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	10/24/2018

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00275930. This visit was in conjunction with the Investigation of Complaint IN00277253. Complaint IN00275930 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00277253 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: October 18, 19, 22, 23, and 24, 2018 Facility number: 000478 Provider number: 155494 AIM number: 100290430 Census bed type: SNF/NF: 67 Total: 67 Census payor type: Medicare: 04 Medicaid: 58 Other: 05 Total: 67 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 30, 2018.	F 0000	**Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Survey on October 24,2018. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance**	
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights.			

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

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	The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			

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	Based on observation and interview, the facility failed to ensure residents were served in a dignified timely manner for 13 of 67 residents receiving meals at the facility. (Residents 46, 50, 4, 169, 1, 24, 29, 52, 8, 25, 269, 6, and 66). Findings include: 1. During a lunch meal service observation, on 10/18/18 from 11:43 a.m. to 12:15 p.m. in the Hope Springs Dining Room the following was observed: The meal cart arrived at 11:47 a.m. with 17 residents present in the dining room. CNA (Certified Nursing Assistant) 3 was the only staff member serving. CNA 3 served a meal tray to Resident 25 at table one at 11:43 a.m. Residents 46 and 50 were sitting at table one waiting to be served. CNA 3 served a meal tray to Resident 52 at table two. Resident 4 was waiting at the table to be served. CNA 3 served a meal tray to Resident 5 at table four. Residents 38 and 169 were sitting at table four waiting to be served. CNA 3 served Resident 31 at table three. Resident 29 was sitting t table three waiting to be served. As the CNA served the residents, she was cutting up the meat for the residents, before obtaining the next meal tray. All trays were served by 12:15 p.m. 2. During an observation of the lunch meal service, on 10/24/18 from 11:38 a.m. to 12:12 p.m. in Hope Springs Dining Room the following was observed:	F 0550	F-550 It is the policy of the facility to ensure that the resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. 1). A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. 2). The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. b). Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. b). 1). The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination or reprisal from the facility. b).2). The resident has the right to be free of interference,	11/23/2018

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	The meal cart arrived at 11:56 a.m. with 18 residents present in the dining room. CNA 5, LPN (Licensed Practical Nurse) 4, and the ABOM (Assistant Business Office Manager) were serving the trays to the following residents: Resident 46 was served a meal tray at table one. Residents 29 and 62 were sitting at the table waiting to be served. Resident 4 was served a meal tray at table two. Residents 52 and 8 were sitting at the table waiting to be served. Resident 1 was served a meal tray at table three. Residents 25 and 66 were sitting at the table waiting to be served. Resident 32 and Resident 48 were served a meal tray at table five. Residents 1, 269, and 24 were sitting at the table waiting to be served. Resident 5 was served a meal tray at table four. Residents 6 and 169 were sitting at the table waiting to be served. Resident 52 was served a meal tray at table two. Resident 8 was sitting at the table waiting to be served. Resident 269 was served a meal tray at table five. Residents 1 and 24 were sitting at the table waiting to be served. Resident 6 was served a meal tray at table four. Resident 169 was sitting at the table waiting to be served. Resident 46 finished eating and left from table		coercion, discrimination, and reprisal from the facility by exercising his or her rights and to be supported by the facility in the exercising of his or her rights as required under this subpart. Residents # 46, 50, 4, 169, 1, 24, 29, 52, 8, 25, 269, 6 and 66 were served their meals in a dignified timely manner. *All residents who reside in the facility have the potential to be affected by this finding.* *An audit was conducted to compile a list of residents at risk for meals being served in a dignified timely manner to ensure that they served in a timely manner. The DON/Designee will monitor 5 residents (on a rotating basis) 3 days weekly to ensure that appropriate interventions related to dignified meal service is planned and being implemented. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, 3 residents will be monitored 3 days weekly for a period of not less than 6-month to ensure ongoing compliance. After that, random monitoring will occur ongoing. Any concerns will be addressed as discovered.* *At an in-service held on or before 11.12.18 by Administ rator for all staff the following was reviewed:*	

