**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER**

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<tr>
<th>X1) PROVIDER/SUPPLIER/CLIA</th>
<th>X2) MULTIPLE CONSTRUCTION</th>
<th>X3) DATE SURVEY</th>
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<tr>
<td>PROVIDER/SUPPLIER/CLIA</td>
<td>A. BUILDING 00</td>
<td>COMPLETED 11/16/2018</td>
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**STATEMENT OF DEFICIENCIES**

**NAME OF PROVIDER OR SUPPLIER**

WATERS OF BATESVILLE, THE

958 E HWY 46

BATESVILLE, IN 47006

**STREET ADDRESS, CITY, STATE, ZIP CODE**

**STATEMENT OF DEFICIENCIES**

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<th>(X4) ID</th>
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**Bldg. 00**

This visit was for a Recertification and State Licensure Survey.

Survey dates: November 09, 13, 14, 15, and 16, 2018

Facility number: 000138

Provider number: 155233

AIM number: 100266500

Census Bed Type:

SNF/NF: 59

Total: 59

Census Payor Type:

Medicare: 5

Medicaid: 46

Other: 8

Total: 59

These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.

Quality review completed on November 26, 2018.

**483.10(e)(2)**

Respect, Dignity/Right to have Prsnl Property

§483.10(e) Respect and Dignity.

The resident has a right to be treated with respect and dignity, including:

§483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

Based on observation, interview, and record

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

_____________________________________________________________________________________________________

**TITLE**

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

**DATE**

12/16/2018

Any deficiencies statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosed 30 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
review, the facility failed to maintain a resident's dignity related to resident services for 1 of 24 residents reviewed for dignity. (Resident 16)

Findings include:

An observation of staff providing toileting assistance for Resident 16 was conducted on 11/15/18 at 11:42 A.M. The resident's soiled night gown was left in the bathroom in a bag on the floor and a dirty brief was left in the trash can. There was a strong smell of feces in the room.

During an interview, on 11/15/18 at 12:15 P.M., Resident 16 expressed her displeasure and indicated the staff leave dirty briefs in her trash can all day long sometimes. The staff leave soiled laundry in her bathroom unless she asks them to take it out.

During an observation and interview, on 11/15/18 at 02:26 P.M., Resident 16 expressed her displeasure and indicated the staff had not taken her soiled laundry out of her room. A clear bag containing the soiled nightgown was still noted on the floor of the bathroom. The resident's room continued to smell of feces and she had a visitor sitting in her room.

The clinical record for Resident 16 was reviewed on 11/15/18 at 11:00 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 09/06/18, indicated the resident was cognitively intact and needed assistance of one staff member for toileting and personal hygiene. Diagnoses included, but were not limited to, anemia, anxiety, depression, muscle wasting, lack of coordination, chronic kidney disease, and contractures of both the right and left hands.

It is the intent of this facility to ensure all residents are treated with respect and dignity including:

- The right to retain and use personal possessions, including furnishings, and clothing as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

Action Taken: Resident #16 has her soiled linens and soiled briefs removed immediately from her room to ensure her environment is dignified and odor free. Soiled linens are not left in bags on the floor. Soiled briefs are not disposed of in the wastebasket in the room.

Others Identified: Residents who reside at the facility have the potential to be affected by this finding.

Systems in Place: The DON/Designee conducted an in-service on 12/6/18 for all staff on the following:

1) Incontinent Care/Peri Care
2) Handling of soiled linen
3) Disposal of wet or soiled briefs
4) Odor prevention in the environment
5) Resident's Right to a safe, clean, comfortable odor free, dignified environment.

Any staff member who fails to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated.
Resident 16's complete Care Plan was provided by the SSD (Social Services Director) on 11/16/18 at 03:33 P.M. A Care Plan, with an initiation date of 04/16/15, indicated the resident required assistance with ADL's (Activities of Daily Living) and was to have all ADLs met by staff.

The current, undated, "Perineal Care" policy and procedure was provided by the DON on 11/16/18 at 05:18 P.M. The policy indicated, "...Purpose: To ensure that resident receive [sic] personal hygiene after periods of incontinence to prevent...odors, and promote comfort...Remove and discard dirty linen..."

3.1-3(t)

Monitoring: a) DON/Designee will monitor compliance with respect and dignity requirements through facility wide rounds 3 days a week for 12 weeks 2 days a week for 8 weeks, and 1 time a week for 4 weeks. Any concerns will be addressed and corrected as found. B) Administrator/Designee will review all rounds daily in QA stand up meeting. C) Results/issues identified will be discussed with IDT at monthly QA meeting and with the Medical Director and the Quarterly QA meeting and/or as needed for determination for ongoing monitoring and/or changes. If any patterns or trends are identified, an action plan will be written by the QAPI committee. Any action plan will be monitored by the administrator until resolution.

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 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.
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<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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(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)(B) of this section; or
(E) A resident has not resided in the facility for 30 days.

§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
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER:** MULTIPLE CONSTRUCTION

**DATE SURVEY COMPLETED:** 11/16/2018

**NAME OF PROVIDER OR SUPPLIER:** WATERS OF BATESVILLE, THE

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

- **958 E HWY 46**
- **BATESVILLE, IN 47006**

**SUMMARY STATEMENT OF DEFICIENCY:**

- Each deficiency must be preceded by full regulatory or LSC identifying information.

**PROVIDER'S PLAN OF CORRECTION:**

- Each corrective action should be cross-referenced to the appropriate deficiency.

**COMPLETION DATE:**

- The mailing and email address and telephone number of the Office of the State Long-Term Care Ombudsman;
- 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
- 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 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 a residents' clinical record related to the transfer and discharge of the residents. This deficient practice affected 2 of 3 residents reviewed for discharge from the facility. (Residents 25 and 62)

Findings include:

1. During an interview, on 11/13/18 at 10:25 A.M., Resident 25 indicated he had gone to the hospital recently for about two to three days.

The clinical record for Resident 25 was reviewed on 11/14/18 at 10:42 A.M. The MDS (Minimum Data Set) assessment records indicated the resident was discharged on 06/11/18 and returned on 06/18/18. There was no documentation in the record indicating the Ombudsman had been notified of the resident's discharge.

