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	08/10/2015

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

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00178732. Complaint IN00178732 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: August 4, 5, 6, 7, and 10, 2015 Facility number: 000478 Provider number: 155494 AIM number: 100290430 Census bed type: SNF/NF: 86 Total: 86 Census payor type: Medicare: 12 Medicaid: 66 Other: 8 Total: 86 Sample: 1 These deficiencies reflect State findings cited in accordance with 410 IAC	F 0000		

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

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	08/10/2015

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

(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
	16.2-3.1.			
F 0157 SS=D Bldg. 00	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.			

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	08/10/2015

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

(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
	Based on interview and record review, the facility failed to notify family/Power of Attorney (POA) of acute onset of edema (swelling), room change, new roommate, and new medication and also failed to notify the physician of medication refusal for 1 of 3 residents (Resident #93), and failed to notify the physician of lab refusals for 2 of 3 residents (Resident #25 and #73) reviewed for notification of changes. Findings include: 1a. The clinical record for Resident #93 was reviewed on 08/07/15 at 9:30 a.m. Diagnoses included, but were not limited to, Asperger's syndrome and dementia. The Minimum Data Set (MDS) quarterly assessment, dated 07/23/15, indicated Resident #93 had a BIMS (Brief Interview of Mental Status) score of 5, which indicated severely impaired cognition. The nurses note, dated 02/27/15 at 8:52 p.m., included the following: "resident [sic] has moderate swelling of bilat [bilateral] hands which is believed to be chronic - I spoke with [Nurse Practitioner name] who states they will evaluate resident when in house [sic] cont [continue] to monitor for issues [sic]".	F 0157	F-157 It is the policy of this facility to inform the resident, the resident's physician and the resident's legal representative when the resident has an accident with injury, a change in their room or roommate or a significant change in condition as per stated criteria. Residents #93, #25 and #73 all have appropriate notifications of any circumstances that meet the criteria for notification of changes. All residents who reside in the facility have the potential to be affected by this finding. A 30 day facility wide "look back" audit was completed to identify any instances that met criteria for notification per regulation. Any identified "changes of condition" that had proper notifications were addressed and notifications were made. At the daily CQI meetings, the "changes of condition" audit tool will be used to log all changes of condition or any changes that meet	09/07/2015

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	08/10/2015

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

(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
	During an interview on 08/10/15 10 10:00 a.m., Licensed Practical Nurse (LPN) #1 indicated new onset of edema would be a significant change and physician and family should be notified. During an interview on 08/10/15 at 10:10 a.m., LPN #7 indicated edema would be a significant change and the physician and family should be notified. The nurses note, dated 02/28/15 at 9:57 a.m., included the following: "bilateral [sic] hands and feet remain edematous [sic] resident chooses to be upright with hands dangling [sic] have been unsuccessful to redirect resident to elevate." As of the date and time of record review, the clinical record lacked family/POA notification regarding Resident #93's edema. 1b. The physician order for Resident #93, dated 05/09/15 at 6:10 p.m., indicated the following: "Haldol [antipsychotic medication used for behaviors] IM [Intramuscularly] 5 mg [milligrams] x [times] 1 [one time only]". The nurses note, dated 05/09/15 at 6:20 p.m., included the following: "new order received at this time. Haldol 5 mg x 1 IM		criteria for notification that have occurred since the previous meeting. The DON/Designee will monitor the audit tool 3 days weekly to see that all changes of condition or instances that require notification have been followed through on. Any discrepancies will be immediately addressed and done and documented. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Then, weekly monitoring will continue for a period of not less than 6 months to ensure ongoing compliance. Afterwards, random monitoring will take place ongoing. At an inservice held 08/20/2015, for nursing staff the following was covered: A. What is the criteria for “notification of change?” (Emphasis on edema, swelling, med/treatment change, lab test refusal, change of room or roommate) B. Who should be notified? When? How? C. Care	

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	08/10/2015

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

(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
	r/t [related to] resident behavior." Resident #93's Medication Administration Record for May 2015 indicated, on 05/09/15 at 6:10 p.m., the resident received Haldol 5 mg, IM x 1 dose related to behaviors. As of the date/time of record review, the clinical record lacked family/POA notification of Resident #93's new order for Haldol. 1c. The nurses note for Resident #93, dated 06/02/15 at 10:18 a.m., included the following: "Informed this am of getting new roommate [sic] he had no commemnt [sic]." The Social Service Note, dated 06/15/15, included, but was not limited to, the following: "...[Resident #93's name] has no recall of incident per my conversation with him 6/11/15 he did agree to & moved into a different room 06/11/15". As of the date/time of record review, the clinical record lacked documentation of physician and family/POA notification regarding the room change and new roommate for Resident #93. 1d. The physician order for Resident #93, dated 06/16/15 and untimed,		Planning D. Follow up E. Documentation Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. At the monthly Quality Assurance meetings, the results of the monitoring will be reviewed. Any patterns will be addressed via an Action Plan written by the committee. The Administrator will monitor the plan weekly until resolution. However, concerns will have been addressed as discovered during the monitoring.	

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	08/10/2015

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

(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
	included, but was not limited to, the following: "...D/C [Discontinue] Haldol 5 mg IM...Give Haldol 5 mg po [by mouth] now...." The clinical record for Resident #93 indicated family/POA was notified of the new medication on 06/17/15, the next day after it was ordered. 1e. The nurses note for Resident #93, dated 07/27/15 at 6:22 a.m., included, but was not limited to, the following: "...TRANSDERM-SC DIS 1.5 [medication for excessive oral secretions]...Apply behind ear topically every 72 hours for secretions...Res [Resident] refused for transdermal patch to be applied x [times] 3 [3 attempts]...." The nurses note, dated 07/30/15 at 6:04 a.m., included, but was not limited to, the following: "TRANSDERM-SC 1.5...Apply to behind ear topically every 72 hours for secretions...Res [resident] refused...." Resident #93's July, 2015 Medication Administration Record indicated the resident refused the Transderm-SC 1.5 patch on 07/27/15 and 07/30/15. As of the date/time of record review, the clinical record lacked family/POA and			

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	08/10/2015

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

(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
	physician notification regarding Resident #93's medication refusal. On 08/10/15 at 1:30 p.m., the Administrator provided a current copy of the document titled, "Family/Responsible Party Notification of Change in Resident Condition", dated 02/28/12. It included, but was not limited to, the following: "...GUIDELINE: It is the intent of the facility to have a family member or responsible party made aware of a change in a resident's condition...CHANGE OF STATUS: Examples of these issues include; change in medical and/or mental status, change in medications and/or dosages, transfer/discharges...." On 08/10/15 at 1:30 p.m., the Administrator provided a current copy of the document titled, "Physician Notification of Resident Change of Condition", dated 02/02/15. It included, but was not limited to, the following: "GUIDELINE: It is the intent of the facility for the attending physician to be notified of a change in a resident's condition...PROCEDURE: 1. Physician notification is to include but is not limited to:...Repeated refusals to take prescribed medication after third refusal...." 2. The clinical record for Resident #25			

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	08/10/2015

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

(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
	was reviewed on 08/06/15 at 10:37 a.m. Diagnoses included, but were not limited to, seizure disorder, metabolic encephalopathy and dementia with mood disorder. The physician order, dated 07/14/15 and untimed, included, but was not limited to, the following: "...TSH in 08/2015...." The document titled,"[name of lab company]", included, but was not limited to, the following: "...Test Name...Refusal (First Attempt)...Notified Nurse...[nurses name]...Lab Will Redraw...08-04-15...Tests Ordered...TSH [Thyroid Stimulating Hormone]...." The document titled,"[name of lab company]", included, but was not limited to, the following: "...Test Name...Refusal (2nd Attempt)...Notified Nurse...[nurses name]...Lab Will Redraw...08-05-15...Tests Ordered...TSH [Thyroid Stimulating Hormone]...." The nurses note, dated 08/03/15 at 3:08 p.m., included the following, "Resident refused lab work today". The nurses note, dated 08/04/15 at 11:22 a.m., included the following, "Resident refused lab work today".			

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	08/10/2015

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

(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
	As of the date and time of record review, the clinical record lacked physician notification regarding Resident #25's lab refusals. 3. The clinical record for Resident #73 was reviewed on 08/07/15 at 9:00 a.m. Diagnosis included, but was not limited to, seizure disorder. The physician order, dated 04/19/15 at 11:45 a.m., included, but was not limited to, the following: "VPA [Valproic Acid] level on 04/29/15...." The document titled,"[name of lab company]", included, but was not limited to, the following: "...Test Name...Refusal (First Attempt)...Notified Nurse...[nurses name]...Lab Will Redraw...04/30...Tests Ordered...VPA [Valproic Acid]...." The document titled,"[name of lab company]", included, but was not limited to, the following: "...Test Name...Refusal (2nd Attempt)...Notified Nurse...[nurses name]...Lab Will Redraw...05/01...Tests Ordered...VPA [Valproic Acid]...." As of the date and time of record review, the clinical record lacked documentation of physician notification regarding Resident #73's lab refusal.			

