STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING 00 B. WING	02/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, THE	1350 N TODD DR SCOTTSBURG, IN 47170

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 25, 26, 27, 28, 29, and February 1, 2016 Facility number: 000478 Provider number: 155494 AIM number: 100290430 Census bed type: SNF/NF: 82 Total: 82 Census payor type: Medicare: 09 Medicaid: 68 Other: 05 Total: 82 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. QR completed by 34849 on February 03, 2016.	F 0000	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. **The facility respectfully requests paper compliance for this citation**	

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

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F 0323 SS=D Bldg. 00	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 record review and interview, the facility failed to ensure residents who sustained multiple falls had a root cause analysis assessment completed to determine root causative factors for 1 of 3 residents reviewed for falls. (Resident #86) Findings include: The clinical record for Resident #86 was reviewed on 1/29/16 at 11:30 a.m. Diagnoses included, but were not limited to, wedge compression fracture of lumbar verterbra, abnormality of gait and mobility and lack of coordination. Review of the Nurses Notes dated between 11/5/15 and 11/7/15 indicated the following entries were documented: - "11/5/15 at 20:45 (8:45 p.m.) - Also notified DON (Director of Nursing) of res (resident) fall and res made 1:1 for the rest of the night. Neurochecks started and WNL (Within Normal Limits), continues to be restless and in pain, c/o (complains	F 0323	F-323 It is the policy of the facility to ensure that the resident environment remains as free of accident hazards as possible. This includes providing proper supervision as well as any needed assistive devices. Resident # 86 has and will continue to have a root cause analysis completed after any fall he might sustain to determine what caused the fall and what measures/interventions need to be put in place in an effort to prevent a future fall. All residents have the potential to be affected by this finding as all residents have some degree of fall potential. The DON/Designee will see that all falls are reviewed at the next CQI meeting following the fall. The CQI meetings are held daily on week days. At that time, the IDT (Inter-Disciplinary-Team) will discuss the fall. The DON/Designee will log the fall onto the QA Falls Compliance Audit Tool. This tool calls for the following: ·Resident Name H. Root Cause Analysis	02/05/2016

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	of) back brace pain. Tramadol (a pain medication) given with HS (nightly) meds. Made 1:1 for safety. Has bruising all around both orbital areas with 0.5 cm (centimeter) laceration to nose with swelling and bruising . Skin tear 1.5 cm to left hand and 3.5 x (by) 3.5 bruise to left thigh and abrasion to left knee. 2 - 0.5 cm skin tears to right inner knee and abrasion to right outer knee." - "11/6/15 at 08:42 (8:42 a.m.) - DON also notified of fall. Resident assisted back to bed, environmental stimuli decreased, room cool for resident comfort and soothing rub til (until) resident dozed off." -"11/6/15 at 09:03 (9:03 a.m.) - DON notified of second fall." On 1/29/16 at 2:50 p.m., the Assistant Director of Nursing (ADON) presented copies of 3 Incident Reports on falls the resident sustained on 11/5/15. These Incident Reports also had a notation on them which indicated they were not part of the actual clinical record. Incident Report #1 was completed on 11/5/15 at 19:20 (7:20 p.m.) with a revision date of 11/6/15 at 23:50 (11:50 p.m.). The resident was found on the floor on the side of the bed and was		·Resident Rm. Number I. Rule Out Abuse ·Assessment J. Determine If Reportable ·Neuro-checks (if applicable) K. IDT Note ·Notifications L. Interventions ·Risk Management Report M. Care Planning ·Investigation N. CNA Information Updated The charge nurse on duty will notify the DON/Designee immediately after each fall as soon as the resident is safe, secure and stable. The DON/Designee will give direction to the notifying nurse as far as how to proceed with any needed further assessment, notifications, care planning and documentation. The DON/Designee may request that the resident be sent to the hospital based on the information reported by the nurse on duty. If possible, the root cause of the fall will be determined at this time. In some cases, further review, investigation, lab work or other activity may be required to determine the root cause. The information gathered at the time of the fall will be part of the discussion by the IDT team as they review the fall at the next scheduled CQI meeting to ensure that needed follow up takes place. Any resident who falls	

