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	12/15/2017

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. Survey dates: December 11, 12, 13, 14, and 15, 2017 Facility number: 000478 Provider number: 155494 AIM number: 100290430 Census Bed Type: SNF/NF: 62 Total: 62 Census Payor Type: Medicare: 7 Medicaid: 48 Other: 7 Total: 62 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 19, 2017	F 0000	Preparation and or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is January 12th, 2018. We respectfully request Desk Review	

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

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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.			

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	(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. [illegible]	F 0657	**F-657-D** It is the policy of the facility to ensure that care plans reflect concerns with measurable goals and interventions to attain those goals for each resident. This includes interventions for residents with a risk for falling (to include a bed in a low position) and those who require interventions for positioning (to include the need to have their heels floated while in bed) in order to achieve proper and safe body alignment for the resident(s) as much as possible. Resident #40 has had their care plan reviewed and updated and it reflects appropriate interventions in an effort to prevent falls as well as to ensure proper and safe body alignment as much as possible. Residents at risk for falls or residents who have an inability to properly position themselves have the potential to be affected by this finding. A facility wide audit was conducted in order to formulate a targeted list of residents who by assessment (Fall and ADLs) trigger for fall risk and/or inability to	01/12/2018

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			independently maintain proper and safe positioning (to include the need to have their heels floated while they are in bed). These residents had their care plans and their CNA Assignment Sheets reviewed. Any concerns were addressed and the care plans and CNA Assignment Sheets were updated as indicated. Going forward, at the time of a resident's admission, re-admission, change of condition (to include a decline in ADLs), or a fall, the care plan will be reviewed by the IDT team as per policy to ensure that appropriate interventions are in place. CNA Assignment Sheets will also be addressed at these times to be sure they reflect required CNA interventions. The 24 Hour Report will be reviewed at the daily CQI Meetings. At this time, falls as well as changes in condition will be reviewed with care plans and CNA Assignment Sheets updated as indicated. This practice will be ongoing as part of the daily CQI Meeting Agenda. The DON/Designee will monitor 5 residents 3 days weekly to ensure that the interventions for residents at risk for falls and/or residents who require interventions for proper and safe alignment/positioning have those interventions care planned and on CNA Assignment Sheets and are in fact being implemented. This monitoring will continue until 4	

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			consecutive weeks of zero negative findings is achieved. Afterwards, 5 residents in this group will be monitored weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will continue ongoing. Any concerns will be addressed as discovered. At an in-service held 12-18-17, for nursing staff with input from the MDS Consultant, the following was reviewed: A.) What is a Care Plan? B.) Where do concerns addressed on the care plans come from? C.) What is an "Assessment" who completes the assessments? D.) What is meant by an "intervention" and a "measurable goal?" E.) How are CNA Assignment Sheets related to the Care Plan? F.) How often are care plans and CNA Assignment Sheets updated? G.) Who should be informed if a care plan intervention is not being implemented for whatever reason? Ex: Intervention is to float heels but resident kicks pillows out of the bed	

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			H.) What are "fall interventions?" Ex: Keeping the bed in low position H.) Questions/Answers—Discussion 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 monthly QA Meetings the results of the monitoring will be reviewed. Any concerns will have been addressed as discovered. Any patterns will be identified. If necessary, an Action Plan will be written by the QA Committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	
F 0842 SS=D Bldg. 00	483.20(f)(5); 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.			

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	§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge			

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	when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	[illegible] 2. During an observation on 12/11/17 at 03:02 P.M., Resident 164 was walking up to all the exterior outside exit doors and pulling/pushing on the doors. The staff redirected the resident three times within five minutes. The resident then walked up to the exit door into the general population and stood beside the door trying to walk out with other staff and/or visitors. During an observation on 12/12/17 at 02:36 P.M., Resident 164 had been sitting at a table in the common area. Two staff members were present in the common area.	F 0842	**F-842-D** It is the policy of the facility to accurately track and document resident behaviors as part of the process to ensure that these residents have their needs met and they are kept safe and have quality to their lives as much as possible. Resident #7 and Resident #164 have their behaviors tracked and documented accurately. Residents who have behaviors have the potential to be affected by this finding. A facility wide audit was conducted in order to compile a targeted list of residents who have behaviors as indicated by assessment. These residents have had their e-mars addressed and	01/12/2018