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	08/10/2015

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

(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
	During an interview on 08/07/15 at 10:00 a.m., the Director of Nursing (DON) indicated the physician should be notified if a lab was not obtained. On 08/07/15 at 9:05 a.m., the DON provided a copy of the document titled, "Lab Scheduling and Tracking", dated 7/1/11. It included, but was not limited to, the following: "GUIDELINE: It is the intent of the facility that all laboratory tests ordered by the physician will be systematically scheduled and traced to ensure that all lab work ordered is obtained and results are received...PROCEDURE...14. Any labs obtained as indicated will be re-scheduled and the physician will be notified...19. If the lab draw was omitted the lab will be contacted to perform the test and the physician will be contacted...." 3.1-5(a)(2) 3.1-5(a)(3) 3.1-5(b)(1)			
F 0244 SS=D Bldg. 00	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed			

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	08/10/2015

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

(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
	policy and operational decisions affecting resident care and life in the facility. Based on observation, record review and interview, the facility failed to respond to and resolve grievances brought forth by the Resident Council in a timely manner for 3 of 7 months of Resident Council Meeting Minutes reviewed. Findings include: On 08/04/15 at 12:45 p.m. and 08/05/15 at 12:27 p.m., lunch was observed to be served in the main dining room. During an interview on 08/04/15 at 12:40 p.m., Resident #68 indicated lunch was always late and "it makes me so mad". On 08/05/15 at 11:45 a.m., with permission from the Resident Council President, the Resident Council minutes for the months of January 2015 through July 2015 were reviewed. The Resident Council Meeting minutes, dated 05/07/15, indicated the residents voiced concern regarding "dietary serving late". The facility's plan of action was to address with department heads. The Resident Council Report Communication, dated 05/07/15, offered no reply regarding dietary serving meals	F 0244	F-244 It is the policy of this facility to respond and act upon any concerns of the residents and/or the Resident Council to the greatest possible level of satisfaction while still operating within the law and the state and federal guidelines for long term care facilities. The meal service in the facility is timely as per scheduled, posted meal times. Meal time service has the potential to affect any resident who receives their meal from the dietary department. Going forward, the Administrator/Designee will monitor meal service for timeliness 5 days weekly at various meals to see that meals are delivered on time per posted schedule. Any meals served late will have the “root cause” defined and addressed immediately with a written plan. The plan will then be monitored by the Administrator/Designee weekly to see that the root cause is not repeated. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards,	09/07/2015

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	08/10/2015

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

(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
	late. Resident Council Meeting minutes, dated 06/04/15, included, but was not limited to, the following: "...Problems identified in last meeting (old business)... Meals serving late... Solutions/Resolutions...Breakfast serving late... New Concerns...Kitchen Running [late][sic] ...Suggested Plan of Action...will address with department heads...." The Resident Council Report Communication, dated 06/04/15, indicated the facility would make a sheet to monitor when meal times were served. The Resident Council Meeting minutes, dated 07/09/15, included, but was not limited to, the following: "...Problems identified in last meeting...Breakfast served late... Solutions/Resolutions...All meals late...." The Resident Council Report Communication, dated 07/09/15, indicated the following: "DM [Dietary Manager] monitoring meal times to track trendiy [sic] [trending]...." During an interview on 08/06/15 at 10:19 a.m., the Dietary Manager, with regards to the Resident Council's concerns with		meal times will be monitored weekly at various times to ensure ongoing compliance. The monitoring will continue ongoing. At an inservice held 08/20/2015, for staff who are involved in meal service, the following was reviewed: A. What are the scheduled meal times? B. Discussion/Trouble shooting possible root causes of what could make meals “late” C. Roles of the dietary staff as related to timely meal service D. Roles of the nursing staff as related to timely meal service E. Roles of the Department Heads as related to timely meal service F. Working together to see that meals are served on time to the residents Any staff who fail to comply with the points of the inservice will have	

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	08/10/2015

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

(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
	meals being served late, indicated "the residents complain about the silliest things". During an interview on 08/10/15 at 11:15 a.m., Resident #112 indicated meals were late quite frequently. On 08/04/15 at 10:50 a.m., the Administrator provided a current copy of the document titled, "Compliment/Grievance/Missing Property", dated 07/01/11. It included, but was not limited to, the following: "GUIDELINE: It is the intent of the facility that all residents have the right to voice concerns...PURPOSE: To provide an opportunity for residents and/or family to present complaints or grievances to the proper authorities at the facility and to receive responses to the issue(s) raised...PROCEDURE:...Resident Complaint Procedure...1. Resident Council Meeting are to allow time for residents to address concerns...Minutes are to reflect the issues and the directions taken...3. Supervisory personnel or Department Managers will make prompt efforts towards resolution and document on the Compliment/Concern Form..." 3.1-3(I)		further education and/or progressively disciplined as indicated. At the monthly QA meetings the results of the monitoring of meal times will be reviewed. Any patterns will be identified. If necessary, an Action Plan will be written by the committee to address. The plan will be monitored weekly by the Administrator until resolved.	

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	08/10/2015

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

(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
F 0247 SS=D Bldg. 00	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review, the facility failed to ensure residents and/or their Power of Attorney was notified in advance of a room change and/or a roommate change for 1 of 1 resident reviewed for resident rights. (Resident #93) Findings include: The clinical record for Resident #93 was reviewed on 08/07/15 at 9:30 a.m. Diagnoses included, but were not limited to, Asperger's syndrome and dementia. The Minimum Data Set (MDS) quarterly assessment, dated 07/23/15, indicated Resident #93 had a BIMS (Brief Interview of Mental Status) score of 5, which indicated severely impaired cognition. The Social Service Note, dated 06/02/15 at 10:18 a.m., included, but was not limited to, the following: "Informed this am of getting new roommate [sic] he had no commemnt [sic]". The Social Service Note, dated 06/15/15, included, but was not limited to, the	F 0247	F-247 It is the policy of the facility to notify a resident and their family or responsible party before a change is made in a room or a roommate. Resident #93 and their POA will be notified of any room or roommate change going forward. Any concerns they might have will be addressed to their satisfaction. Any resident who resides in the facility has the potential to be affected by this finding. Going forward, and as stated in the response to F-157, the resident and other responsible party will be notified of any changes as defined per federal guidelines including change in rooms or roommates. The monitoring, inservicing and QA follow up will be done as stated in the response to F-157 which includes room and/or roommate changes.	09/07/2015

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	08/10/2015

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

(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
	following: "...[resident name] has no recall of incident per my conversation with him 6/11/15 he did agree to & moved into a different room 06/11/15". During an interview on 08/05/15 at 1:50 p.m., the POA (Power of Attorney) indicated she was not notified of a room change regarding Resident #93. During an interview on 08/07/15 at 2:30 p.m., the Social Services Director indicated she notified Resident #93, but could not find documentation of family (POA) notification of the room change. The Administrator provided a copy of the document titled, "Social Services Job Description", on 08/10/15 at 10:59 a.m. It included, but was not limited to, the following: "...B. Role Responsibilities - Administrative Duties & Resident Care...4. Demonstrates responsibility for resident transfers to the following...Inter-Facility Transfer (Room Change)...a) Obtains consent from family or responsible party...." On 08/10/15 at 1:30 p.m., the Administrator provided a current copy of the document titled, "Family/Responsible Party Notification of change in Resident Condition", dated 02/28/12. It included, but was not limited to, the following:			

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	08/10/2015

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

(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
	"...GUIDELINE: It is the intent of the facility to have a family member or responsible party made aware of a change in a resident's condition...CHANGE OF STATUS: Examples of these issues include...transfer/discharges...." 3.1-3(v)(2)			
F 0250 SS=D Bldg. 00	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to provide Social Services follow up on alternate placement for a resident, per family request, for 1 of 1 resident reviewed for discharge planning. (Resident #93) Findings include: The clinical record for Resident #93 was reviewed on 08/07/15 at 9:30 a.m. Diagnoses included, but were not limited to, Asperger's syndrome and dementia. The Social Services Note, dated 03/06/15 at 1:47 p.m., included the following: "Medical records faxed 03/05/15 to [name of healthcare facility] per family	F 0250	F-250 It is the policy of this facility to provide Social Services follow up on alternative placement for a resident when a resident or their (appropriate) family makes this request. The SSD has and is trying to locate placement for Resident #93 closer to the family. SSD will continue the effort until placement is found. The family will continue to be advised of progress. All efforts will be documented. Going forward, the	09/07/2015

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	08/10/2015

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

(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
	request to try & relocate closer placement." As of the date/time of the clinical record review, the clinical record lacked documentation regarding follow up on the family's request for placement closer to home. During an interview on 08/07/15 at 1:40 p.m., the Social Service Director indicated follow up was not done regarding alternate placement per Resident #93's family request. The Social Services Director indicated follow up should have been completed within a week after the request was made. The Administrator provided a copy of the document titled, "Social Services Job Description", on 08/10/15 at 10:59 a.m. It included, but was not limited to, the following: "...POSITION SUMMARY: Responsible for...determining and assessing residents' long range and short range goals for social...emotional...needs...B. Role Responsibilities - Administrative Duties & Resident Care...4. Demonstrates responsibility for resident transfers to the following...Discharge to the Community...b...assists resident and family members/responsible party in preparation of discharge...."		SSD will keep a log of any requests by residents and/or families for a change in placement location. These requests will be presented as received at the daily CQI meetings so that discussion can take place and discharge planning can begin. Each case will be examined on an individual basis and the IDT will offer suggestions (with resident and family involvement) as to why another location would or would not benefit the resident. The resident and POA will ultimately decide on available options after information is shared with them by SSD. SSD will update progress daily at the CQI meetings. Residents who seek alternate placement location have the potential to be affected by this finding. The Administrator/Designee will monitor the SSD Discharge Log 3 days weekly for activity and progress as well as resident and family notifications. Any concerns will be addressed as found. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, weekly monitoring will occur for a period of not less than 6 months to ensure ongoing compliance. Afterwards,	