A progress note, dated 06/11/18, indicated Resident 25 was admitted to the local hospital following a dialysis treatment for pneumonia, urinary retention, and an elevated white blood cell count. No other progress notes were added until 06/19/18.

2. The clinical record for Resident 62 was reviewed on 11/14/18 at 09:51 A.M. The most recent Quarterly MDS assessment indicated the resident was cognitively intact. Diagnoses included, but were not limited to, heart failure, hypertension, and diabetes. Resident 62 was admitted to the facility on 05/12/18.

F 0623  F623-D  12/16/2018
It is the intent of this facility to ensure that in addition to providing the notice of transfer/discharge to each resident and notifying the ombudsman, that documentation of notification of the Ombudsman is included in the clinical record. Action Taken: The Ombudsman has been notified of the discharges of Resident #25 and Resident # 62

Others Identified: Residents who are transferred or discharged from the facility have the potential to be affected by the findings.

Systems in Place: a) Additional education provided to social services director on 11/26/18 through social services consultant regarding requirement of documentation of notification of Ombudsman being included in the d/c progress note of each transfer/discharge from the facility. Failure to comply with education provided will result in future education and/or progressive discipline as indicated. B) Any future social services director will be educated in regard to this requirement as well. D) Review of each transfer/discharge chart will be conducted during daily QA meeting will include review of
A progress note dated 08/12/18 indicated the resident was discharged home with family. The resident's clinical record lacked documentation that the ombudsman was notified of the discharge.

During an interview, on 11/16/18 at 12:50 P.M., the Social Service Director indicated Resident 62 was discharged home. She sends a weekly list to the ombudsman notifying them of the discharged residents. She would file the discharge paperwork into a binder in her office. She did not put it into the individual residents clinical record.

The current facility policy titled "Transfer and Discharge Policy and Procedure", dated 1/1/17 was provided by the Administrator on 11/16/18 at 03:31 P.M. The policy indicated, "...DISCHARGE: to leave the facility without plans or intention to return...TRANSFER: To leave the facility with plans or intention to return..."

3.1-12(a)(6)(A)

F 0636  
SS=D  
Bldg. 00

483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing  
§483.20 Resident Assessment  
The facility must conduct initially and periodically a comprehensive, accurate, clinical record to ensure documentation of notification of ombudsman is included.  
Monitoring:  a) Administrator/Designee will monitor documentation of notification of ombudsman in clinical record the day following each transfer/discharge for 12 weeks and the day following each transfer/discharge for 8 weeks, and the day following each transfer/discharge for 4 weeks.  
B) All discharge charts will be reviewed the following day of transfer/discharge as part of the daily QA meeting. Any issues will be immediately addressed and corrected.  
C) Results/issues identified will be discussed with IDT at monthly QA meeting and with the Medical Director and the Quarterly QA meeting and/or as needed for determination for ongoing monitoring and/or changes to the QA meeting.  
D) Monitoring will be ongoing as part of the morning QA meeting agenda. Any patterns identified and any needed action plan will be written by the QAPI committee as indicated. Any action plan will be monitored by the Administrator until resolved.
§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 155233

MULTIPLE CONSTRUCTION
A. BUILDING 00
B. WING

DATE SURVEY COMPLETED: 11/16/2018

NAME OF PROVIDER OR SUPPLIER:
WATERS OF BATESVILLE, THE
958 E HWY 46
BATESVILLE, IN 47006

SUMMARY STATEMENT OF DEFICIENCY:

ID: 155233
PREFIX: F
TAG: 0636

F 0636 F636-D

It is the intent of this facility to ensure that this facility conducts initial and periodic comprehensive, accurate, standardized reproducible assessments of each resident's functional capacity.

Action Taken: MDS Coordinator corrected the MDS of resident #161 on 11/16/18 by checking the box indicating resident receives dialysis.

Others Identified: Residents who reside at the facility have the potential to be affected by this finding.

Systems in Place: a) MDS Coordinator was educated on 11/16/18 regarding accuracy of MDS related to dialysis by MDS consultant. Failure to comply with education will result in further education and or progressive

Findings include:

The clinical record for Resident 161 was reviewed on 11/14/18 at 11:31 A.M. The most recent Admission MDS assessment indicated the resident was moderately cognitively impaired. Diagnosis included, but was not limited to, renal insufficiency. The Special Treatments, Procedures, and Programs section indicated the resident did not receive dialysis while a resident at the facility within the last 14 days of the assessment time.

A progress note dated 10/29/18 at 03:52 P.M., indicated the resident arrived at the facility. The resident had dialysis on Monday, Wednesday, and Fridays.
During an interview on 11/16/18 at 01:01 P.M., the MDS Coordinator indicated, Resident 161 had been going to dialysis since admission. The Admission MDS assessment should have been marked to indicate the resident received dialysis treatments.

3.1-31(c)(6)
comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv) In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

Based on record review and interview, the facility failed to develop a Care Plan related to discharge. This deficient practice effected 1 of 2 closed records reviewed. (Resident 62)

Findings include:

It is the intent of this facility to develop care plans for residents related to discharge.
Action Taken: Resident 62 has discharged from facility.
Others Identified: a) Residents
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION

**Date Survey Completed:** 11/16/2018

**Provider or Supplier:** WATERS OF BATESVILLE, THE

**Address:**

- **Street Address:** 958 E HWY 46
- **City:** BATESVILLE
- **State:** IN
- **Zip Code:** 47006

### Summary Statement of Deficiency

**Prefix and Tag:**

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The clinical record for Resident 62 was reviewed on 11/14/18 at 09:51 A.M. The most recent Quarterly MDS (Minimum Data Set) assessment indicated the resident was cognitively intact. Diagnoses included, but were not limited to, heart failure, hypertension, and diabetes. Resident 62 was admitted to the facility on 05/12/18.

Resident 62's Care Plan did not indicate the resident's discharge plans.

During an interview, on 11/16/18 at 01:06 P.M., the Social Service Director indicated all residents should be care planned for short or long term stay at the facility. Resident 62 should have been care planned for short term stay.

The current facility policy titled "Care Plans" with an issue date of 07/01/11 was provided by the Administrator on 11/1/18 at 03:31 P.M. The policy indicated, "...It is the intent of the facility that each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care..."

3.1-35(a)

who reside in the facility have the potential to be affected. 100% audit of discharge care plans completed and any corrections have been made.