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	The resident stood up and wondered into another resident's room. After a few minutes, CNA (Certified Nursing Aide) 2 went into the room and redirected the resident out of the room and down the hall to his room to lay down. During an interview on 12/12/2017 at 02:39 P.M., CNA 2 indicated the resident was new and he was easy to redirect. During an interview on 12/12/2017 LPN (Licensed Practical Nurse) 5 indicated last week the resident was trying to follow visitors and staff out of the door. He currently has no alarms and staff watch him closely. During an interview on 12/12/2017 at 03:50 P.M. the DON (Director of Nurse) indicated she was just in a behavior care plan meeting last week and questioned why there were blanks on the behavior forms. During an interview on 12/12/2017 at 04:23 P.M. the SSD (Social Service Director) indicated there should not be any blanks on the behavior forms. During an interview on 12/13/17 at 10:36 A.M. LPN 5 indicated Resident 164 was up and walking on his own for two weeks.		appropriate staff are documenting and tracking behaviors timely and accurately. This information is available for review and discussion at the monthly Behavior Meetings. Going forward, the DON/ADON and/or SSD will monitor 5 residents daily 3 days a week to ensure that their behaviors are being documented accurately and timely. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, 5 residents will be monitored weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will continue ongoing. Any concerns will be addressed as discovered. Additionally, the SSD/Designee will monitor the 24 Hour Report daily to see that behaviors documented in the progress notes have been documented in the tracking system. Any concerns will be addressed as found. This practice will be ongoing as part of the daily CQI Meeting agenda. Also, any new behaviors will be addressed and any new or revised interventions that need to be implemented will be discussed and added to the care plan and also added to the CNA Assignment Sheet if applicable. Note: Any new or significant or increase in behaviors will be reported to the resident's responsible party as well as the resident's physician.	

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	The resident had been walking around looking and trying to get out of doors for the last week. The clinical record for Resident 164 was reviewed on 12/13/2017 at 1:52 P.M. The admission MDS (Minimum Data Set) assessment, dated 11/23/2017, indicated the resident did not exhibit any wandering behaviors. The resident's diagnoses included, but were not limited to, dementia and anxiety. The Review of the care plan for at risk for elopement, exit seeking indicated the interventions included, but were not limited to, redirect when wandering and wander risk assessment quarterly and as needed. initiated 12/04/2017. The "Behavior Monthly Flow Sheet" dated December 2017 indicated the resident was monitored for wandering and elopement/exit seeking. The form was left blank on the following days for evening shift: December 7, 8, 9, and 10, 2017. The form was left blank on the following days for day shift: December 4, 5, 6, 7, and 11, 2017. The form had no exit seeking behaviors indicated for December 1 through 11, 2017.		At an in-service held 12-18-17, for all staff given by the Administrator and the DON, the following was reviewed: A.) What is a “behavior?” B.) What should you do in your role if you witness a resident “behavior?” Whom should you report it to? When should you report it? Why is reporting it so important? C.) Questions/Answers--Discussion NURSES: A.) Why is it important to have behaviors documented in a “tracking” system? B.) What is a GDR? C.) What is the relation between behavior tracking results and GDRs? D.) Instruction on the proper way to document behaviors for tracking in PCC E.) Why care plan interventions for behaviors? F.) Why must CNA Assignment Sheets include	

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	On 12/12/17 at 12:49 p.m., the Administrator provided a current copy of the document titled "Behavior Management Program." The policy included, but was not limited to, the following: "Policy: It is the policy of the facility to assess those residents exhibiting problematic behavior...each resident who exhibits problematic behaviors will have a form for monitoring his/her status and will be maintained weekly by the team. Residents experiencing more than one problematic behavior will need a separate form for each behavior for more accurate documentation..." 3.1-50(a)(1) 3.1-50(a)(2)		non-pharmacological interventions for behaviors? G.) Questions/Answers—Discussion 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 monthly QA Meetings, the results of the monitoring will be reviewed. Any concerns will have been addressed as found. However, any patterns will be identified. If necessary, an Action Plan will be written by the QA Committee. Any written Action Plan will be monitored weekly by the Administrator until resolution.	
F 0880 SS=E 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.			

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	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 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			

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	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. 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 [illegible]	F 0880	**F-880-E** It is the policy of the facility to ensure that the Infection Control Log is accurate and complete and reflects all required infection related facts and statistics that have occurred in the facility month to month. Since the time of the survey, the Infection Control Log has been kept accurately and completely and will continue to be kept accurately and completely month to month. Residents who reside in the facility have the potential to be affected by this finding.	01/12/2018

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			The DON/ADON will meet weekly with the Administrator to review the accuracy and completeness of the Infection Control Logs until 4 consecutive weeks of zero negative findings is achieved. Afterwards, this monitoring will be done monthly ongoing as a part of the monthly QA Meeting agenda. Additionally, the Nurse Consultant for the building will monitor the Infection Control Logs monthly for a period of not less 6 months to ensure ongoing compliance. Note: On 12-28-17, the Nurse Consultant for the facility in=serviced the DON/ADON on the Infection Prevention and Control policies. At an in-service held 12-18-17, for the nursing staff given by the DON/ADON, the following was reviewed: A.) Infection Control—IPCP (Review of the Infection Prevention Control Policy) B.) Why is it important to track and map infections in the facility? C.) What should you do if a resident demonstrates signs and symptoms of infection? (Review of examples of infectious signs and symptoms)	

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			D.) How important is hand washing as related to infection? E.) What should be documented related to infections? Where should the documentation appear? F.) Questions/Answers--Discussion Any staff who fail to comply with the points of the in-servicing will be further educated and or progressively disciplined as indicated. At the monthly QA Meetings the results of the Infection Control Log monitoring will be reviewed. Any concerns would have been addressed as discovered. However, any patterns will be identified. If necessary, an Action Plan will be written by the QA Committee. Any written Action Plan will be monitored weekly by the Administrator until resolution.	