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	08/10/2015

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

(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
	3.1-34(a)		random monitoring will occur ongoing. At an inservice held 08/20/2015, for SSD staff the necessity of providing discharge planning timely and appropriately was reviewed as well as all parts of the SSD Job Description. Any SSD staff who fails to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings the results of the discharge monitoring log will be reviewed. However, any concerns will have been addressed as found.	
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to administer physician ordered change in medication for 6 weeks and failed to obtain daily weights and blood oxygen levels (O2 SATs) per plan	F 0282	F-282 It is the policy of the facility to provide services by qualified persons in accordance with each resident's plan of care. Resident #58 receives meds as per physician's orders. Further, Resident #58 is weighed as per	09/07/2015

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	08/10/2015

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

(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
	of care for 1 of 1 resident reviewed for dialysis. (Resident #58). The facility also failed to obtain physician ordered labwork for 2 of 3 residents reviewed for laboratory services. (Resident #73 and #109). Findings include: 1a. Review of the clinical record for Resident #58 on 08/06/15 at 11:08 a.m., indicated the resident had diagnoses which included, but were not limited to, hypothyroidism, heart failure, end stage renal disease, chronic obstructive pulmonary disease, and diabetes. On 9/17/14, a care plan was developed for Resident #58 for "Hypothyroidism (slow thyroid)" with approaches that included, but was not limited to: "Meds as ordered." The care plan had been reviewed quarterly and was considered to be a current problem. Based on a 01/22/15 TSH level (lab used to test thyroid level in the body) of 252.449 (normal values = 0.340 - 5.600), a new physician's order was received for Synthroid (a medication for overactive thyroid) to be increased from 12.5 mcg (micrograms) to 100 mcg every day and to repeat the TSH level on 03/06/15. Review of the January, 2015 Medication		order and care plan and has O2 sats done and recorded as per order and care plan. Resident #73 has had a VPA lab level done and will have all ordered labs performed timely as ordered. Resident #109 has had a CBC, CMP and HgA1C done and will have all ordered labs performed timely as ordered. All residents have the potential to be affected by this finding. A 30 day "look back" audit was completed To identify any med orders or lab orders to see that they were properly carried out and care planned as appropriate. Any discrepancies will be addressed as found. Going forward, all orders received will be double checked by the DON/Designee to see that all orders are carried out and followed through on and care planned as appropriate. The review will be part of the daily CQI meetings. The DON/Designee will monitor 10 charts weekly to see that all orders received over the past 30 days Have been implemented and carried out timely and have been care planned as appropriate. Any discrepancies will be addressed and corrected as found. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, 2 charts will be reviewed weekly for not less than a period of 6 months to ensure ongoing compliance. After that, random checks will take place	

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	08/10/2015

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

(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
	Administration Record (MAR) indicated the order was written on 01/22/15 but the medication was only given on 01/28/15. The February, 2015 Monthly Physician orders for Resident #58 indicated the old order of Synthroid 12.5 mcg had been crossed through and marked D/C (discontinued). The February, 2015 MAR was also highlighted with a note to "see new order". Review of the February, 2015 and the March, 2015 MAR's indicated the new order was never documented which caused the medication not to be administered until 03/12/15, causing the resident to go without this medication from 01/28/15 to 03/12/15. On 03/11/15, the Physician visited and noted that the new medication order, written on 01/22/15, was never implemented and the TSH level drawn on 03/09/15 was 257.879 - high. The Physician then wrote the order, again, for the Synthroid to be increased to 100 mcg. The Physician also indicated he spoke to the unit manager who indicated he would address the issue. During an interview with the Unit Manager on 08/10/15 at 9:00 a.m., he indicated it occurred 8 months ago and he couldn't remember what the outcome was or why the medication for Resident #58		ongoing. At an inservice held 08/20/2015, for nurses, the following was reviewed: A. Physician orders-receiving, noting, follow through, notifications, reporting, Documentation, care planning B. 24 Hour Report C. Shift to shift report D. Care Planning Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings the results of the monitoring will be reviewed. Any identified patterns will be addressed via an Action Plan written by the committee. The Administrator will monitor the plan weekly until resolution. Any concerns will have been addressed as found.	

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	08/10/2015

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

(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
	was never ordered as the physician directed. During a second interview with the Unit Manager on 08/10/15 at 9:45 a.m., he indicated that he remembered that he had referred the matter to the Assistant Director of Nursing (ADON) to handle. In an interview with the Director of Nursing (DON) and the ADON on 08/10/15 at 11:15 a.m. the DON indicated he thought the TSH level was lower and coming down, but then remembered the Unit Manager had come to him and said something about the TSH level but he did not realize a medication had been missing. The ADON indicated she would have to research the record as she didn't remember anything about the incident. During a second interview with the ADON on 08/10/15 at 11:44 a.m., she indicated that in looking into the incident, they discovered that because the nurse who did the February re-write (reconciliation of medication orders) had already been terminated from employment, no further paperwork was completed. She also indicated she did not think a medication error report had been completed because the nurse was already gone and could not sign it.			

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	08/10/2015

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

(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
	1b. On 09/17/14, a care plan was developed for Resident #58 for "DX (diagnosis): ESRD (end stage renal disease)". Approaches included, but were not limited to: "Daily weights." The care plan was reviewed quarterly and remained as a current problem. Review of the Treatment Administration Records (TAR) between January and March 2015, indicated weights were missing on the following dates: - January 1st through the 12th, 16th, 19th, and 31st - February: no weights recorded - March: no weights recorded On 04/24/15, a clarification order was obtained for "Daily weight - record on TAR (Treatment Administration Record)." Review of the Treatment Administration Records (TAR) between April and July 2015, indicated weights were missing on the following dates: - May: 3rd, 11th and 31st - June: 6th, 8th and 9th 1c. On 09/17/14, Resident #58's care plan was developed for: "Risk for SOA (shortness of air) due to dx COPD and Emphysema, Obstructive Sleep apnea".			

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	08/10/2015

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

(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
	Approaches included, but were not limited to: "Vital signs as indicated". This care plan was reviewed quarterly and remained as a current problem. On 5/28/15, a new order was received to monitor O2 SATS (blood oxygen level) every shift and record on TAR related to chronic obstructive pulmonary disease (COPD). The May and June 2015 TAR's indicated the O2 SATs had not been checked on the following dates: - May: 5/28 - 5/31 - June: 6/16 - 6/20, 6/22, 6/23, 6/26 - 6/30 - July: 7/24 - 7/28 During an interview with the Director of Nursing (DON) on 8/7/15 at 10:55 a.m., he indicated the daily weights and O2 SATs were considered nursing measures and not physician orders, so it may not always have to be obtained. In an interview with the Corporate Nurse Consultant on 8/7/15 at 11:00 a.m., she indicated that if nursing measures were listed as approaches on the resident care plans, then those vital signs should have been obtained as written. 2. The clinical record for Resident #73 was reviewed on 8/6/15 at 9:40 a.m. Diagnosis included, but was not limited to, seizure disorder.			

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	08/10/2015

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

(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

The physician order, dated 6/18/15 at 3:20 p.m., included, but was not limited to, the following: "...VPA [valproic acid] [medication used to treat seizures] level in am [morning]...."

The clinical record for Resident #73 lacked a VPA level lab for 6/9/15.

During an interview on 8/7/15 at 11:16 a.m., the DON (Director of Nursing) indicated he could not find where the physician order was followed through.
3. On 08/07/15 at 10:04 a.m., Resident # 109's clinical record was reviewed. Diagnoses included but were not limited to, Diabetes Mellitus (DM), Atrial Fibrillation (A-Fib), chronic airway obstruction, anemia, renal failure, Congestive Heart Failure (CHF), and hypertension. The MDS (Minimum Data Set) assessment for Resident #109 indicated a BIMS (Brief Interview of Mental Status) score of 11; mild cognitive impairment.