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	one. Resident 29 was observed with a frown and was still waiting to be served a tray. An interview, on 10/24/18 at 2:24 p.m., Resident 29 indicated, "I always get my food last and it's cold by the time I get it. I always sit with ... [Resident 46] and ... [Resident 62] and they always get served before me. It bothers me but there ain't nothing I can do about it. I've told them before and nothing changes." Review of Resident 29's Quarterly MDS (Minimum Data Set) assessment, on 08/20/18, indicated the resident's cognition was mildly impaired. An interview, on 10/24/18 at 02:28 p.m., CNA 6 indicated, "We try for table to table. If we can get the ...[residents who need assistance] to the top of the cart so we can get them last. If they start yelling I'm hungry we try to get their trays." An interview, on 10/24/18 at 02:50 p.m., the Administrator indicated staff should serve a table at a time. When staff are pulling trays from the carts they serve the trays in the order they were on the carts instead of one table at a time. On 10/24/18 at 3:10 p.m., the Dietary Assistant provided a copy of most current policy for, "The Dining Experience" which indicated, but was not limited to, "...Staff will serve residents seated at the table as close to the same time as possible..." 3.1-32(a)		*A. The facility policy & procedure on meal service* *B. The facility policy & procedure on residents' rights related to dignity* *Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated.* *At the weekly QA meetings, the monitoring of the DON/Designee will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.*	
F 0623 SS=B Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a			

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	resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.			

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	§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the			

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	facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on record review and interview, the facility failed to document notification of the ombudsman in the resident's clinical records related to the transfer and discharge of residents for 4 of 5 residents reviewed for resident rights. (Residents 54, 61, 169 and 2). Findings included: 1. Clinical record review, on 1019/18 at 8:35 a.m., indicated Resident 54 had diagnoses which included, but were not limited to, acute respiratory failure with hypoxia, dysphagia, essential hypertension, hemiplegia, and hemiparesis following unspecified cerebrovascular disease CVA (stroke). Resident 54's Quarterly MDS (Minimum Data Set) assessment, dated 9/7/18, indicated the resident was moderately cognitively impaired. The Care Plans for Resident 54 included, but were not limited to, Resident is at risk of CVA due to past history of CVA with hemiparesis.	F 0623	F-623 It is the policy of the facility to give notice of transfer. Before a facility transfers or discharges a resident, the facility must- (i) notify the resident and the residents' representative(s) of the transfer or discharge and the reason for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical recorded in accordance with paragraph (c)(2) of this section; and (iii) include in the notice the items described in paragraph (c)(5) of this section. (c)(4) Timing of the notice. Except as	11/23/2018

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	A Change in Condition nursing note, dated 7/1/18, indicated the resident had symptoms which appeared as if the resident had a stroke and was sent to the hospital. No information was included in the resident's record regarding notification of the ombudsman. On 10/22/18 at 1:02 p.m., the Social Worker indicated "The Ombudsman told us to just send her a monthly list. I do not send her a copy of the notices. A copy of the notice sent with the resident to the hospital is just put in the chart. I don't document in the clinical record that I have notified her." 2. Clinical record review for Resident 61, on 10/22/18 at 9:27 a.m., indicated the resident had diagnoses which included, but were not limited to, Hepatic failure, alcoholic liver disease, abnormality of gait and mobility, alcoholic hepatitis without ascites, Vitamin B12 deficiency anemia, and multiple endocrine neoplasm type 1. Review of the Quarterly MDS assessment, dated 9/12/18, indicated the resident was unable to respond to the questions to determine cognitive status. On 10/22/18 at 10:00 a.m., review of the resident's care plans, dated 8/16/18, included, but were not limited to, Potential for pain related to chronic pain, liver failure, general or acute pain/ The resident was at risk for abnormal labs related to anemia, B12 deficiency, and Hepatitis; an altered Endocrine System related to multiple endocrine neoplasia; an alteration in hematological status related to anemia; a gastrointestinal bleed; and Liver disease related to Hepatitis.		specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of the individual in the facility would be endangered under paragraph (c)(1)(i)(D) of this section; (C) The residents health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(A) of this section ; or (E) A resident has not resided in the facility for 30 days. (c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i)The reason for transfer or discharge; (ii) the effective date (iii) the location to which the resident is transferred or discharged; (iv) a statement of the resident's appeal rights, including the name,, address (mailing and email) and telephone number of the Office of the state Long-Term Care Ombudsman; (vi) for nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental	