Systems in Place: a) The Social Services Director and the MDS Coordinator as well as the IDT (interdisciplinary team) were in-serviced on 12/5/18 by the administrator on the discharge process to include care planning and the fact that discharge planning must begin immediately upon admission. Any staff member who fails to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated.

Monitoring: Social Services Director/MDS coordinator/Designee will monitor discharge care plans 3 days a week for 12 weeks, 2 days a week for 8 weeks and 1 day a week for 4 weeks. Random monitoring will occur ongoing. B) Discharge care plans will be initiated and reviewed upon admission, and updated as indicated throughout the discharge planning process. C) Administrator/Designee will review all audits/proficiency as completed in daily QA stand up meeting. Any issues will be immediately addressed and corrected. C) Results/issues identified will be discussed with IDT at monthly QA meeting and with the medical
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<td>483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</td>
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director and the Quarterly QA meeting and/or as needed for determination for ongoing monitoring and/or changes to the QA meeting. Any patterns identified in need of an action plan will be written by the committee and monitored by the Administrator weekly until resolution.
§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.

Based on observation, interview, and record review, the facility failed to prevent UTIs (Urinary Tract Infections) related to appropriate toileting and catheter care. This deficient practice affected 2 of 3 residents reviewed for UTIs. (Residents 16 and 32)

Findings include:

1. During an interview on 11/13/18 at 10:06 A.M., Resident 16 indicated she had a UTI about a month and a half ago and was treated with an antibiotic. Staff did not help her wash her hands after she used the bathroom. She needed help getting off the toilet.

An observation of staff providing toileting assistance for Resident 16 was conducted on 11/15/18 at 11:42 A.M. CNA (Certified Nurse Aide) 2 entered the resident's room carrying a pair of plastic gloves, donned the gloves, then picked out clothes from the closet for the resident. She gathered wash cloths from a bin in the residents bathroom, layed them in the sink, and ran water over rags. She removed the night gown from the resident's shoulders per the resident's request. The resident indicated the gown was soiled and she did not want to "get it all over" her. CNA 2 cleaned the resident's buttoc area, retrieved a garbage bag out of her pocket, and put the rag in the bag. She picked up another wash cloth, continued to clean the resident, wiped from front to back, left the bag of rags in the bathroom and left the room.

Action Taken: a) Residents #16 and #32 received catheter care in accordance with infection control standards of practice as indicated by facility policy as well as state and/or federal regulation.

Others Identified: Residents who need any assistance with toileting or who have a catheter for urinary drainage have the potential to be affected by this finding.

Systems in Place: a) all nursing staff will be educated upon orientation/hire on appropriate toileting and catheter care techniques. B) All current nursing staff has been in-serviced on appropriate toileting and catheter care by DON on 12/6/18. Any staff member who fails to comply with the points of the in-service will be further in-serviced and/or progressively disciplined as indicated.

Monitoring: a) DON/Designee will monitor toileting and catheter care
to back, turned the rag, wiped again, turned the rag, wiped again, then put the rag in garbage bag. The CNA flushed the toilet, then pick up a bra out of the resident's dresser touching the drawer handle. The resident requested a different bra so the CNA went back to the dresser and retrieved a different one. She assisted the resident with her bra and with a fresh brief. She applied the resident's socks and assisted her with her pants and shirt. The CNA retrieved a bottle of aspercream from the resident's table in her bed room and took off the cap. She asked the resident if she was allowed to have the cream then replaced the cap. The CNA removed her gloves, washed her hands, and left the room to ask a nurse if the resident could have the aspercream. The resident was never offered assistance with washing their hands following toileting nor did the CNA change her gloves or wash her hands during the procedure.

The clinical record for Resident 16 was reviewed on 11/15/18 at 11:00 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 09/06/18, indicated the resident was cognitively intact and needed assistance of one staff for toileting and personal hygiene. Diagnoses included, but were not limited to, anemia, anxiety, depression, muscle wasting, lack of coordination, chronic kidney disease, and contractures of both the right and left hands.

Resident 16's complete Care Plan was provided by the SSD (Social Services Director) on 11/16/18 at 03:33 P.M. A Care Plan, with an initiation date of 07/30/18, indicated the resident had chronic UTIs and received a prophylactic antibiotic. A Care Plan, with an initiation date of 04/16/15, indicated the resident required assistance with ADL's (Activities of Daily Living) and to assist the techniques of 10 residents for 3 days a week for 12 weeks, 10 residents 2 days a week for 8 weeks, and 10 residents 1 day a week for 4 weeks. Random monitoring will occur ongoing. B) Administrator/Designee will review all proficiency as completed in daily QA stand up meeting. Any issues will be immediately addressed and corrected. C) Results/issues identified will be discussed with IDT at monthly QA meeting and with the Medical Director and the Quarterly QA meeting and/or as needed for determination for ongoing monitoring and/or changes to the QA process. An action plan will be developed by the QA committee if needed and monitored by the Administrator until resolution.
**Resident as needed so "resident is clean and dry".**

The Physician's orders for Resident 16 were provided by the MDS Coordinator on 11/16/18 at 04:16 P.M. The resident had an order for Macrobid 100 mg (milligrams), by mouth, two times a day for a UTI with a start date of 08/20/18 and an end date of 08/25/18. The resident had an order for Macrobid 50 mg, by mouth, one time a day for prophylactic with a start date of 08/26/18.

The current undated "Perineal Care" policy and procedure was provided by the DON on 11/16/18 at 05:18 P.M. The policy indicated "...Purpose: To ensure that resident receive [sic] personal hygiene after periods of incontinence to prevent infection, odors, and promote comfort...wash hands and DON gloves...Clean the rectal area...Remove and discard dirty linen...Remove and discard the gloves and wash hands..."

The current undated "INCONTINENCE CARE" policy was provided by the DON on 11/16/18 at 05:18 P.M. The policy indicated "...If feces present...Discard soiled materials and gloves...perform hand hygiene..."

2. Resident 32's clinical record was reviewed on 11/15/18 at 03:00 P.M. A Quarterly MDS assessment dated 10/04/18 indicated the resident was severely cognitively impaired and was totally dependent on staff for toileting. Diagnoses included, but were not limited to, malnutrition, septicemia, and neurogenic bladder. The resident had an indwelling urinary catheter and had a urinary tract infection within the last 30 days prior to the assessment.

