> <p>- 8:25 a.m. - observation of Room 115 indicated 3 flies were observed in this room - 1 sitting on a resident's pillow on the overbed table and 2 others flying around landing off and on on the resident's bed and curtains. No resident was observed in Bed 1 at this time.</p> <p>In an interview with the Administrator at 8:50 a.m., he indicated that no flies or other bug issues were seen when the pest control company came in for their visit in April and May. Review of the Pest Control logs for April, May and June 2014 confirmed no issues had been noted.</p> <p>- 9:25 a.m. - 1 fly was observed sitting on Bed 2 in Room 130. In an interview with Resident #B at this time, he indicated the</p>		<p>service call. Those reports will be reviewed by the Maintenance Supervisor and any and all vendor recommendations will be discussed with the Administrator. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Monthly service calls will be made by New Pest Control vendor for the first 3 months. Ongoing, they will then make their service calls on a quarterly or as-needed basis. Pest control service call reports will be provided to the administrator following each visit. All results of the Pest Control reports will be taken to the monthly and Quarterly QA meeting for review and reassessment for further ongoing monitoring.</p>				

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	<p>flies have been an issue for awhile, especially over the past weekend and even before that. He indicated that in the last couple of days, they had not been too much of a problem, but the there was one fly who continued to pest him, especially when he was eating.</p> <p>- 9:30 a.m. - 1 fly was observed sitting on the soiled linen barrel outside of Room 113. Observation inside the room noted 1 fly sitting on the resident's blanket while he was up in his wheelchair that continued to fly back and forth on him. He indicated there were flies in his room.</p> <p>In an interview with CNA #5 on 7/17/14 at 11:35 a.m., she indicated that she had seen the residents on Sapphire Stream hall shoo the flies the most and were especially more prevalent during meal times.</p> <p>In an interview with Activities #1 at 11:45 a.m., she indicated that there had been flies in the building occasionally.</p> <p>4. During a meal observation on 7/17/14 between 11:50 a.m. and 12:35 p.m., the following was observed: - 11:55 a.m. - Room 111 - 2 flies were observed on the overbed table where the resident was sitting at. These flies were observed to fly and then land on the</p>			

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	<p>resident every time he moved.</p> <p>- Main Dining Room: 12:00 p.m. - 2 flies were observed on the resident's table (3 residents observed at this table) and 1 was sitting on the resident's bib on the table.</p> <p>- 12:10 p.m. - after a staff member placed a tray on this table for a resident, the 2 flies flew up and returned to land back onto the bib and another resident's shoulder.</p> <p>- 12:15 p.m. - 1 fly was observed to be flying back and forth landing on a resident who sat in front of an overbed table by the door. The fly landed not only on the blanket around the resident's shoulders but also on his food until the resident went to take a bite.</p> <p>- 2:20 p.m - 1 fly observed on Room 111's resident's back while up in wheelchair. Whenever the resident moved, the fly would also but then re-land back onto the resident's body.</p> <p>Review of the resident Council Minutes from January 2014 to July 2014 indicated that on 7/9/14, the residents voiced concerns about flies and gnats in residents' room. The Director of Nursing and the Administrative Assistant were documented to have been present at this meeting also.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
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NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
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	<p>On 7/9/14, the Housekeeping Director responded to the Resident Council concern by indicated the fly and gnat problem had been taken care of the previous week by spraying. She also indicated that fly curtains will be installed 7/14/14.</p> <p>Review of the follow-up concern forms indicated the Resident Council concerns had been reported to the Department Heads by the Director of Nursing on 7/9/14 and the Morning QA (Quality Assurance) stand up meeting on 7/11/14 for a finalized plan of action.</p> <p>In an interview with the Administrator on 7/22/14 at 9:53 a.m., he indicated the new fluorescent bug lights and the fly curtain had been ordered on 6/6/14 and were received on 6/10/14. Review of the invoices provided by the Administrator at this time confirmed the order and when received.</p> <p>During an interview with the Administrator on 7/22/14 at 6:20 p.m. during the final exit meeting, he indicated that the curtains were never installed as previously planned on 7/14/14 as other things took priority.</p> <p>This Federal tag relates to Complaint</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IN00151165 and Complaint IN00152141. 3.1-19(f)(4)				