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	A Nurses Note, dated 10/6/18, indicated the resident was found by staff on the floor. Resident was non-responsive for five minutes. The resident was oriented to self only with a Blood Pressure of 99 systolic and 53 diastolic. The residents temperature was 87.8 fahrenheit and his heart rate was 131. New orders were received to send the resident to the hospital for evaluation and treatment. No information was included in the resident's record regarding notification of the ombudsman for the discharge of the resident to the hospital. 3. Closed clinical record review for Resident 169, on 10/22/18 at 1:13 p.m., indicated the resident had diagnoses which included, but were not limited to, Pneumonia, other cerebrovascular disease, chronic pain, unspecified dementia with behavioral disturbance, and dysphagia oropharyngeal phase The Quarterly MDS assessment, dated 10/5/18, indicated the resident was cognitively intact and able to make decisions. A Nurses Note, dated 9/1/18, indicated the resident was sent out to the hospital due to fever, difficulty to arouse, diminished lung sounds, low oxygen saturation levels with productive coughing, and gurgling. No information was included in the resident's record regarding notification of the ombudsman related to the residents discharge to the hospital. 4. Resident 2's Quarterly MDS assessment, dated 09/07/18, indicated the resident had moderate cognitive impairment, a diagnosis of Alzheimer's disease, and dementia.		disabilities established under Par C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000; and (vii) for nursing facility residents with a mental disorder or related disabilities, the mailing ad email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection an Advocacy for Mentally III Individuals Act. (c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharges, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. Notice in advance of facility closure in the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the residents All notices to the Ombudsman realted to transfers and or discharges will be documented in the resident's medical record . Ombudsman was notified of Resident #54 discharge on 10-22-18 A note will be placed in this Resident's medical record stating	

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	The care plans for Resident 2, dated 09/06/18, were reviewed on 10/22/18 at 10:44 a.m. The resident's care plans included, but were not limited to, approaches for a diagnosis of dementia with behavioral disturbance, history of sexual behavior, and a history of physical aggression with peers and staff. The clinical record for Resident 2 was reviewed on 10/22/18 at 11:07 a.m. A nurse's note, dated 09/07/18, indicated the resident was sent to the behavioral hospital. No information was included in the resident's record regarding notification of the Ombudsman. 3.1-12(a)(6)(A)(iv)		this Ombudsman was notified how and by whom Ombudsman was notified of Resident #2 discharge on 10-22-18 A note will be placed in this Resident's medical Record stating this Ombudsman was notified how and by whom Ombudsman was notified of Resident #169 discharge on 10-22-18 A note will be placed in this Resident's medical Record stating this ombudsman was notified how and by whom All Residents who reside in the facility have the potential have to be affected by this finding. A 30 day look back to identify all residents who were discharged to ensure notification was made to area ombudsman and area of concerns were addressed. A note was placed in the medical record of these residents stating the Ombudsman was notified to include when, how and by whom. *An audit was conducted to compile a list of residents at risk for ombudsman not being notified of transfer or discharge from facility. The SS/Designee will monitor all discharge residents 3 days weekly to ensure that ombudsman is notified*	

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			appropriately and in a timely manner. Notification will be placed in the Residents medical record to include when and by whom. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, all residents discharged will be monitored weekly for a period of not less than 6-month to ensure ongoing compliance. After that, random monitoring will occur ongoing. Any concerns will be addressed as discovered. *At an in-service held on 11-7-18 Social Serivces was inserviced by administer on Facility Policy related to Ombudsman notice of Transfer and Discharge. To include the fact that notifications to them Ombudsman are to be documented in the Resident's medical record to include when and by whom.* Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. *At the weekly QA meetings, the monitoring of the SS/Designee will be reviewed. Any concerns will*	

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			have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment,			