On 08/10/15 at 9:53 a.m., the review of the Physician's Orders, dated 07/22/15, indicated an order was written to obtain a CBC (complete blood count), CMP (comprehensive metabolic profile), and HgA1C (blood glucose level) on 07/27/15. The lab results could not be

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	08/10/2015

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

(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
	found by the ADON. The resident's clinical record lacked documentation of the labs being completed as of the time of record review on 08/10/2015. During an interview on 08/10/15 at 10:04 a.m., the DON indicated the labwork was never done. On 8/7/15 at 9:05 a.m., the DON provided a copy of the document titled, "Lab Scheduling and Tracking", dated 7/1/11. It included, but was not limited to, the following: "GUIDELINE: It is the intent of the facility that all laboratory tests ordered by the physician will be systematically scheduled...." 3.1-35(g)(2)			
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 interview and record review, the facility failed to determine the root cause analysis of a fall in order to provide	F 0323	F-323	09/07/2015

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	08/10/2015

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

(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
	effective interventions for 1 of 3 residents reviewed for accidents. (Resident #25) Findings include: The clinical record for Resident #25 was reviewed on 08/06/15 at 10:37 a.m. Diagnoses included, but were not limited to, seizure disorder, metabolic encephalopathy and dementia with mood disorder. The Minimum Data Set (MDS) assessment, dated 06/13/15, indicated Resident #25 required an assist of 2 staff persons with ambulation. The nurses note, dated 07/27/15 at 7:30 a.m., included, but was not limited to, the following: "Was notified by cna [sic] [Certified Nursing Assistant] that resident was at the end of sapphire hall when she heard a [sic] alarming noise and upon looking noticed resident was laying in [sic] [on] floor on right side. Resident stated that his legs gave out and he couldn't [sic] stand any longer...." The Incident Report, dated 07/27/15 at 7:30 a.m., included, but was not limited to, the following: "Incident Description...Was notified by cna [sic] [Certified Nursing Assistant] that resident was at the end of sapphire hall when she heard a [sic] alarming noise and upon looking noticed resident was		It is the policy of the facility to determine the root cause of falls in an effort to implement interventions to prevent further falls. Resident #25's fall on 7/27/15 has been revisited by the IDT and a root cause has been determined and documented. Intervention(s) have been implemented to address the root cause finding. Any resident who resides in the facility has the potential to be affected by this finding. All falls will continue to be reviewed daily at the CQI meetings. All falls will be added to the Falls Compliance Log and the IDT will discuss the root cause. Based on the root cause, appropriate interventions will be rolled out and care planned. The DON/Designee will monitor the Falls Compliance Log 3 days weekly to see that all falls are addressed thoroughly including any needed investigations, notifications, education, reporting, root cause, interventions, care planning, follow up and documentation. Any concerns will be addressed as found. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Then the monitoring will continue weekly	

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	08/10/2015

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

(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
	laying in [sic] [on] floor on right side. Resident stated that his legs gave out and he couldn't [sic] stand any longer...Mental Status...Oriented to Person...Confused/Disoriented...Mobility: Ambulatory without staff assistance...Predisposing Physiological Factors...Incontinent...Gait Imbalance...Impaired Memory...Weakness/Fainted...Impulsive...Decreased Strength/Endurance...Decreased Safety Awareness...Predisposing Situation Factors...Using Walker...." The Fall Risk Assessment, dated 07/27/15 at 7:30 a.m., included, but was not limited to, the following: "...Reason for Assessment Request...1) Recent Falls...1a. Level of consciousness/Mental Status...Intermittent Confusion...2. Ambulation/Elimination Status...2. Chair Bound - requires restraints and/or assistance w [with]/elimination...4. Visual Status...2. Poor [with or without glasses]...5. Gait Balance...5d. Decreased muscular coordination...5g. Requires use of assistive devices...." During an interview on 08/06/15 at 11:30 a.m., the DON (Director of Nursing) indicated, when a resident had a fall, the first thing determined was the root cause analysis. The DON indicated the root		for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur. Note: Adding falls to the Falls Compliance Log will be part of the daily CQI meetings. This will be ongoing. At an inservice held 08/20/2015, for nursing staff the following was reviewed; A. Falls Program-Policy/Procedure B. What to do when a fall occurs C. Falls Compliance Audit Tool Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated.	

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	08/10/2015

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

(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
	cause analysis was documented in the interdisciplinary notes. The IDT (Interdisciplinary Team) Note, dated 07/28/15 at 9:59 a.m., included the following: "Team met & [and] reviewed fall from yesterday morning. He obtained no injuries from fall. New intervention was added to care plan to change his room closer to nurses station to lessen walking distance". The clinical record lacked a root cause analysis for Resident #25's fall that occurred on 07/27/15. On 08/06/15 at 11:35 a.m., the Policy and Procedure on "Falls" was requested from the DON. On 08/06/15 at 2:05 p.m., the document titled, "Fall Risk Assessment", was provided by the DON. A second request for the Policy and Procedure on "Falls" was requested at this time. On 08/06/15 at 2:48 p.m., the Administrator indicated there was not a specific policy that indicated step by step on what to do after a fall. The Administrator indicated staff are trained on the (name of computer program system the facility used for charting) and staff were trained to follow the incident report which guided them on what they were supposed to do.		At the monthly QA meetings the monitoring of the Falls Compliance Log will be reviewed for any patterns. However, any concerns will have been acted upon as found.	

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	08/10/2015

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

(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
	During an interview on 08/10/15 at 2:45 p.m., during the exit conference, the Administrator indicated Resident #25 indicated his legs were weak and that was the root cause analysis. 3.1-45(a)(2)			
F 0332 SS=D Bldg. 00	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure medication administration was free of a medication error rate of greater than 5% for 2 of 25 opportunities observed. This resulted in a medication error rate of 8%. This deficient practice had the potential to impact 1 resident. (Resident #22) Findings include: During an observation on 08/07/2015 at 9:54 a.m., Licensed Practical Nurse (LPN) #2 was observed to administer Resident #22 his Divalproex, (an anticonvulsant medication) and Namenda (a dementia medication). The Divalproex and Namenda were crushed before	F 0332	F-332 It is the policy of this facility to see that the meds are administered accurately as ordered and without error. Resident #22 does not receive any DO NOT CRUSH meds in a crushed form. Any resident who has their meds "crushed' has the potential to be affected by this finding. A facility	09/07/2015

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	08/10/2015

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

(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
	administration. The clinical record for Resident #22 was reviewed on 08/07/14 at 11:00 a.m. Diagnoses for Resident #22 included, but was not limited to, dementia with behavioral disturbances. Current signed physician's orders for Resident #22 included, but were not limited to, Divalproex Extended Release 250 milligrams (mg) - 1 tablet by mouth daily, and Namenda Extended Release 28 mg - 1 capsule by mouth daily. The physician orders lacked a may crush medication order. The label on the medication card and indications from the pharmacy indicated do not crush the Divalproex and Namenda. During an interview with the Director of Nursing (DON) on 08/10/15 at 11:55 a.m., the DON indicated if a medication was a do not crush medication and the residents preferred way of taking the medications were for the medications to be crushed, then it should not be administered to the resident. The nurse would first need to contact the doctor and get an updated order on the medication before administering the medication to the resident. Review of the current facility policy,		wide audit was conducted to ensure that any resident who has their meds crushed has the reason documented. Further, any meds that are crushed have an order to be crushed. Any meds recommended not to be crushed are either in a liquid form or a capsule form that can be opened. In the rare instance when a needed medication is not recommended to be crushed and does not come in a liquid or capsule, the benefits of taking the med although in a crushed form will be weighed against the potential concerns. The physician and family will discuss this concern and the decision will be documented. The med will be administered as ordered. A list of DO NOT CRUSH meds will be posted in the front of the med books. The DON/Designee will monitor 3 med passes weekly to ensure that no inappropriate crushing of meds occurs. Any potential inappropriate crushing will be stopped before it occurs during this monitoring. The monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Then, weekly monitoring will continue for a period of not less than 6 months to ensure ongoing compliance. After that, random med pass audits will take place ongoing as part of the QA program.	

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	08/10/2015

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

(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
	updated 02/06/14, titled "Medication Administration Procedure", provided by the Director of Nursing on 08/07/15 at 12:20 p.m., included, but was not limited to, the following: "...If there is any discrepancy between the MAR (medication administration record) and the label, check physician orders before administering medication. If the label is wrong, it is the responsibility of the nurse to apply a 'direction change' sticker to the medication label...." Two errors divided by twenty-five opportunities for error times 100 resulted in a medication error rate of 8%. 3.1-48(c)(1)		As part of the daily CQI meetings any new med orders will be reviewed. Any meds that are DO NOT CRUSH will be addressed (for those residents who have their meds crushed) to either get the med in another form or get an order to crush the med as the benefit of the med outweighs the potential harm from crushing. This will have to be discussed and decided upon between the physician and the resident/family. At an inservice held 08/20/2015, for nurses, the following was reviewed: A. Medication Administration-DO NOT CRUSH meds B. List of DO NOT CRUSH meds C. Resident/family education and discussion if a DO NOT CRUSH med is ordered and does not come in a liquid or capsule form	

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	08/10/2015

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

(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
			Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings the results of the monitoring of the med passes will be reviewed, however, any concerns and education will have been provided and addressed during the monitoring.	
F 0364 SS=E Bldg. 00	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to ensure pureed food was served at the proper temperature. This practice had the potential to affect 8 of 8 residents who receive pureed foods prepared in the facility kitchen.	F 0364	F-364 All residents who receive pureed food receive that food at acceptable temperatures per regulation. All residents who receive pureed food have the potential to be affected by this finding. The Administrator/Designee will monitor the temp of puree foods during 3 breakfasts, 3 lunches	09/07/2015