During an observation on 11/16/18 at 01:13 P.M., CNA 4 washed her hands, donned gloves, and proceeded to provide perineal care for Resident 32.
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<td>32.</td>
<td>CNA 4 noted the resident had had a bowel movement. She cleansed the resident's front perineal area with a wash cloth, noted visible soilage from feces on her gloved hand, used the wash cloth to wipe feces off of her glove, and continued to cleanse the resident. She finished cleansing the front, removed the resident's brief, assisted the resident to his side with help from another CNA, cleansed the resident's bottom, and assisted the resident onto his back again. She then took a clean wash cloth and indicated she was going to provide catheter care. She cleansed Resident 32's penis, cleaned around the indwelling catheter insertion site and cleansed down the tubing. She visualized more feces on the resident's perineal area, cleaned that area again, doffed her gloves, and washed her hands. CNA 4 did not change her gloves or wash her hands at any time during the observation of perineal care or indwelling catheter care.</td>
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During an interview on 11/16/18 at 01:48 P.M., CNA 4 indicated there was visible feces on her gloves when she was providing patient care to Resident 32. If gloves were visibly soiled, you should change them before you continue to provide care. She should have changed her gloves before providing catheter care.

The current, undated facility policy titled "Catheters" was provided by the Administrator on 11/16/18 at 03:31 P.M. The policy indicated "...a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections...ongoing care and catheter removal protocols that adhere to professional standards of practice and facility policy and procedure with adherence to infection prevention and control techniques..."
The current, undated facility policy titled "Incontinence Care" was provided by the Director of Nursing on 11/16/18 at 05:18 P.M. The policy indicated "...8. If feces is present, remove with toilet paper or disposable wipe...discard soiled materials and gloves...perform hand hygiene...

3.1-41(a)(2)

483.25(g)(1)-(3)
Nutrition/Hydration Status Maintenance
§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to regularly assess and provide assistance to a resident related to nutrition for 1 of 2 residents reviewed for nutrition. (Resident 16)

Findings include:
During an observation, on 11/15/18 at 12:18 P.M., Resident 16 received her lunch tray in her room. A one fourth inch thick slice of ham was on the resident's plate. It was not cut up, nor did staff offer to cut up the residents meat for her.

During an interview, on 11/13/18 at 10:03 A.M., Resident 16 indicated she ate in her room and her food was often cold. Her meat was supposed to be cut up and it was not.

During an interview and observation, on 11/14/18 at 11:14 A.M., Resident 16's hands were noted to be contracted (deformity). She indicated it was from arthritis.

The clinical record for Resident 16 was reviewed on 11/15/18 at 11:00 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 09/06/18, indicated the resident was cognitively intact. She needed supervision and set up help for eating. Her diagnoses included, but were not limited to, anemia, anxiety, depression, muscle wasting, lack of coordination, chronic kidney disease, and contractures of both the right and left hands.

A "Registered Dietician Assessment", dated 03/12/18, for Resident 16 was provided by the DON (Director of Nursing) on 11/16/18 at 02:32 P.M. The assessment indicated the resident was at risk for weight changes. The DON indicated no other assessments had been completed by the RD (Registered Dietician) or other dietary staff for the resident in the past year.

Resident 16's complete Care Plan was provided by the SSD (Social Services Director) on 11/16/18 at 03:33 P.M. A Care Plan, with an initiation date of 04/22/15, indicated the resident had the potential resident 16 was conducted to determine level of assistance needed in regard to nutrition and hydration. B) Resident 16 care plan updated as indicated. C) Dietary tray card updated for all meals as indicated. Others Identified: 100% audit was conducted in order to identify any other residents who needed updated assessments in regard to hydration and nutrition assistance needs. Any findings were immediately corrected. Systems in Place: a) Registered Dietician to provide education and training to dietary manager regarding nutrition assessment requirements per policy on 12/6/18. Any staff who fail to comply with points of education will be provided further education and/or progressive discipline as indicated. B) All residents will be assessed upon admission, quarterly, and/or with a significant change in condition. C) Care plans will be updated to accurately reflect most current assessment. D) Dietary tray cards will be updated as indicated. Monitoring: a) DON/Designee will monitor 10 residents who require assistance with eating, 3 days weekly for 12 weeks then 2 days weekly for 8 weeks, and 1 day weekly for 4 weeks to observe for adequate supervision and assistance with meal consumption. Any concerns will
for nutritional problems, weight loss, and was to be evaluated by the RD. A Care Plan, with an initiation date of 02/09/16, indicated the resident was to have assistance with cutting of meat and other food items.

The current, undated, "Dietary Recommendations" policy was provided by the Administrator on 11/16/18 at 02:08 P.M. The policy indicated, "...Purpose: To ensure that all residents received adequate nutrition and hydration in relation to individual needs of the resident...All residents will be assessed...quarterly..."

3.1-46(a)(2)

483.25(l)
Dialysis
§483.25(l) Dialysis.
The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

Based on record review and interview, the facility failed to assess a resident following dialysis treatments. This deficient practice effected 1 of 1 residents reviewed for dialysis. (Resident 161)

Findings include:

The clinical record for Resident 161 was reviewed on 11/14/18 at 11:31 A.M. The most recent Admission MDS (Minimum Data Set) assessment indicated the resident was moderately cognitively impaired. Diagnosis included, but was not limited

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<td>F 0698</td>
<td>SS=D</td>
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<td>12/16/2018</td>
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</table>
A physician order, with a start date of 11/08/18, indicated the resident's weight was to be checked and recorded on dialysis days pre (before) and post (after) dialysis. The weights were to be documented in the dialysis binder.

The resident's clinical record or dialysis binder had no indication that a post weight was completed on 11/09/18 and 11/14/18.

During an interview, on 11/16/18 at 01:49 P.M., the ADON (Assistant Director of Nursing) indicated the resident's weights should be recorded in the dialysis binder or in the resident's record.

The current facility policy titled "Physician Orders-(Following Physician Orders)" dated, July 2017, was provided by the Administrator on 11/16/18 at 03:31 P.M. The policy indicated, "...It is the policy of the facility to follow the orders of the physician...