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	including both the comprehensive and quarterly review assessments. Based on observation, record review, and interview, the facility failed to revise a resident's care plan related to noncompliance of fluid restriction. This deficit practice effected 1 of 19 residents reviewed for care plans. (Resident 37). Findings include: A review of the clinical record for Resident 37, on 10/19/18 at 1:52 p.m., indicated the resident's diagnoses included, but were not limited to, end stage renal disease, hypertension, dependence on renal dialysis, and type 2 diabetes mellitus with diabetic autonomic neuropathy. On 10/24/18 at 10:52 a.m., a review of the physician's orders for October 2018 indicated the resident had an order for a 1600 ml (milliliter) fluid restriction in 24 hours. The resident may have 100 ml in 24 hours from nursing. "Dietary will provide 500 ml per meal." A review of the clinical record, on 10/23/16 at 07:09 p.m., indicated the clinical record lacked documentation for the interventions of the resident's noncompliance to the fluid restriction. An admission MDS (Minimum Data Set) assessment, dated 08/16/18, indicated the resident was alert and oriented. A record review of the Fluid Restriction Document, on 10/24/18 at 12:13 p.m., indicated the following, total fluid allowed per day 1600 ml/cc (cubic centimeter), 500 ml/cc at breakfast, lunch and supper. Total amount of fluid nursing staff can give with medications includes 100 ml/cc to be given with	F 0657	F-657 It is the policy of the facility to ensure that a comprehensive care plan be developed after the completion of the comprehensive assessment. Which shall be reviewed and revised byt the IDT team after each assessment, including both the comprehensive and quarterly review. Resident #37 care plan has been reviewed and upadated accordingly. All residents who reside in this facility has the potential to be affected by this finding. All care plans were reviewed to ensure that they are accurate based on the assessed needs of the residents with appropriate interventions and measurable goals. *An audit was conducted to compile a list of residents at risk for failure to revise residents care plans. DON/designee will monitor 5 residents 3 days weekly to ensure that care plans are revised and updated accordingly. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, 3 residents care plans will be monitored weekly for a period of not less than 6-month to ensure ongoing compliance. After that, random monitoring will occur ongoing. Any concerns will be*	11/23/2018

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	medications, day shift 40 ml/cc, evening shift 40 ml/cc and night shift 20 ml/cc. On 10/22/18 at 02:28 p.m., during an observation the resident had a regular coke (20 ounces/591ml) sitting on his bedside table with about three fourths of the bottle gone. The resident had several snacks at his bedside and was observed drinking a coke. During an observation, on 10/18/18 at 10:50 a.m., the resident had a can of Pepsi, bottle of coke, and snacks at the bedside. The resident indicated, "I go to the Dollar Store and get my snacks and drinks." On 10/23/18 at 01:08 p.m., during an observation the resident had a twelve pack of coke sitting on his bed side table. There were two twelve fluid ounce empty coke cans along with one empty twenty fluid ounce coke bottle and one twenty fluid ounce coke bottle with about half of the coke gone. An interview, on 10/22/18 at 02:25 p.m., (Licensed Practical Nurse)14 indicated the resident was aware of his fluid restriction. Nursing staff provided 500 ml with his meals and 100 ml with medications. He was noncompliant with his fluid restriction and often went out to eat at fast food restaurants with friends and family. He was very vocal about his wants. An interview, on 10/23/18 at 01:48 p.m., the DON indicated the resident was noncompliant with his fluid restrictions. "We know what we give him, but we have no idea what he drinks when he goes out. He brings back cokes to drink when he goes out. He should be care planned for non-compliance."		*addressed as discovered.* *At daily CQI meeting orders received from previous CQI meeting will be reviewed and care plans will be reviewed and updated according.* At an in-service held on 11-7-18 IDT Team was inserviced by Administrator on Facility Policy related to Care Plans and revision of Care Plans. *Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated.* *At the weekly QA meetings, the monitoring of the DON/Designee will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.*	

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	An interview, on 10/23/18 at 02:25 p.m., the Dietary Manager indicated, "He was on a fluid restriction and I knew he was non-compliant with that. We don't set up any of the drinks on the meal trays. Nursing will add them when the trays are served. We send all the drinks down on a cart on ice to be served." A current Care Plan policy was provided by the MDS Coordinator on 10/24/18 at 09:34 a.m., and included, but was not limited to, "...The Comprehensive Care Plan will be reviewed and updated every quarter at a minimum. The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psycho-social issues." 3.1-35(a) 3.1-35(b)(1)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and			