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	unable to elaborate what happened. The nurse indicated the reason he fell was because he was unaware of his surroundings. No injuries were noted. Incident Report #2 was completed on 11/5/15 at 19:30 (7:30 p.m.) with a revision date of 11/6/15 at 08:37 (8:37 a.m.). The nurse heard a thud and found the resident crawling on the floor between the beds with heads towards the door and was unable to elaborate what happened. The resident also appeared anxious and unable to follow directions. No injuries were noted. Incident Report #3 was completed on 11/5/15 at 20:20 (8:20 p.m.) with a revision date of 11/6/15 at 01:58 (1:58 a.m.). Nurse was called to the room by the CNA (Certified Nursing Assistant) and resident found on floor between the beds with his head towards the door and feet towards the window. Was observed crawling/rolling around the floor and nearly pulled the bedside table over on himself but nurse was able to catch it. He was unable to elaborate what had happened. The nurse determined the reason the resident fell was because of anxiousness, pain, unsteady gait and unaware of his own safety. The resident had also sustained bruising to right knee, a laceration to the back of the left hand		more than once in any given week will have that information reported to the facility's Nurse Consultant for further review and recommendations. The DON/Designee will monitor all falls to be certain that all necessary action is taken as listed on the QA Falls Compliance Audit Tool. This will also include input and documentation by the IDT team. All falls will have the root cause defined with corrective actions/interventions put into place and care planned. This monitoring will occur daily at the CQI meetings. All falls will be followed until resolution of the root cause is established and follow through takes place. At an inservice held for the nursing staff 02/04/16, the following was reviewed: ·Fall Prevention Guidelines ·Fall Assessment/Risk Factors ·Interventions ·Care plans/CNA assignment information ·What to do immediately "post fall" (Roles of nurse/CNA) ·Assessments/Notifications/Interventions/Care Planning/Documentation ·What is a root cause analysis? ·IDT/CQI (Roles in the Falls Process) ·QA Falls Compliance Audit Tool ·Questions/Answers Any staff who fail to comply with the points of the inservice will be	

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	and a facial laceration. An 11/5/15 Quarterly MDS (Minimum Data Set) assessment determined the resident was a limited assist of one for locomotion on/off unit, ambulation, bed mobility, and transfers. During an interview with the DON on 1/29/16 at 1:20 p.m., he indicated he was unaware of what happened with Resident #86 on 11/5/15 and how or when the resident sustained all the bruising and how many falls the resident actually had. During an interview with LPN (Licensed Practical Nurse) #2 on 1/29/16 at 1:35 p.m., he indicated recently the nurses have had to start doing root cause analysis whenever nursing completed an incident report and implemented an intervention, but this was not started until long after Resident #86 had left the facility. Documentation could not be located in the resident's clinical record of the Interdisciplinary team having assessed the resident after the falls to determine a root cause analysis as to why the resident had sustained multiple falls. On 2/1/16 at 8:36 a.m., the DON presented a copy of the steps to follow		further educated and/or progressively disciplined as indicated. At the monthly QA meetings, the results of the monitoring of the falls by the DON/Designee will be reviewed for any patterns/trends. As necessary, an Action Plan will be written by the committee. Any Action Plans will be monitored weekly by the Administrator until resolution.	

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	when a fall occurred. Review of this policy included, but was not limited to: "Steps to follow when a fall occurs - All staff members should be aware of the steps to take when a resident has a fall. Steps to take when a resident has fallen:...Have an immediate team meeting with current staff members to determine an intervention to prevent further falls..." 3.1-45(a)(1)(2)			
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on record review, observation and interview, the facility failed to prepare and serve food under sanitary conditions in that male employees did not have facial hair fully covered, serving utensils in the clean bin were coated with food debris, and range hood vents and pipes connecting to the fire sprinkler system had greasy, dusty build up hanging from them during 3 of 6 survey days. This deficient practice had the potential to affect 81 of 85 current residents receiving meals from the facility kitchen.	F 0371	F-371 It is the policy of the facility to prepare and serve food under sanitary conditions at all times. Male staff have their facial hair sufficiently covered while working in the department near food. Serving utensils in the clean bin are clean and free of any debris or particles of food residue. The range hood vents and pipes connected to the sprinkler system are clean. Residents who receive meals prepared in the dietary department have the potential to	02/17/2016