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	08/10/2015

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

(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
	Findings include: 1. On 08/04/15 between 11:39 a.m. and 12:45 p.m., an observation of meal preparation was conducted with Cook #1 and the Dietician present. Cook # 1, was observed to prepare pureed foods for the lunch service. The food was prepared and placed into serving trays and then placed onto the steam table. The cook was about to dish up the food without obtaining a temperature and upon request, temperatures were obtained of the food on the steam table. The following out-of-range temperatures were obtained by the Dietician: pureed ravioli-130 degrees Fahrenheit (F) pureed garlic bread-80 degrees F pureed salad-70 degrees F During an interview on 08/04/15 at 11:59 a.m., Resident # 13 indicated the food was cold most of the time. 2. On 08/05/15 between 11:30 a.m. and 12:30 p.m., Cook # 1, was observed to prepare pureed foods for the lunch service. The food was prepared and placed into serving trays and then placed onto the steam table. The following out-of-range temperatures		and 3 dinners weekly to see that temps are within the acceptable range per regulation. Any concerns will be addressed prior to serving. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Then, 1 breakfast, 1 lunch and 1 dinner will be monitored weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur. Note: Temps will continue to be taken and recorded with each meal in the dietary department. At an inservice held 08/20/2015, for the dietary staff, the following was reviewed: A. Food temperatures and how to best maintain them B. Preparation, "holding," (until served) and serving (as related to temps) C. Usage, cleaning and storage food thermometers D. Documentation of food temps Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings the temp monitoring audits for pureed food will be reviewed. Any patterns will be discussed and addressed via an Action Plan written by the committee. The plan will be monitored weekly by the Administrator until resolution, however any concerns and education will have been addressed as discovered and	

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	08/10/2015

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

(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
	were obtained by the Cook: pureed hot dogs-150 degrees F 3. On 08/10/15 at 1:04 p.m., the last lunch tray was delivered to the Ruby/Emerald Halls. The following out-of-range food temperatures were obtained by the Dietary Manager on the last tray containing pureed food: mashed potatoes- 120 degrees F green beans- 100 degrees F mostaccioli-120 degrees F During an interview on 08/10/15 at 10:18 a.m., the Dietary Manager indicated all of the burners were working well today. She indicated the Maintenance Director looked at the burners and got the burner that wasn't working to work again. She also indicated, "The steam table (that wasn't working) did not have enough water in it the other day. After adding more water, it now works. We have 8 pureed diets and 17 mechanical soft diets. The puree looks like baby food and the mechanical soft has to be ground, a lot of the same as the regular." The Dietary Manager indicated she didn't understand the low temperatures and that the facility just spent a lot of money on the plate covers to prevent the food from cooling. The Administrator had been checking the		prior to the food having been served.	

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	08/10/2015

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

(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
	temperatures in the halls periodically and they had been fine. The review of the CMS (Centers for Medicaid and Medicare Services) Guidelines indicated cold foods served from the tray line should be a maximum of 41 degrees Fahrenheit (F) and hot foods served from the tray line should be a minimum of 140 degrees F. Poultry should be heated to a minimum of 165 degrees F. Ground meat, fish, and eggs should be cooked to a minimum of 155 degrees F. Fish and other meats should be cooked to a minimum of 145 degrees F. 3.1-21(a)(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 observation, interview, and record review, the facility failed to ensure the kitchen staff prepared and/or served food under sanitary conditions. This deficient practice had the potential to	F 0371	F-371 It is the policy of this facility to	09/07/2015

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	08/10/2015

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

(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
	affect 86 of 86 residents residing in the facility who were provided meal service from the facility kitchen. Findings include: On 08/04/15 between 10:10 a.m. and 10:30 a.m., during the initial tour of the kitchen with the Dietary Manager, the following was observed: 1. The Dietary Manager performed handwashing for 14 seconds and then obtained dishes for washing. She then washed her hands for 10 seconds and went back to obtain additional dishes for washing. 2. The Activities Director performed handwashing for 8 seconds. 3. Cook # 2 performed handwashing for 12 seconds and then obtained ice for the milk service. He then washed his hands for 12 seconds and obtained a container of orange juice for the residents, handing the container to another staff member. On 08/04/15, between 11:39 a.m. and 12:40 p.m., the kitchen staff was observed preparing lunch. The following was observed: 4. Cook # 1, was observed to prepare		prepare and store all foods in the dietary department under sanitary conditions. All dietary staff wash their hands when indicated for at least 20 seconds using proper technique. Further, hands are washed between glove changes and after touching a contaminated surface. Gloves are changed between tasks. Thermometers are kept in a clean area with clean covers. Thermometers are properly cleaned between uses. Oven mitts are not worn over gloved hands. Oven mitts are kept in a clean area. Hands are properly washed between uses of oven mitts. Dietary staff are not to touch their hair, skin, or clothes with gloved hands or with oven mitts. Scoops/spoons are not placed on counters between uses. Any resident who consume food prepared in the dietary department have the potential to be affected by this finding. The Administrator/Designee will monitor 1 meal daily 5 days a week at various meal times to see that proper hand hygiene and proper glove donning and removing (including oven mitts) is practiced. Any concerns will be	

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	08/10/2015

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

(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
	pureed food. She removed her gloves and threw them away, obtained fresh gloves and pulled bread from the bags. She placed the bread onto the hot plate and applied melted butter using a brush. She removed her gloves and threw them away, touching the trash can lid. She then applied clean gloves and turned the bread over. Using the bread, she prepared grilled cheese sandwiches wearing the same gloves throughout preparation. The same gloves were observed to be worn while Cook #1 removed garlic toast from the oven, obtained a small amount of the ravioli from the pan that was removed to be pureed, and placed the ravioli into the puree machine. 5. Cook #1's thermometer cover was observed dangling from a string around her neck. The thermometer cover was observed to touch the grilled cheese sandwiches while she was transferring them to another pan. The thermometer cover was also observed touching the plates. 6. Cook #1 was observed to leave the kitchen area while gloved, to obtain ice and with the same gloves, placed the salad on ice in the serving tray. The cook touched the door knob three times with gloved hands. She then brought the hall		immediately addressed and corrected. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Then, 2 meals will be monitored weekly at various meal times for a period of not less than 6 months to ensure ongoing compliance. Then, random monitoring will continue as part of the QA program. Further, the dietician will monitor during dietician visits. At an inservice held 08/20/2015, for the dietary staff the following was reviewed: A. Safe food handling in the dietary department B. Hand hygiene in the dietary department C. Glove and Oven mitt usage in the dietary department D. Thermometers in dietary-Usage/Cleaning/Storage E. Scoops/Utensils in dietary-Usage/Cleaning/Storage	

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	08/10/2015

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

(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
	cart into the kitchen from the dining room, without changing gloves or washing her hands. She obtained plate liners/lids, placing her gloved, right hand into the inside of the lid on top of the stack. She removed the covers from the food on the steam table, placed the plates beside the food pans, adjusted her shirt and pants, re-sorted the plate covers and began dishing out the food for the Onyx Dining Room. On 08/05/15 between 11:30 a.m. and 12:30 p.m., the kitchen staff was observed preparing lunch. The following was observed: 7. Cook #1 was observed to place oven mitts over her gloved hands while placing a pan of pureed hot dogs into the oven. She removed the oven mitts, then picked up the dishes and placed them into the dishwasher. She then proceeded to stir the fried potatoes. The Cook removed the clean dishes from the dishwasher and pureed more hot dogs. She poured it into a warming pan, pureed more hot dogs and poured it into the same warming pan. Foil was placed over the pan and it was placed into the oven for heating. She reapplied the oven mitts over her gloved hands and placed the pan of hot dogs back into the oven. She placed oven mitts over her gloved hands again and		Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as necessary. At the monthly QA meetings the monitoring of hand hygiene, glove usage and oven mitt usage will be reviewed. However, any concerns or education will be addressed as found.	

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	08/10/2015

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

(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
	moved the beans to the back burner. She then moved the pan of hot water closer, removed the mitts, and poured mashed potato flakes into the pan of water, and stirred with a whisk. Cook # 1 indicated the pilot light was out on the burner. The Cook picked up the ink pen to mark the temperature on the log sheet with her gloved hands. She applied one oven mitt, removed the mitt and sprayed a pan with cooking spray and obtained cornbread to puree, while wearing the same pair of gloves. She opened the refrigerator and obtained milk, dropping a lid onto the floor. She picked up the lid and placed it onto the counter. Cook # 1 then poured the milk into the cornbread and pureed the cornbread. She poured the pureed cornbread into the warming pan and then pureed more cornbread. At this point she removed her gloves and washed her hands for 20 seconds. This was the first observation of glove removal and handwashing during this observation. Cook #1 applied clean gloves, obtained a temperature of the mashed potatoes, applied oven mitts, and placed the pan into the steam table. The Cook removed the oven mitts and checked the temperature log. She reapplied the oven mitts and carried the hot dogs to the steamer, then proceeded to carry the remaining food pans over to the steamer for service. She removed the oven mitts			

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	08/10/2015

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

(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
	and placed foil over the food pans without changing gloves or performing handwashing. She then placed the hot dogs into a smaller warmer pan, placed the mitts over her gloved hands and carried the pan to the steam table. Cook #1 obtained scoop spoons and placed them onto the counter. At this point she dropped one of the spoons and picked it up and placed it on the counter. While wearing the same pair of gloves, she placed plates onto the counter, obtained plate covers/lids and placed them onto the counter. The Cook began dishing the food onto the first plate. She adjusted her pants, removed her gloves, washed her hands for 24 seconds, applied clean gloves and dished out more food. During an interview on 08/06/15 at 10:19 a.m., the Dietary Manager indicated the staff had 20 seconds to wash their hands after entering the kitchen. When the gloves are removed they have to replace them [with clean gloves]. When the cook was working on a specific food and needed to change to another food, the cook needed to remove the gloves, perform handwashing and replace the gloves to prevent cross contamination; 40 to 60 seconds was required for handwashing. She indicated she had a lot of new people training - 3 people/staff on day shift and 2 in the afternoon shift.			