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	assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure physician's orders were followed related to the placement of a resident's splinting device for 1 of 1 residents reviewed for mobility. (Resident 26). Findings include: During an observation and interview, on 10/18/18 at 10:36 a.m., Resident 26 was observed to have a left hand contracture. No splint device was observed in place. The resident indicated therapy had worked with him for a little while and he did not have any splinting devices. During an observation of the resident, on 10/19/18 at 01:34 p.m., he was laying in his bed. No splinting device was on the left hand or elbow. During an observation, on 10/22/18 at 09:50 a.m., the resident was sitting in his wheelchair in the Main Dining Room. The resident was not wearing a left elbow brace or left hand brace. During an observation, on 10/22/18 at 01:40 p.m. and 10/24/18 at 01:49 p.m., the resident was sitting in his wheelchair in the television area. No brace was observed on the left elbow, hand, or ankle. A review, on 10/19/18 at 01:06 p.m., of Resident 26's diagnoses included, but were not limited to, hemiplegia, hemiparesis, contracture of the muscle, left hand, ankle and foot, and a traumatic brain injury. On 10/19/18 at 01:11 p.m., the review of the Care	F 0688	**F-688** *It is the policy of the facility to ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.* *Resident #26 has been assessed for range of motion and has been care planned with interventions in place to improve or at least maintain mobility function to the greatest degree possible going forward.* *All residents who reside in the facility have the potential to be affected by this finding.*	11/23/2018

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	Plan, initiated on 04/27/17 and updated on 02/07/18, indicated "The resident requires a restorative program for splint/brace to prevent further loss of movement and ensure proper limb alignment...Evaluate and revise the program as needed. left elbow splint up to 8 hours daily. left flex boot [ankle] up to 8 hours daily. left hand splint up to 8 hours daily. Notify therapy, md and family of any decline or changes as needed. Resident will wear left foot splint/boot daily for up to 8 hours, staff to assist with applying splints and to monitor skin while using." The Care Plan, initiated on 08/12/14 and revised on 10/07/15, indicated "Resident has a contracture to left shoulder, elbow & hand r/t [related to] DX [diagnosis] of hemiplegia." Interventions indicated "Inform MD of any changes to contracture...Splint per order..." A review, on 10/19/18 at 01:23 p.m., of the Physician's Orders for Resident 26, dated 10/10/18, indicated "Left hand splint up to 8hrs [hours] dly [daily] every day shift for prevent contracture," and "Left elbow splint up to 8hrs dly every day shift for prevent contracture....left flex boot [ankle] to be worn 8 hours Q [every] shift. Assess skin before et [and] after use every shift for Left ankle." On 10/19/18 at 01:27 p.m., the review of the Progress Note, dated 11/17/17 at 3:54 p.m., by LPN (Licensed Practical Nurse) 7 indicated Resident 26 continued with the splinting of his left elbow, hand, ankle and foot at least six days per week. "Continue much encouragement to wear and to continue ROM [range of motion]..." At 3:40 p.m., the LPN indicated, "... [resident] continues to participate and receive PROM [passive range of motion] to upper and lower affected left side. No		*An audit was conducted to compile a list of residents at risk for loss of range of motion to ensure that they had appropriate interventions in place to improve or at least maintain mobility and function to the greatest degree possible going forward. The DON/Designee will monitor 5 residents (on a rotating basis) 3 days weekly to ensure that appropriate interventions related to range of motion are care planned and being implemented. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, 3 residents will be monitored 3 days weekly for a period of not less than 6-month to ensure ongoing compliance. After that, random monitoring will occur ongoing. Any concerns will be addressed as discovered. As residents are admitted or have a change of condition that affects their range of motion abilities, they will be added to the targeted list based on the need for interventions to improve or at least maintain their range of motion ability.* *At an in-service held on or before 11.12.18 for all staff the following was reviewed:* *A. The facility policy & procedure on range of motion*	