3.1-37(a)
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER 155233

X2) MULTIPLE CONSTRUCTION
A. BUILDING 00
B. WING

X3) DATE SURVEY COMPLETED 11/16/2018

NAME OF PROVIDER OR SUPPLIER
WATERS OF BATESVILLE, THE
958 E HWY 46
BATESVILLE, IN 47006

SUMMARY STATEMENT OF DEFICIENCY
PREFIX SS=D
TAG Bldg. 00

F 0744

5483.40(b)(3)
Treatment/Service for Dementia
§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.

Based on record review and interview, the facility failed to monitor behaviors for 2 of 5 residents reviewed for dementia care and unnecessary medications. (Residents 49 and 47)

Findings include:

The clinical record for Resident 49 was reviewed on 11/15/18 at 03:37 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 10/17/18, indicated the resident was moderately cognitively impaired. Diagnoses included, but were not limited to, dementia, anxiety, depression, and psychotic disorder.

The October 2018 "BEHAVIOR MONTHLY FLOW SHEET" for Resident 49 was provided by the SSD (Social Services Director) on 11/16/18 at 02:32 P.M. The flow sheet indicated the resident was monitored for the following behaviors: anxiety, false beliefs, and jittery or nervousness. The form lacked documentation for the following dates and shifts:

10/01/18 - night shift
10/02/18 - night shift
10/03/18 - night shift
10/04/18 - night shift
10/05/18 - night shift
10/08/18 - night shift
10/09/18 - night shift

It is the intent of this facility to ensure all residents diagnosed with dementia receive appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.

Action Taken: Resident #47 and resident #49 have their behavior monitoring logs completed each day, each shift.

Others Identified: Residents who have behaviors that require tracking have the potential to be affected by this finding. A 30 day "look back" audit was done to evaluate the required every shift charting of behaviors.

Systems in Place: All current nurses were in-serviced by DON on 12/9/18 on completion of monthly behavior flow sheets as a part of daily documentation requirements. Any staff member who fails to comply with points of the in-service will be further in-serviced and/or progressively disciplined as indicated.

Monitoring: a)Based on the list of
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER
155233

MULTIPLE CONSTRUCTION

A. BUILDING
00

B. WING

DATE SURVEY COMPLETED
11/16/2018

NAME OF PROVIDER OR SUPPLIER
WATERS OF BATESVILLE, THE

STREET ADDRESS, CITY, STATE, ZIP CODE
958 E HWY 46
BATESVILLE, IN 47006

ID
PREFIX
TAG
SUMMARY STATEMENT OF DEFICIENCY
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

10/12/18 - night shift
10/14/18 - night shift
10/15/18 - night shift
10/16/18 - night shift
10/17/18 - night shift
10/18/18 - night shift
10/20/18 - night shift
10/21/18 - night shift
10/22/18 - day shift
10/23/18 - day shift
10/24/18 - day shift
10/25/18 - night shift
10/26/18 - night shift
10/27/18 - day and night shift
10/28/18 - day and night shift
10/29/18 - night shift
10/30/18 - night shift
10/31/18 - night shift

The November 2018 "BEHAVIOR MONTHLY FLOW SHEET" for Resident 49 was provided by the ADON (Assistant Director of Nursing) on 11/16/18 at 02:25 P.M. The flow sheet indicated the resident was monitored for the following behaviors: anxiety, false beliefs, jittery or nervousness, and screaming and yelling. The form lacked documentation for the following dates and shifts:
11/14/18 - day shift and night shift

2. The clinical record for Resident 47 was reviewed on 11/16/18 at 10:33 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 10/16/18, indicated the resident was severely cognitively impaired. Diagnoses included, but were not limited to, dementia, anxiety, and depression.

The October 2018 "BEHAVIOR MONTHLY FLOW SHEET" for Resident 47 was provided by the SSD (Social Services Director) on 11/16/18 at

(targeted residents (to be edited as residents with behaviors are admitted, discharged), the DON/Designee will monitor monthly behavior flow sheets 3 days a week for 12 weeks, 2 days a week for 8 weeks, and 1 day a week for 4 weeks. Random monitoring will occur ongoing. B) Administrator/Designee will review all audits/proficiencies as completed in daily QA stand up meeting. Any issues will be immediately addressed and corrected. C) Results/issues identified will be discussed with IDT at monthly QA meeting and with the Medical Director and the Quarterly QA meeting and/or as needed for determination for ongoing monitoring and/or changes to the QA meeting. If needed, an action plan will be developed by the committee. Any action plan will be followed weekly by the administrator until resolved.)
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<th>ID</th>
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<th>REGULATORY OR LSC IDENTIFYING INFORMATION</th>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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02:32 P.M. The flow sheet indicated the resident was monitored for anger, agitation, and uncooperativeness. The form lacked documentation for the following dates and shifts:

- 10/01/18 - night shift
- 10/03/18 - night shift
- 10/04/18 - night shift
- 10/09/18 - night shift
- 10/12/18 - night shift
- 10/14/18 - night shift
- 10/15/18 - night shift
- 10/16/18 - night shift
- 10/17/18 - night shift
- 10/18/18 - night shift
- 10/20/18 - night shift
- 10/21/18 - night shift
- 10/25/18 - day shift
- 10/26/18 - night shift
- 10/29/18 - night shift

The November 2018 "BEHAVIOR MONTHLY FLOW SHEET" for Resident 47 was provided by the ADON (Assistant Director of Nursing) on 11/16/18 at 02:25 P.M. The flow sheet indicated the resident was monitored for the following behaviors: agitation, anger, anxiety, false beliefs, fighting, mood changes, restlessness, scratching, slapping, striking out, suspiciousness, and uncooperativeness. The form lacked documentation for the following dates and shifts:

- 11/07/18 - night shift
- 11/14/18 - day shift and night shift
- 11/15/18 - day shift and night shift

During an interview, on 11/16/18 at 02:08 P.M., RN 3 indicated the behavior monitoring logs in the front of the narcotic administration book should be filled out every day, for every shift. Nurses can document behaviors in a nurses note in addition to documenting on the behavior logs, but the
behavior monitoring logs should be filled out each day.