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	08/10/2015

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

(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
	This included a cook, an aide and a mid-shifter who prepared snacks and washed dishes. On 08/04/15 at 10:20 a.m., the Dietary Manager provided a copy of the facility policy on handwashing. The policy indicated, but was not limited to, "...wash hands well for approximately 15 seconds to aid in the mechanical removal of bacteria". The "Instructions on Fundamentals of a Safe Food Service", indicated: "Clean Hands - Dirty hands spread germs/bacteria. Hands and fingernails should be washed thoroughly with soap and water before work, after using the toilet and any time they are soiled, after handling raw foods, between work tasks, any time the employee leaves and re-enters the kitchen. Artificial fingernails and nail polish are to be avoided. If artificial fingernails cannot be removed and/or fingernail polish the hands must be gloved during all times of food preparation and changed according to proper procedures. Clean Service - Handling utensils the wrong way may spread disease. Paper service is clean and should be handled carefully to keep it sanitary. After use, other utensils should be scraped, washed and cleaned in hot, soapy water, sanitized as required by the health department, then carefully stored			

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	08/10/2015

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

(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
	and never handled by the area that makes contact with the food. The food contact part of any utensil or tableware is never touched with a bare hand." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0431 SS=E Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for			

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	08/10/2015

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

(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
	storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to label medications properly, store the medications following the manufacturer, pharmacy, or supplier recommendations, store residents food in the appropriate locations, and store medications in the correct resident's labeled container. This deficient practice affected 2 of 4 medication carts and 1 of 1 medication storage rooms observed for medication storage. (Residents #7, #21, #68, #87, #101, and #107) Findings include: During the medication storage observation on the Sapphire Hall medication cart, with the Licensed Practical Nurse #3 (LPN), on 08/06/15 at 11:20 a.m., the following was observed: 1. Observed in the top drawer of the cart was an opened resident pudding cup. 2. Observed in the top drawer were two medication cups with only first names	F 0431	F-431 It is the policy of this facility to see that all drugs and biologicals in the facility are labeled and stored according to currently accepted professional principles for pharmacy. Residents #7, #21, #68, #87, #101 and #107 have their meds stored per policy and regulation. All residents who reside in the facility and receive meds have the potential to be affected by this finding. All med rooms and med carts were audited by the nursing leadership in the facility and any concerns were addressed. The DON/Designee will monitor all med carts and med rooms 3 days weekly at various times to check for pre-poured meds, proper storage, accurate labels,	09/07/2015

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	08/10/2015

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

(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
	identifying who the residents medications belonged to. The cups contained medications that were crushed and mixed in pudding. At the time of the observation, LPN #2 indicated the cups of medication were for the 9 a.m. medication pass for Resident #68 and Resident #101. 3. Observed in the top drawer was Resident #7's unopened Lantus injection insulin syringe. The bag containing the medication and the label on the medication itself indicated the medication should be refrigerated. The medication was not refrigerated and was at room temperature. 4. Observed in the bottom drawer of the medication cart, were two opened, undated and unlabeled packages of ipratropium bromide and albuterol sulfate inhalation medications. During the medication storage observation on the Ruby Bay Hall medication cart with the Licensed Practical Nurse #4 (LPN), on 08/06/15 at 2:05 p.m., the following was observed: 5. Observed in the top drawer, Resident #21's Novolog Flex prefilled insulin syringe was located in Resident #87's bag. The outside of the bag indicated the		expired meds, food improperly stored either in the med room or a med cart. Any concerns will be immediately addressed and corrected as found. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, the monitoring will continue weekly for med rooms and med carts for a period of not less than 6 months to ensure ongoing compliance. After that, random audits will take place as part of the QA program. At an inservice held for nurses 08/20/2015, the following was reviewed. A. Medication Administration-no pre-pouring B. Medication Storage-insulin (that needs refrigeration) and other meds requiring refrigeration C. Label- name, room number, med, dose, expiration date and/or "opened" date, physician etc.	

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	08/10/2015

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

(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
	medication inside was for Resident #87's Lantus Solostar injection insulin syringe, but inside the bag was Resident #21's Novolog Flex prefilled insulin syringe. 6. Observed in the top drawer were two opened and undated Novolog Flex prefilled insulin syringes for Resident #21. 7. Observed in the top drawer was an unlabeled, opened and undated Spiriva inhaler. During the medication storage observation of medication room, with the Licensed Practical Nurse #3 (LPN), on 8/10/15 at 11:47 a.m., the following was observed: 8. Observed in the refrigerator were two bags of Total Parenteral Nutrition (TPN) for IV (intravenous) use for Resident #107. One of the bags indicated to discard after 6/28/2015 and the other bag indicated it should be discarded after 07/02/2015. An interview on 8/10/2015 at 11:55 a.m., with the Director of Nursing (DON), confirmed all above issues. The DON indicated the pharmacist makes monthly checks on the medications carts and the nurses working the floor should check		D. Expired meds-how/when to discard E. Food/drink used in med pass Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as necessary. At the monthly QA meetings the results of the med room/med cart monitoring will be discussed. Any concerns will be immediately corrected as found. Any patterns identified will be addressed via an Action Plan written by the committee. The plan will be monitored by the Administrator weekly until resolution.	

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	08/10/2015

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

(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
	them as needed. The DON indicated all medications in the carts should be labeled with resident identifiers. The DON indicated he personally checked the medication room for expired medication but forgot to check the refrigerator. The DON indicated all expired medications should not be kept in the refrigerator. The DON indicated no opened food should be located in the medication carts. The DON indicated the medications should be stored and dated per manufacturer, pharmacy, or supplier recommendations. A policy dated June 19, 2012 and titled, "3.1: Medication Storage In The Facility," was provided by the Administrator on 8/7/2015 at 1:25 p.m. and was identified as current. The policy indicated, "Medications are not to be transferred into different containers than what the medications were received in. Medications requiring 'refrigeration' or temperatures between 36 degrees Fahrenheit and 46 degrees Fahrenheit are kept in a refrigerator. Outdated medications will be immediately withdrawn from the stock, and disposed of properly. Medication storage areas are to be kept clean, well lit, and free of clutter." 3.1-25(j)			

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	08/10/2015

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

(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
	3.1-25(k) 3.1-25(m) 3.1-25(o)			
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by			

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	08/10/2015

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

(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
	accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure proper handwashing and glove use by staff during the provision of care for 3 of 3 observations of resident care. (Residents # 35, #101 and #110) Findings include: 1. On 08/06/15 at 10:36 a.m., Certified Nursing Assistant (CNA) # 1 was observed providing incontinence care for Resident # 101. CNA # 2 and CNA # 3 entered the room. All three CNAs applied gloves without performing handwashing. CNA # 1 performed incontinence care wearing the same gloves throughout the cleaning and drying process. CNA #1 applied barrier cream to the residents buttocks using the same gloves. CNA # 1 removed her gloves and applied fresh gloves to bag the trash. She then removed the gloves and washed her hands for 32 seconds. 2. On 08/07/15 at 10:13 a.m., Licensed Practical Nurse (LPN) # 5 was observed to wash her hands for 15 seconds. She applied gloves and opened the wound	F 0441	F-441 It is the policy of this facility to maintain an Infection Control Program to provide a safe, sanitary environment that helps prevent the development and transmission of disease and infection. Residents #35, #101, and #110 receive care by staff who practice proper hand washing and glove usage as per policy and regulation. All residents who reside in the facility have the potential to be affected by this finding. CNAs will be observed will be and “checked off” after having demonstrated proper hand hygiene and glove usage techniques including proper technique during incontinence care. Nurses will be observed and “checked off” after having demonstrated proper hand hygiene and glove usage techniques including proper technique during clean dressing changes. The DON/Designee will observe incontinent care on various residents by various staff members 10 times weekly until 4 consecutive weeks of zero negative findings are achieved. Afterwards, the monitoring will occur 5 times weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will	09/07/2015

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	08/10/2015

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

(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
	care supplies. Resident # 110 was rolled onto the right side, the buttocks were observed to be reddened. The bandages in place were removed. The LPN removed her gloves. She then washed her hands for 10 seconds and applied clean gloves. She cleansed the wounds and applied the clean dressings. The LPN removed her gloves, and washed her hands for 12 seconds. She applied clean gloves. A clean bed pad was applied under the resident's buttocks. The soiled supplies were removed in separate bags, and disposed of in the utility room. The LPN washed her hands for 30 seconds after being queried about the proper handwashing technique. During an interview on 08/07/15 at 10:51 a.m., LPN # 5 indicated she did not normally do wound care on the resident. She also indicated the proper hand washing procedure was to wash for 30 seconds, and handwashing was done if the hands were soiled, before dressing changes, and after care. 3. On 08/07/15 at 1:52 p.m., CNA # 5 and CNA # 1 were observed providing incontinence care for Resident # 35. CNA # 1 washed her hands for 38 seconds. CNA # 5 washed her hands for 15 seconds. They applied clean gloves and CNA # 5 wet the washcloths		take place as part of ongoing QA. The DON/Designee will observe 5 dressing changes weekly on various shifts by various nurses to monitor technique. Any concerns will be corrected prior to a breach in technique taking place. The monitorings will continue until 4 consecutive weeks of zero findings are achieved. Afterwards, 3 dressings will be observed weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur as part of the ongoing QA program. At the monthly QA meetings the results of the monitoring will be reviewed, however, any needed education and or progressive discipline will have taken place as necessary.	