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F 0881 SS=E Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on interview and record review, the facility failed to ensure the antibiotic stewardship was put in place, per the facility policy, for 2 of 2 months reviewed for antibiotic use. This had the potential to effect 15 residents. Findings include: The November 2017 infection control log indicated 8 residents were documented with infections within the facility. The December 2017 infection control log indicated 7 residents were documented with infections within the facility. There was no documentation of the implementation of the antibiotic stewardship compliance tool for infections or discussion with the physician related to antibiotic use.	F 0881	**F-881-E** It is the policy of the facility to ensure that the Antibiotic Stewardship Program is in place and its components are implemented for each resident who has an antibiotic ordered, or who has signs and symptoms suggestive of an infectious process. This includes defining whether or not the McGeer's criteria is met. Further, to include completion of the Antibiotic Stewardship Worksheet—case by case. Going forward, residents who have an antibiotic ordered or who have signs and symptoms suggestive of an infectious process will have the components of the Antibiotic Stewardship Program rolled out to include completion of the Antibiotic Stewardship Worksheet. These residents will be reviewed in the CQI meetings daily and they will be tracked via the White Board System. As nurses report signs and symptoms of a potential infectious	01/12/2018

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	155494	A. BUILDING 00 B. WING	12/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	During an interview on 12/14/17 at 10:10 a.m., the Director of Nursing indicated the compliance tool for the antibiotic stewardship had not yet been put into place. During an interview on 12/14/17 at 4:19 p.m., the Administrator indicated they had recently selected a staff member to serve as the Infection Preventionist and have scheduled her for certification, however, the facility had not yet begun using the antibiotic stewardship compliance tool. On 12/12/17 at 12:49 p.m., the Administrator provided a current copy of the document titled "Antibiotic Stewardship". It included, but was not limited to, the following: "...It is the policy of the facility to ensure that ANTIBIOTIC STEWARDSHIP is practiced within the facility...to include ensuring that antibiotics are prescribed and administered using the guidelines as stated in the...Criteria...The purpose being to ensure that residents are not subjected to the inappropriate use of antibiotics...The Infection Preventionist/Designee will have documented discussions with the physician as indicated related to antibiotic use and the...criteria being met and the facility's responsibility related to what could be considered unnecessary medications..."		process to the physician, the discussion of McGeer's criteria will take place in an effort to avoid an unnecessary drug. Residents who reside in the facility have the potential to be affected by this finding. The Infection Preventionist in conjunction with the DON/ADON will review the 24 Hour Report daily at the CQI Meetings as well as the orders received since the prior CQI meeting to ensure that residents who have an antibiotic ordered or who present with signs and symptoms suggestive of an infectious process have the components of the Antibiotic Stewardship Program implemented. Any concerns will be addressed as discovered. The Medical Director will be consulted as necessary for support and reference to assist the facility in compliance with the related state and federal regulations associated with Antibiotic Stewardship. The DON/Designee will monitor 5 residents on antibiotics weekly to ensure that compliance with the Antibiotic Stewardship Program has been considered and any concerns addressed. Any concerns will be immediately presented to the Administrator and the Medical Director.	

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			Note: On 12-28-17, the Nurse Consultant for the facility in-serviced the DON/ADON on the Antibiotic Stewardship Program. At an in-service held 12-18-17, for nurses the following was reviewed: A.) Antibiotic Stewardship Program B.) Antibiotic Stewardship Worksheet—Who fills it out? When? C.) What is McGeer's Criteria? D.) When can an antibiotic be considered an "unnecessary drug?" E.) What information should the physician be given prior to an antibiotic being ordered? F.) What is the Medical Director's role in the Antibiotic Stewardship Program? G.) Questions/Answers—Discussion Any staff who fail to comply with the points of the in-servicing will be further educated amd/or progressively disciplined as indicated.	

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			At the monthly QA Meetings the results of the Antibiotic Stewardship Program will be reviewed. Any concerns will have been addressed. However, any patterns will be identified. If needed, an Action Plan will be written by the QA Committee. Any written Action Plan will be monitored weekly by the Administrator until resolution.	