A nursing reminder in the Narcotic Count Book was provided by the ADON on 11/16/18 at 02:25 P.M. The form indicated, "NURSING STAFF, PLEASE MAKE SURE YOU ARE FILLING OUT THE BEHAVIOR FLOW SHEETS DAILY! EVEN WHEN THERE ARE NO BEHAVIORS THE FLOW SHEET NEEDS TO SHOW THAT. THANK YOU! SOCIAL SERVICES"

3.1-37(a)

F 0755
SS=D
Bldg. 00

A nursing reminder in the Narcotic Count Book was provided by the ADON on 11/16/18 at 02:25 P.M. The form indicated, "NURSING STAFF, PLEASE MAKE SURE YOU ARE FILLING OUT THE BEHAVIOR FLOW SHEETS DAILY! EVEN WHEN THERE ARE NO BEHAVIORS THE FLOW SHEET NEEDS TO SHOW THAT. THANK YOU! SOCIAL SERVICES"

3.1-37(a)

483.45(a)(b)(1)-(3)
Pharmacy
Srvcs/Procedures/Pharmacist/Records

§483.45 Pharmacy Services
The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.
§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Based on observation, interview, and record review, the facility failed to properly label and administer medications related to the use of an insulin pen for 1 of 4 medication carts reviewed.

(39 Back/77 Back medication cart)

Findings include:

The "39 Back/77 Back" medication cart was observed with RN 6 on 11/09/18 at 10:34 A.M. An insulin pen, one quarter full, containing Levimir insulin was noted with no date documenting when the pen was first opened. The pen had a delivered date of 09/30/18 on the insulin pen label for Resident 25. The label indicated he received the insulin at bedtime each day. The Levimir pen was stored in a plastic bag and the label on the plastic bag indicated the resident received 12 units subcutaneously at bedtime for type 2 diabetes. The resident had received the medication the previous night.

During an interview, on 11/09/18 at 10:35 A.M., RN 6 indicated she thought the insulin (Levimir) pen expired 28 days after being opened. The levimir insulin pen should have been disposed of since she was unsure of when it was pulled from the refrigerator. She proceeded to dispose of the pen in the sharps container. The insulin pens should be refrigerated until opened, dated when

It is the intention of this facility to ensure that all medications are properly labeled and administered.

Action Taken: Resident #25 has their insulin pen refrigerated until use, then dated when opened and discarded after 28-30 days per policy and/or manufacturer’s instructions.

Others Identified: a) any resident who receives insulin via pen have the potential to be affected by this finding.

Systems in Place: a) DON/Designee in-serviced all current nurses on 12/6/18 on proper labeling and administration of insulin pens. Any staff member who fails to comply will with the points of the in-service will be further educated and/or progressively disciplined as indicated.

Monitoring: a) DON/Designee will monitor for insulin pens as being dated when opened and being discarded after 28-30 days per policy and/or manufacturer’s
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<tr>
<th>X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
<th>X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 0758</td>
<td>opened, and disposed of after 28 to 30 days or how ever long they were good for.</td>
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During an interview on 11/16/18 at 09:20 A.M., the DON (Director of Nursing) indicated insulin pens should be dated when opened.

The insulin insert instruction leaflet was provided by the Administrator on 11/16/18 at 03:31 P.M. The instructions indicated, "...Once you take...out of cool storage...you can use it for up to 28 days..."

The current "INSULIN PEN INJECTION ADMINISTRATION" policy, dated March 2018, indicated, "...appropriate and safe administration of insulin...Follow manufacturer instructions for expiration dating..."

3.1-25(k)(6)

483.45(c)(3)(e)(1)-(5)
Free from Unnec Psychotropic Meds/PRN Use

§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

instruction 3 times a week for 12 weeks, 2 times a week for 8 weeks, and 1 time a week for 4 weeks. Random monitoring will occur ongoing. B) Administrator/Designee will review all audits/proficiencies as completed in daily QA stand up meeting. Any issues will be immediately addressed and corrected. C) Results/issues identified will be discussed with IDT at monthly QA meeting and with the Medical Director and the Quarterly QA meeting and/or as needed for determination for ongoing monitoring and/or changes to the QA meeting. If needed, an action plan will be developed by the committee. Any action plan will be followed weekly by the administrator until resolved.
§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.

Based on record review and interview, the facility failed to monitor the residents' behaviors related to psychotropic medication usage. This deficient practice effected 3 of 5 residents reviewed for unnecessary medications. (Residents 12, 26, and 52)

F 0758
F758-D
12/16/2018
It is the intent of this facility to monitor the resident's behaviors related to psychotropic medication usage.

Action Taken: Residents #12, #26, and #52.
Findings include:

1. The clinical record for Resident 12 was reviewed on 11/16/18 at 03:25 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 08/23/18, indicated the resident was moderately cognitively impaired. Diagnoses included, but were not limited to, hypertension, diabetes, traumatic brain injury, and schizophrenia. The resident received antipsychotic medications for 7 of 7 days during the assessment look back period.

Resident 12's current orders included an order for olanzapine (an antipsychotic medication) 2.5 mg (milligrams), by mouth every day except Sunday, and an additional 10 mg by mouth, at bedtime every day.

A October 2018 "BEHAVIOR MONTHLY FLOWSHEET", for Resident 12 was provided by the Social Services Director on 11/16/18 at 02:32 P.M. The flow sheet listed the olanzapine medication and the diagnosis of schizoaffective disorder, unspecified. The form lacked any documentation that indicated behaviors had been monitored in October 2018.

2. The clinical record for Resident 26 was reviewed on 11/15/18 at 02:00 P.M. An Annual MDS assessment, dated 09/20/18, indicated the resident was cognitively intact. Diagnoses included, but were not limited to, hypertension, anxiety, depression, bipolar disorder, and a psychotic disorder. The resident received antidepressant medications for 7 of 7 days during the assessment look back period.

Resident 26's current orders included orders for the following medications:

- Olanzapine 2.5 mg, orally daily except Sunday
- Olanzapine 10 mg, at bedtime daily

Others Identified: Residents who have behaviors that require monitoring have the potential to be affected by these findings.

Systems in Place: All current nurses were in-serviced by DON on 12/9/18 on completion of monthly behavior flow sheets as a part of daily documentation requirements. Any staff member who fails to comply with points of the in-service will be further in-serviced and/or progressively disciplined as indicated.