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	rest breaks needed, no increase in pain noted. Continue to encourage splints, exercise and extensions of limbs to further prevent contractures..." The Progress Note, dated 05/09/18 at 10:14 a.m., by MDS (Minimum Data Set) Coordinator indicated, "Res [Resident 26] continue programming for splinting of Left foot/ankle/upper extremity. Left foot/ankle is encouraged but resident does not wear daily. Left elbow/wrist splinting noted to be worn daily..." The Progress Note, dated 08/09/18 at 10:45 a.m., by the MDS Coordinator indicated "res [Resident 26] continues to receive assist for ...splinting...staff provide all care..." The Progress Note, dated 10/10/18 at 3:13 p.m., by ADON (Assistant Director of Nursing) indicated "Orders for brace left elbow and hand via therapy recommendation, clarification to left ankle brace per MD..." Resident [26] and resident's representative aware. On 10/24/18 at 01:53 p.m., during an interview and observation RN 9 indicated she did not know about the resident wearing braces. "He had them the last time I was over on this hall a few weeks ago." After reading the resident's orders she indicated the splints were to be applied when he was up in his chair. She entered the resident's room and found his left elbow and boot splint inside the bedside table. During an interview, on 10/24/18 at 01:57 p.m., the PTA (Physical Therapy Assistant), indicated the resident was supposed to have an ankle foot splint on for up to three hours or as tolerated. He had an elbow and hand splint to be worn for up to		*B. The facility policy & procedure on positioning and mobility* *C. Splinting and therapy services* *Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated.* *At the weekly QA meetings, the monitoring of the DON/Designee will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.*	

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	four hours daily or as tolerated. On 10/24/18 at 02:02 p.m., during an interview with CNA 11 she indicated she has tried to get Resident 26 to wear the splints this week and Monday was the only day she could get him to wear them. During an interview, on 10/24/18 at 02:06 p.m., the MDS Coordinator indicated the CNAs documented when the resident wears his splints. On 10/24/18 at 2:22 p.m., the Administrator indicated for splint therapy the MDS Coordinator sets up the restorative information and the CNAs makes sure the splints are done. On 10/24/18 at 03:07 p.m., during an interview RN 9 indicated the resident's splints were supposed to be worn for eight hours daily. The resident sometimes refused the splints and when he refused it was documented in the Nurse's Notes. During an interview, on 10/24/18 at 03:15 p.m., the MDS Coordinator indicated the CNA charting for the resident's splint device application could not be accessed. Later she provided a copy of the August charting but indicated the information had been wiped clean for some reason. A review of the staff charting for Resident 26 indicated, between 07/30/18 and 08/10/18, the resident was wearing the device every day except for two days. The review, on 10/24/18 at 3:18 p.m., of the Physical Therapy PT Evaluation & Plan of Treatment, dated 01/30/18 of the, "Orthotic Management indicated, "...patient was compliant with wearing brace but nursing staff have not			

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	beenn [sp]consistent with putting it on patient..." The Physical Therapy Discharge Summary dated 03/03/18 indicated, "...Pt and Caregiver Training: Instructed primary caregivers in splinting/orthotic schedule and self care/skin checks in order to minimize L ankle contracture and increase tolerance for wearing without skin compromise. Patient Response. Progress & Response to Tx [treatment]: Resident is able to tolerate up to 6 hours of wearing L ankle orthosis with good skin integrity after removal. Pt. is cooperative during therapy treatment; Patient responded positively to treatment strategies provide..." 3.1-35(g)(1)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment			

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	conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.			