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	08/10/2015

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

(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
	in the bathroom sink. The resident's brief was removed and CNA # 5 applied perineal spray onto the wet washcloth. She washed the groin, labial area, folding the washcloth two times, wiping back and forth. She then sprayed a second washcloth, folding four times wiping back and forth over the same area. The resident was turned onto her right side and another washcloth was sprayed and while folding was used wiping from front to back over the anal area and the buttocks. The resident was patted dry with a dry towel by CNA # 1. CNA # 1 then applied butt/barrier cream to the resident's buttocks/anal area, with gloved hands. The clean brief was placed onto the clean bed pad and CNA # 1 rubbed the cream from her gloved hand onto the brief to clean it off. The brief was fastened. The resident was repositioned and covered. The CNAs removed their gloves. This was the first observation of gloves being removed during the provision of care. CNA # 1 washed her hands for 30 seconds. CNA # 5 washed her hands for 17 seconds. CNA # 5 applied clean gloves and bagged up the trash, soiled linen in one bag and the brief in another. CNA # 5 washed her hands for 14 seconds. During an interview on 08/07/15 at 2:18 p.m., CNA # 5 indicated, "When			

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	08/10/2015

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

(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
	handwashing, turn on the water, scrub with soap, let the water flow down when rinsing, sing happy birthday." She also indicated to change gloves for draping, after peri care is done, and to change bedding. On 08/05/15 at 1:46 p.m., the Director of Nursing (DON) provided the facility policies and procedures for infection control, handwashing, incontinence care, catheter care, and wound care. The DON also provided a copy of their handwashing policy, inserviced to all staff upon hire. On 08/10/15 at 10:15 a.m., the DON provided a copy of the CDC (Center for Disease Control) guidelines the facility had recently in-serviced the staff on handwashing. The policy indicated the duration of the entire handwashing procedure was 40 to 60 seconds. The procedure indicated to: "Wet the hands with water; Apply enough soap to cover all hand surfaces; Rub hands palm to palm; Right palm over left dorsum with interlaced fingers and vice versa; Palm to palm with fingers interlaced; Backs of fingers to opposing palms with fingers interlocked; Rotational rubbing of left thumb clasped in right palm and vice versa; Rotational rubbing, backwards and forwards with clasped fingers of right			

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	08/10/2015

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

(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
	hand in left palm and vice versa; Rinse hands with water; Dry hands thoroughly with a single use towel; Use towel to turn off faucet; Your hands are now safe." On 08/10/15 at 10:42 a.m., the LPN # 6 indicated the staff were inserviced on handwashing recently. They were taught to keep their hands pointed down, with no flicking of the water, no rubbing with the paper towels, to pat them, clean the knuckles and the nails, use the same paper towels to turn the water off. Sing the Happy Birthday song twice, and to scrub the hands for 30 to 40 seconds. 3.1-18(l)			
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to provide maintenance and housekeeping services to keep the facility dining room clean and in good repair. This deficient practice had the potential to affect 58 of 86 residents who ate their meals in the dining room. Findings include:	F 0465	F-465 It is the policy of this facility to keep the dining room clean and in good repair. The streaking on the ceiling beams	09/07/2015

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	08/10/2015

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

(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
	During initial tour on 8/4/15 at 10:00 A.M. and during the environmental tour on 8/7/15 at 11:21 A.M., with the Maintenance Supervisor, Housekeeping Supervisor and the Administrator present, the following observations were made in the dining room: 1. There were 51 dark brown streaks running down the ceiling beams above the residents eating area. 2. There was a two foot by three foot plaster piece missing in the ceiling above the residents eating area. 3. There was a two foot by one foot piece of ceiling chipping away above the residents eating area. 4. There was a four foot by one foot plaster piece missing in the ceiling above the residents eating area. 5. A 2 foot by one foot cobweb with dust, was blowing in the air flow on the ceiling above the residents dining table. 6. A 3 inch by one inch cobweb with dust, was blowing in the air flow on the ceiling above the residents dining table. 7. A 1 foot by 1 foot cobweb with dust,		has been removed. The plaster in the ceiling has been repaired. The chipping on the ceiling has been repaired. All cobwebs and dust has been removed from the dining room. All residents who reside in the facility especially those who eat in the dining room, have the potential to be affected by this finding. The Administrator/Designee will monitor the MDR (Main Dining Room) for any issues with the ceiling (repairs/cleanliness) weekly. Any concerns will be addressed as found. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, monthly monitoring will continue ongoing as part of the Preventive Maintenance rounds. At an inservice held 08/20/2015, for Housekeeping and Maintenance the following was reviewed: A. Regulatory requirements for a clean	

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	08/10/2015

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

(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
	was blowing in the air flow on the ceiling above the residents dining table. 8. A 1 foot by 1 foot cobweb with dust, was blowing in the air flow on the ceiling above the residents dining table. 9. A three inch long piece of dust, was blowing in the air flow on the vent above the residents dining table. During an interview on 8/4/15 at 1:22 p.m., with the Dietary Manager, she indicated there were a total of 58 of 86 residents who would eat in the dining room area during a meal service. During an interview on environmental tour observation on 8/7/15 at 11:21 a.m. with the Maintenance Supervisor and Administrator, they both acknowledged all above issues. During an interview on 8/7/15 at 11:42 a.m., the Housekeeping Supervisor acknowledged all above issues. She first indicated the last time the ceiling was dusted or cleaned was in September 2014, and later in the interview, she indicated it was in May 2015. She indicated the ceilings should be deep cleaned or dusted monthly. She indicated she did not have this on her checklist of things to do, but she would add it to her		and sanitary dining area for residents B. How to clean the dining room ceiling C. Who is responsible to keep the ceiling clean and in good repair? D. How often should the MDR ceiling be cleaned? Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings the monitoring of the MDR ceiling will be reviewed. Any concerns will have been addressed.	

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	08/10/2015

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

(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
	checklist. She indicated she could not reach the ceiling so she would have to get the maintenance department to help her reach the ceiling. She also indicated she did not have a policy or procedure for Housekeeping, just a checklist. During an interview on 8/7/15 at 11:48 a.m., with the Maintenance Supervisor, he indicated he was unaware that he would have to help with the dusting of the dining room area, and was unaware of the last time the ceiling had been cleaned in the dining room. During an interview on 8/10/15 at 1:12 p.m., with the Administrator, she indicated she was aware of the issues in the dining room area. She indicated the dining room area should be deep cleaned and ceilings cleaned monthly. She also indicated the facility does not have a policy or procedure in place, as they just use an effective program. 3.1-19(f)			
F 0469 SS=E Bldg. 00	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.	F 0469	F-469 It is the policy of this	09/07/2015

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	08/10/2015

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

(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
	Based on observation, interview and record review, the facility failed to provide a pest free environment in the dining room, kitchen and in 2 of 4 hallways. This practice had the potential to affect 86 of 86 residents residing in the facility. Findings include: During an observation on 08/04/15 at 11:39 a.m., 2 flies were observed in the kitchen during the lunch meal preparation. During an observation on 8/4/2015 at 11:58 a.m., one fly was observed landing on Resident #45's head in his room. During an observation on 8/4/2015 at 11:58 a.m., one fly was observed in Resident #21's room. During an observation on 8/4/2015 at 12:27 p.m., one fly was observed in the main dining room hallway. During the lunch dining observation, on 8/4/15 at 12:55 p.m., a fly landed on Resident #3's head during the meal. It then landed and crawled around the edge of Resident #3's salad bowl. During an observation on 8/4/2015 at		facility to maintain a pest free environment. There are no pests/gnats/rodents in the facility dining areas, kitchen, hallways, common areas, or resident rooms. The following residents are not bothered by flies or gnats: #45, #21, #3, #73, #54, #60, #112, #25, #99, #35, #110, #50, #134, #101, #17 and #70. Any residents who reside in the facility have the potential to be affected by this finding. A pest control visit has been made to eradicate any flies/gnats. The Administrator/Designee will monitor daily 5 days weekly to observe for flies and gnats. Any findings will be addressed immediately by the maintenance department if appropriate or by a pest control provider if necessary. Afterwards, monthly monitoring will occur ongoing as part of the Preventive Maintenance Program as well as the QA program. At an inservice held 08/20/2015, for maintenance staff the following was reviewed: A. Regulatory requirements for a pest/rodent free environment B. Preventive Maintenance rounds/schedule to observe for pests/rodents or evidence of pests/rodents C. What to do if pests/rodents or evidence of pests/rodents is observed Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. At the monthly	

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	08/10/2015

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

(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
	1:32 p.m., one fly was observed in the Onyx Hall dining room. During an observation on 8/4/2015 at 1:34 p.m., one fly was observed in Resident #73's room. During an observation on 8/4/15 at 1:35 p.m., across from the nurses station, a fly was observed crawling on Resident #3's left arm and on and around her wheelchair. During an observation on 8/4/2015 at 2:00 p.m., one fly was observed in Resident #54 and Resident #60's room. During an observation on 8/4/2015 at 2:12 p.m., three flies and one gnat were observed in Resident #54 and Resident #60's room. During an observation on 8/5/15 at 10:55 a.m., a fly was observed flying around in Resident #112's room. At the time of observation, Resident #112 indicated, "I would get plenty of therapy if they would give me a fly swatter". During an observation on 8/6/15 at 10:00 a.m., 3 flies were observed flying around in Resident #25's room. Resident #99 indicated, "There are always flies in here. I don't know why but there are".		QA meetings the result of the monitorings of the pest/rodent evidence will be reviewed, however, any findings will have been immediately addressed.	