Monitoring: a) Based on the list of targeted residents (to be edited as residents with behaviors are admitted, discharged), the DON/Designee will monitor monthly behavior flow sheets 3 days a week for 12 weeks, 2 days a week for 8 weeks, and 1 day a week for 4 weeks. Random monitoring will occur ongoing. B) Administrator/Designee will review all audits/proficiencies as completed in daily QA stand up meeting. Any issues will be immediately addressed and corrected. C) Results/issues identified will be discussed with IDT at monthly QA meeting and with the Medical Director and the Quarterly QA meeting and/or as needed for determination for ongoing monitoring and/or changes to the QA meeting.
Bupropion (an antidepressant) 150 mg by mouth, once during the day, and 75 mg by mouth, at bedtime for bipolar disorder.

Trazodone (an antidepressant) 25 mg by mouth, at bedtime for insomnia.

A October 2018 "BEHAVIOR MONTHLY FLOWSHEET", for Resident 26 was provided by the Social Services Director on 11/16/18 at 02:32 P.M. The flow sheet listed the trazodone and bupropion medications with the diagnoses of bipolar disorder, other specified depressive episodes, and insomnia. The form lacked any documentation that indicated behaviors had been monitored in October 2018.

3. The clinical record for Resident 52 was reviewed on 11/14/18 at 12:18 P.M. The most recent Quarterly MDS assessment, dated 10/23/18, indicated the resident was cognitively intact. Diagnosis included, but was not limited to, depression. The resident received antidepressant medications for 7 of 7 days during the assessment look back period.

Resident 52's current orders included the following medications:

- sertraline (a antidepressant medication) 100 mg, by mouth, give 2 tablets once a day for depression.
- Trazodone 100 mg by mouth at bedtime for sleeping.

The October 2018 "BEHAVIOR MONTHLY FLOW SHEET" for Resident 52 listed the resident's sertraline and trazodone medications. The form only had documentation for the needed, an action plan will be developed by the committee. Any action plan will be followed weekly by the administrator until resolved.
The November 2018 "BEHAVIOR MONTHLY FLOW SHEET" for Resident 52 listed the sertraline and trazodone medications. The form only had documentation for the following dates and shifts:

- 10/07/18-day shift
- 10/09/18-day shift
- 10/14/18-night shift
- 10/15/18-night shift
- 10/16/18-night shift
- 10/20/18-night shift
- 10/21/18-night shift
- 10/22/18-night shift
- 10/23/18-night shift
- 10/24/18-night shift
- 10/25/18-night shift
- 10/27/18-day shift

The form lacked documentation for all other dates in November.

During an interview, on 11/16/18 at 02:08 P.M., RN 3 indicated the behavior monitoring logs in the front of the narcotic administration book should be filled out every day, for every shift. Nurses can document behaviors in a nurses note in addition to documenting on the behavior logs, but the behavior monitoring logs should be filled out each day.

A nursing reminder in the Narcotic Count Book was provided by the ADON on 11/16/18 at 02:25 P.M. The form indicated, "NURSING STAFF, PLEASE MAKE SURE YOU ARE FILLING OUT THE BEHAVIOR FLOW SHEETS DAILY! EVEN WHEN THERE ARE NO BEHAVIORS THE FLOW SHEETS MUST BE FILLED OUT EVEN IF THERE ARE NO BEHAVIORS."
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Waters of Batesville, The  
**Address:** 958 E HWY 46, Batesville, IN 47006

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<tr>
<th>ID</th>
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<th>Summary Statement of Deficiency</th>
<th>Code</th>
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<tbody>
<tr>
<td>F 0761</td>
<td>SS=D</td>
<td>Bldg. 00</td>
<td>SHEET NEEDS TO SHOW THAT. THANK YOU! SOCIAL SERVICES&quot;</td>
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<td></td>
<td>483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals</td>
<td>§483.45(g) Labeling of Drugs and Biologicals</td>
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<td>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.</td>
<td>§483.45(h) Storage of Drugs and Biologicals</td>
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<td>§483.45(h)(1) 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.</td>
<td>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for 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.</td>
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**Observation:**  
Based on observation and interview, the facility failed to store resident's medications in an appropriate manner related to loose pills and pill fragments in the medication carts for 4 of 4 medication carts reviewed. (39 Front, 77 Back, 39 Back/77 Back, and 77 Front)

**Correction:**  
It is the intention of this facility to store resident's medications in an appropriate manner to keep the med cart drawer floors free of loose pills/meds or particles of...
Findings include:

1. The "39 Front" medication cart was observed on 11/09/18 at 10:00 A.M. with LPN (Licensed Practical Nurse) 5. The following loose pills were noted in the bottom of the drawers:

2nd drawer - 13 loose pills and 3 pill halves
3rd drawer - 4 whole pills and 1 partial pill
The pills included 12 white pills and pill parts, 1 red pill, 1 aqua and orange capsule, 1 whole and one part of an orange pill, and 5 pink pills.

During an interview, on 11/09/18 at 10:01 A.M., LPN 5 indicated medications were discarded in the sharps container and then preceded to dispose of them.

2. The "77 Back" medication cart was observed on 11/09/18 at 10:18 A.M. with LPN 5. The following loose pills were noted in the bottom of the drawers:

1st drawer - 2 used pain patches to be witnessed and disposed of sitting in medication cups in the same drawer with other medications
2nd drawer - 2 whole white pills
3rd drawer - 2 whole white pills and several paper fragments in the back of the drawer on the right side
4th drawer - powdery substance along the back edge.

3. The "39 Back/77 Back" medication cart was observed on 11/09/18 at 10:34 A.M. with RN 6. The following loose pills were noted in the bottom of the drawers:

3rd drawer drawer - 2 whole pink pills, 2 whole pills/meds.

Action Taken: Med carts are kept free of loose pills/meds and/or particles of pills/meds on the med cart drawer floors.

Others Identified: Residents who receive meds stored in med carts have the potential to be affected by this finding.

Systems in Place: a) all current nurses were in-serviced on proper medication storage by DON on 12/4/18. Any staff member who fails to comply will be further in-serviced and/or progressively disciplined as indicated. B) Each nurse will conduct a med cart audit at the beginning of each shift. Nurses will properly dispose of any loose meds discovered in their med cart audit. Nurses will ensure that there are sufficient meds on hand to administer meds to residents as ordered.