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	Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to follow proper infection control guidelines related to suprapubic urinary catheter and perineal care for 2 of 4 residents reviewed for infection control. (Resident's 26 and 32) Findings include: 1. During an observation, on 10/23/18 at 10:27 a.m., LPN (Licensed Practical Nurse)12 provided suprapubic catheter care for Resident 26. LPN 12 removed the drain sponge and cleansed the stoma and suprapubic area using normal saline and gauze. She then dried the area and applied a new dressing around the insertion site. She did not cleanse the catheter tubing during care. The physician's orders for Resident 26 were reviewed on 10/24/18 at 09:09 a.m. His orders included, but were not limited to, a catheter was needed for a diagnosis of urethral erosion and to provide suprapubic catheter care every shift. The care plans for Resident 26 were reviewed on 10/24/18 at 09:12 a.m. The care plans included, but were not limited to, "... Obstructive Uropathy from Urethral Erosion with need for Suprapubic Catheter... cath[catheter] care every shift and prn [as needed]..." During an interview, on 10/24/18 at 10:06 a.m., the	F 0880	**F-880** *It is the policy of the facility to provide an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to (e) and following accepted national standards; (a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or*	11/23/2018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	DON (Director of Nursing) indicated she would expect during catheter care, the nurse would cleanse the insertion site from the inside out using normal saline and gauze, and then using a clean gauze cleanse the catheter tubing about 3 to 4 inches before applying a clean dressing. She would definitely expect the staff to cleanse the tubing during supra-pubic catheter care. 2. During an observation, on 10/22/18 at 01:40 p.m., CNA (Certified Nursing Assistant) 5 and CNA 6 provided perineal care for Resident 32. Both CNAs assisted the resident to bed. CNA 6 removed the resident's brief. CNA 6 then used pre-moistened wipes to cleanse the resident. Starting with the groin, she made two swipes down each side, and then made two swipes between the labia using the same side of the cloth. Using a new cloth she made two more swipes between the labia, changed sides, and continued to swipe four more times before throwing the wipe away and getting a new one. CNA 5 then helped roll the patient onto her right side. CNA 6 used a clean wipe to cleanse the rectum from front to back. She made four passes with the same side of the wipe before discarding the wipe and putting a clean brief on the resident. During an interview, on 10/24/18 at 10:04 a.m., the DON indicated she would expect, during perineal care, CNAs to cleanse the resident from front to back, using a clean wipe or changing sides of the cloth with each swipe. During an interview, on 10/24/18 at 11:08 a.m., CNA 2 indicated she normally would cleanse the resident's perineal area from front to back and would always change sides of the cloth or grab a new cloth for each swipe. She stated" I shouldn't have made multiple passes with the same cloth, I		*infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. (a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.*	

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	155494	A. BUILDING 00 B. WING	10/24/2018

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	was just nervous." The review of the most current "Supra-Pubic Catheter Care" policy and procedure, provided on 10/23/18 at 11:15 a.m., indicated, but was not limited to, "... Cleanse the catheter area by washing the stoma area first followed by cleansing proximal 1/3 of catheter with normal saline soaked gauze..." The review of the most current "Incontinence Care" policy and procedure, provided on 10/23/18 at 11:15 a.m., indicated, but was not limited to, "... Cleanse peri-area and buttocks with cleansing agent wiping from front of perineum toward rectum. Use separate area of cloth for each stroke..." 3.1-18(a)		*Resident #26 had their suprapubic catheter care performed by qualified staff who followed proper techniques in full compliance with regulatory requirements related to infection control as well as the facility's infection control policies.* *Residents #32 had their perineal care performed as per regulatory requirements as well as the facility's infection control policies.* *Residents who reside in the facility have the potential to be affected by this finding.* *At an in-service held on or before 11.12.18 for facility staff by the DON/Designee the following was reviewed:* *A. The facility policy and procedure on infection control* *B. The facility policy and procedure on suprapubic catheter care* *C. The facility policy and procedure on perineal care* *Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated.* *An audit was completed to compile a targeted list of 1) Residents who have suprapubic catheters and 2) residents who*	

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			require perineal care. *The DON/Designee will monitor 3 suprapubic catheter cares 3 days weekly on various shifts to include some weekend shifts as well as different nurses to ensure that all protocol is followed to include proper procedure. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, at least 1 suprapubic care 3 days a week will be monitored for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur ongoing. Any concerns will be addressed and corrected as discovered.* *The DON/Designee will monitor 5 perineal cares 3 days weekly on different shifts and to include some weekend shifts to ensure that appropriate protocol related to perineal care is followed. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, residents receiving perineal care will be monitored at least weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur ongoing. Any concerns will be addressed and corrected as discovered.* *At the weekly QA meetings, the*	

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			monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	