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	08/10/2015

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

(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
	During an observation on 08/05/15 at 11:30 a.m., during the lunch meal preparation, 1 fly was observed in the kitchen landing on the wax paper placed over the cherry pie slices. The Dietary Manager placed the wax paper over the pie slices as she cut them for the lunch service. A bug light was observed on the kitchen wall to the left upon entering the kitchen from the dining room. During an observation on 8/6/2015 at 12:00 p.m., one fly was observed in the main dining room hallway. During an observation on 8/6/15 at 2:30 p.m., a fly was observed crawling on the pillow of Resident #35 while resting in bed with eyes closed. During an observation in Resident #110's room, with the Maintenance Supervisor present on 8/7/2015 at 2:39 p.m., two gnats were observed in his bathroom. During an observation on 8/7/2015 at 2:39 p.m., one fly was observed in Resident #60's room. During an observation on 8/7/2015 at 2:40 p.m., two flies were observed in Resident #134's room.			

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	08/10/2015

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

(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
	During an observation on 8/7/2015 at 2:41 p.m., one fly was observed in the Sapphire Hallway. During an observation on 8/7/2015 at 2:43 p.m., one fly was observed in Resident #112's room. During an observation on 8/7/2015 at 2:43 p.m., one fly was observed in Resident #101's room. During an observation in the main dining room on 8/10/2015 at 12:41 p.m., one fly was observed on Resident #17's green beans and Resident #70's coffee cup. During an interview with Resident #112 on 8/7/2015 at 11:35 a.m., she indicated there was a cricket that came into her room from under the baseboard. During an interview with Resident #21 on 8/10/2015 at 10:15 a.m., he indicated the flies bothered him when they landed on his face. During an interview on 8/10/15 at 12:27 p.m., Certified Nurses Assistant (CNA) #6, indicated that she had noticed an increase in flies in the past two weeks. During an interview on 8/10/2015 at 1:12 p.m., the Administrator indicated there had been an increase in flies due to the increase in the temperature and the			

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	08/10/2015

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

(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
	rainfall. She also indicated she did not have a pest control policy and procedure. 3.1-19(f)(4)			
F 0504 SS=D Bldg. 00	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. Based on interview and record review, the facility failed to obtain physician ordered labs (Resident #73 and #109) for 2 of 6 residents reviewed for unnecessary medications. Findings include: 1. On 08/07/15 at 10:04 a.m., the clinical record of Resident # 109 was reviewed. Diagnoses included, but were not limited to, diabetes, osteoarthrosis, atrial fibrillation, renal failure, congestive heart failure, hypertension. On 08/10/15 at 9:53 a.m., the review of the Physician's Orders, indicated on 07/22/15, an order was written for a CBC (Complete Blood Count), CMP (Comprehensive Metabolic Profile) , HgA1C (a rest of blood glucose level) on 07/27/15. The lab results could not be	F 0504	F-504 It is the policy of this facility to provide lab services when ordered by the attending physician. Residents #73 and #109 receive ordered labs timely. Resident #109 has had a CBC, CMP and HgA1C done. Resident #73 has had a VPA done. All residents who have labs ordered have the potential to be affected by this finding. At the daily CQI meetings new orders will be reviewed and lab orders will be added to the lab tracking log/schedule. A facility wide audit was conducted to see that all ordered labs were properly scheduled and documented on the log. The DON/Designee will monitor labs 3 days weekly to see that all currently or newly ordered labs are on the lab schedule as well as the care plan as appropriate. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, the lab	09/07/2015

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	08/10/2015

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

(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
	found by the Assistant Director of Nursing (ADON). During an interview on 08/10/15 at 10:04 a.m., the Director of Nursing (DON) indicated Resident #109's labwork scheduled to be drawn on 7/27/15 was never done.2. The clinical record for Resident #73 was reviewed on 8/6/15 at 9:40 a.m. Diagnosis included, but was not limited to, seizure disorder. The physician order dated 6/18/15 at 3:20 p.m., included, but was not limited to, the following: "...VPA [valproic acid] [medication used to treat seizures] level in am [morning]...." The document titled, "Consultant Pharmacist's Medication Regimen Review", dated 6/18/15, included, but was not limited to, the following: "...Per order written on 6/8, a VPA was to be drawn on 6/9. Please obtain results and place in chart..." As of the review date of 8/6/15, the clinical record lacked a VPA level from the lab ordered to be drawn on 6/9/15. During an interview on 8/7/15 at 11:16 a.m., the DON indicated he could not find where the physician order was followed through. The DON indicated		tracking schedule will be monitored weekly for a period of not less than 6 months to ensure ongoing compliance. Then, random audits will occur ongoing as part of the QA program. At an inservice held 08/20/2015, the policy and procedure for lab tracking was reviewed in depth. This included tracking/reporting/notifications (as appropriate) and reporting. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings the lab monitoring will be reviewed. Any patterns will be addressed via an Action plan written by the committee and monitored by the Administrator weekly until resolved.	

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	08/10/2015

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

(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
	(name of lab company) did not have a VPA level for 6/9/15 and there was not a lab requisition filled out for that day. On 8/7/15 at 9:05 a.m., the DON provided a copy of the document titled, "Lab Scheduling and Tracking", dated 7/1/11. It included, but was not limited to, the following: "GUIDELINE: It is the intent of the facility that all laboratory tests ordered by the physician will be systematically scheduled and traced to ensure that all lab work ordered is obtained and results are received...PROCEDURE...4. The Charge Nurse will complete the appropriate Lab Requisition form supplied by the vendor...14. Any labs not obtained as indicated will be re-scheduled and the physician will be notified...19. If the lab draw was omitted the lab will be contacted to perform the test and the physician will be contacted...." 3.1-49(f)(1)			
F 0514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented;			

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	08/10/2015

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

(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
	readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to obtain admission paper work, on 2 separate occasions, for 1 of 1 resident reviewed for admissions. (Resident #93) Findings include: The clinical record for Resident #93 was reviewed on 8/7/15 at 9:30 a.m. Diagnoses included, but were not limited to, Asperger's syndrome and dementia. During an interview on 8/5/15 at 2:05 p.m., the POA (Power of Attorney) indicated she had not signed any admission paperwork. The nurses notes indicated Resident #93 was admitted on 2/25/15, discharged on 3/18/15, then admitted, again, on 4/18/15. During an interview on 8/7/15 at 2:40 p.m., the Admission Coordinator indicated she remembered scanning the admission paperwork information to the POA. She indicated she would call the	F 0514	F-514 It is the policy of this facility to obtain all necessary admission paperwork upon admission. Resident #93 has all of their paperwork completed. All residents have the potential to be affected by this finding. All admissions will be added to the New Admission QA tool upon admission. This will take place at the CQI meetings. The Administrator/Designee will monitor the log 3 days weekly to ensure that all admissions are completed in a timely manner. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, monitoring will continue weekly for not less than 6 months to ensure ongoing compliance. After that, random	09/07/2015

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	08/10/2015

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

(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
	POA to see if she had the paperwork. The Admissions Coordinator provided a copy of an email, dated 3/2/15 at 7:51 a.m. It included, but was not limited to, the following: "...To: [Resident #93's POA]...Please see forwarded consent forms to sign, [sic] also see admission aggreement [sic] to sign and return...." During an interview on 8/7/15 at 3:55 p.m., the Admissions Coordinator indicated, on Resident #93's first admission, the paperwork was faxed to the Power of Attorney. She indicated Resident #93's second admission "fell through the cracks". The Administrator provided a copy of the document titled "Admission Director Job Description" on 8/10/15 at 10:59 a.m. It included, but was not limited to, the following: "POSITION TITLE: Director of Marketing & Admissions...B. Role Responsibilities - Administrative duties & Resident Care...7. Obtains signature of resident and/or responsible party on the Admission Basic Services Agreement and the Responsibility for Charges Sheet. Submits signed forms to appropriate departments for processing..." The Administrator provided a copy of the current guidelines and procedures for		monitoring will occur, however, the audit tool will be an ongoing part of the daily CQI meetings. An inservice was held 08/20/2015, for the Admissions staff at which time the admission process was reviewed as well as the Job Description of the Admissions Director. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings any concerns of the monitoring will be reviewed, however, the admissions audit tool used to track admission paperwork requirements will be an ongoing part of the daily CQI meeting.	

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	08/10/2015

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

(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
	admissions, dated 7/1/11, on 8/10/15 at 10:59 a.m. It included, but was not limited to, the following: "...PROCEDURE...8. At the time of admission, the resident and/or responsible party shall sign the Admission Agreement and related admission documents to establish consent of receipt of Resident Rights and to verify that the resident and or responsible party has been informed of all matters required to be conveyed to individuals upon admission to the facility." 3.1-50(a)(1)			