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	Findings include: During the initial kitchen tour with the Dietary Manager on 1/25/16 between 9:20 a.m. and 10:00 a.m., the following was observed: 1. The pipes which connected the fire sprinkler system to the range had a moderate amount of gray greasy dust on them. 2. Three scoops in the clean bin had dried food debris on them. 3. The Dietary Manager was observed to have a full bushy beard and side burns and a short moustache - although most of the beard in the front was covered, the bushy sideburns and moustache were not covered by the face mask. 4. Dietary Aide #1 was also observed to have a moustache and small beard - only the chin was covered by the face mask. 5. The vents in the range hood were observed to have a heavy build-up of gray greasy dust on the vent slats. Interview with the Dietary Manager at this time indicated this area was wiped down during general cleaning once a week.		be affected by this finding. The Dietary Manager/Designee will see that the pipes and vents that connect to the sprinkler system are monitored daily and are cleaned 2 x weekly as per the cleaning schedule. Any additional needed cleaning will take place. This monitoring will be ongoing. The Dietary Manger/Designee will check the clean bin is 2 x daily; once in the a.m. and once in the p.m. to ensure that all of the contents are in fact clean. Any concerns will be corrected as found. This monitoring will be ongoing. The Administrator/Designee will monitor 5 days weekly at various times of the day to see that all male staff who work in the dietary department have their facial hair properly covered while in the department. Any facial greater than ¼" in length will be considered as needing to be covered as per policy. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, monitoring will take place 2 days weekly on various shifts. This monitoring will continue for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will continue. Note: Any concerns will be corrected as discovered. At an inservice held for the Dietary Department 02/16/16, the following was reviewed:	

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	During observation of the tray line while accompanied by the Dietary Manager on 1/25/16 at 11:40 a.m., both the Dietary Manager and Dietary Aide #1 were again observed with uncovered facial hair as previously identified at 9:20 a.m. The Dietary Manager was collecting clean plates to give to the cook to serve from and moving throughout the kitchen. The Dietary Aide was observed making peanut and butter jelly sandwiches at this time. During an observation on 1/26/16 at 11:40 a.m., both the Dietary Manager and Cook #1 were observed with only their chin hair covered. Both had their moustaches exposed as well as the sides of the Dietary Manager's bushy beard and sideburns. While speaking with the Activity Director on 2/1/16 at 10:35 a.m. outside the kitchen, Dietary Aide #1 was observed in the kitchen with only his chin hair covered leaving his moustache exposed. He then quickly covered his facial hair upon looking out the kitchen door. During the final kitchen tour and observation of food temperatures accompanied by the Dietary Manager on 2/1/16 between 11:22 a.m. and 11:55		·Cleaning Requirements/Schedules in the Dietary Department ·"Clean" vs "Dirty"----Infection Control in the Dietary Department ·Facial Hair—Requirements for covering in the Dietary Department Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as appropriate. At the monthly Quality Assurance meetings the results of the monitoring of the cleaning in the Dietary Department; contents of the clean bins and covering of facial hair will be reviewed. Any concerns would have been addressed as discovered. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any Action Plans will be monitored by the Administrator weekly until resolved.	

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	a.m., the following as observed: 6. Dietary Aide #1 was observed with only his beard covered - his moustache was exposed. He was observed preparing the bins of drink mixes for the resident hall carts. The Dietary Manager was observed without any facial covering over his bushy beard and sideburns and also his moustache while walking around the kitchen and only covered his beard while taking food temperatures. - upon this observation, both were noted to fix their masks to cover all of their facial hair. 7. Three scoops and 1 ladle were observed in the clean bin with dried food debris on the inside. 8. The range hood vents had a heavy build up of grease and dust on them, especially in the upper and lower edges. Gray cobwebs were observed swinging in the air flow across several of the vents. During an interview with the Dietary Manager at this time, he indicated the vents were wiped down during general cleaning every Tuesday and had been done on 1/26/16. He also indicated that he may have to consider adding a second day during the week to clean the vents. During the exit conference with the			

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	Department Heads on 2/1/16 at 3:50 p.m., the Dietary Manager indicated the moustaches of his Dietary Aide, Cook and himself did not need to be covered as they were shorter than 1/4 of an inch. On 1/26/16 at 1:49 p.m., the Administrator presented a copy of the facility's current policy titled, "Hair Restraints". Review of the policy at this time included, but was not limited to, the following: "Guideline: Hair restraints shall be worn by all Dining Services staff when in food production, dishwashing areas or when serving food items from the steam table. Procedure: 1. Staff shall wear hair restraints in all food production, dishwashing and serving areas. 2. Hair restraints, hats, and/or beard guards shall be used to prevent hair from contacting exposed food. Facial hair is discouraged. Any facial hair that is longer than the eyebrow shall require covering with a beard guard in the production and dishwashing area. 3. All staff members who serve food in a location visible to the residents will be required to have no facial hair or shaven shorter than eye brow length..." 3.1-21(i)(2) 3.1-21(i)(3)			

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