Monitoring: Monitoring: a) DON/Designee will audit med carts 3 days a week for 12 weeks, 2 days a week for 8 weeks, and 1 day a week for 4 weeks. Random monitoring will occur ongoing. B) Administrator/Designee will review all audits/proficiencies as completed in daily QA stand up meeting. Any issues will be immediately addressed and corrected. C) Results/issues identified will be discussed with IDT at monthly QA meeting and with the Medical Director and the Quarterly QA meeting and/or as
4. The "77 Front" medication cart was observed on 11/09/18 at 10:46 A.M. with RN 6. The following loose pills were noted in the bottom of the drawers:

3rd drawer - 2 whole white pills, 1 whole pink pill, 1 whole brown pill

During an interview, on 11/09/18 at 10:39 A.M., RN 6 indicated the pharmacy consultant came in periodically to audit the medication carts and checked for loose pills. Both the DON (Director of Nursing) and the ADON (Assistant Director of Nursing) did cart audits.

During an interview, on 11/16/18 at 09:20 A.M., the DON indicated the pharmacy has audited the medication carts quarterly. The loose medications should have been removed and put in the sharps container.

The current "MEDICATION STORAGE IN THE FACILITY" policy, dated March 2018, indicated, "...Medications and biologicals are stored safety [sic]...properly..."

3.1-25(a)

483.60(i)(1)(2)

Food

Procurement, Store/Prepare/Serve-Sanitary

§483.60(i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.

(i) This may include food items obtained needed for determination for ongoing monitoring and/or changes to the QA meeting. If needed, an action plan will be developed by the committee. Any action plan will be followed weekly by the administrator until resolved.
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION A. BUILDING 00

**Date Survey Completed:** 11/16/2018

**Name of Provider or Supplier:** WATERS OF BATESVILLE, THE

**Street Address, City, State, Zip Code:** 958 E HWY 46 BATESVILLE, IN 47006

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>Summary Statement of Deficiency</th>
<th>(X5) Completion Date</th>
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<tbody>
<tr>
<td>PREFIX</td>
<td>(Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</td>
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<tr>
<td>F 0812</td>
<td>F812-E</td>
<td>It is the intent of this facility to ensure it provides safe and sanitary foods. Action Taken: Residents who receive eggs for intake in any form receive only pasteurized eggs that are within their &quot;use by date. Nourishment refrigerators throughout the facility contain foods that are labeled and dated as per policy and regulation. Any foods outside acceptable labeling and/or date requirements will be discarded. Others Identified: Residents who consume meals at the facility have the potential to be affected by this finding. Systems in Place: a) Administrator in-serviced all dietary staff and nursing staff on proper storage, preparation, distribution, and food service in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure they provided safe and sanitary food related to the use of unpasteurized eggs and outdated foods. This deficient practice had the potential to effect residents that have consumed undercooked fried eggs for 58 of 59 residents that received food from the kitchen and 2 of 2 snack refrigerators. Findings include: 1. During an observation and interview, on 11/09/18 at 09:38 A.M., a refrigerator in the dry storage room had a box containing eggs that had no indication they were pasteurized eggs. The dietary manager indicated the eggs were used for breakfast and the residents could get them made to order, such as over easy or over medium. She indicated she thought they were pasteurized eggs. A refrigerator by the milk cooler contained the following items: - a 2 quart full container of mashed potatoes with an open date of 11/02/18 and a use by date of...</td>
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<td>12/16/2018</td>
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</table>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 155233

DATE SURVEY COMPLETED: 11/16/2018

NAME OF PROVIDER OR SUPPLIER: WATERS OF BATESVILLE, THE

STREET ADDRESS, CITY, STATE, ZIP CODE: 958 E HWY 46, BATESVILLE, IN 47006

ID PREFIX TAG
11/06/18

- one half full container of cabbage rolls with a use by date of 11/08/18
- one half full container of applesauce with a use by date of 11/08/18

During an interview, on 11/09/18 at 09:45 A.M., the ADON (Assistant Director of Nursing) indicated there had not been any food borne illnesses in the facility.

2. During an observation and interview of the snack refrigerator for the 39 and 77 hallways with the Dietary Manager, on 11/16/18 at 01:32 P.M., the refrigerator contained the following items:

- a three fourth full container of cottage cheese contained a greenish fuzzy looking substance on the top with a use by date of 10/16/18
- a container of soup and a hamburger with no date belonging to Resident 4.

The Dietary Manager indicated the cottage cheese should have been thrown out and the other foods should have been dated.

During an observation of the snack refrigerator for the rehab hallway, on 11/16/18 at 01:38 P.M., the following items were observed:

- one half full container of tuna salad with no name or date.

The current undated facility policy titled "Use of Shell Eggs and Pasteurized Eggs and Procedure for Undercooked Eggs" was provided by the Administrator on 11/09/18 at 10:25 A.M. The policy indicated "...5. Pasteurized eggs or egg products shall be used when eggs are served undercooked and for fried eggs...6. Unpasteurized standards for food service safety on 12/3/18. Any staff member who fails to comply with the points of in-service will be further in-serviced and/or progressively disciplined as indicated.

B) Requested removal of unpasteurized eggs from food vendor order form.

C) Dietary Manager will check kitchen refrigerators on a daily basis and discard outdated items. In addition, the cook on each shift will check dates of food items at the beginning of each shift and discard outdated items.

D) Dietary Aide will check dates of items stored in refrigerator s in snack pantry refrigerators when daily restocking is done. Outdated items will be discarded. Monitoring: a) The contents of kitchen refrigerators will be monitored daily by dietary manager/designee.

B) Cooks will monitor contents of refrigerators daily at the start of each shift.

C) Dietary Aides will monitor contents of snack pantry refrigerators daily at the time of restocking.

D) Administrator/Designee will randomly monitor kitchen and pantry refrigerators. This monitoring will be ongoing.

E) Results/issues identified will be discussed with IDT at monthly QA meeting and with the Medical Director and the Quarterly QA meeting and/or as needed for...
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<td>F 0842 SS=D Bldg. 00</td>
<td>shell eggs may be used if the food item will be cooked completely...&quot;</td>
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The current facility policy titled, "Food Storage" dated 2017 was provided by the DON (Director of Nursing) on 11/16/18 at 05:16 P.M. The policy indicated, "...Label all food items. The label must include the name of the food and the date by which it should be sold, consumed, or discarded...If the item has not been used by the determined date, the remaining product is discarded...Discard food that has passed the expiration date..."

The current facility policy titled, "Food Brought into the Facility by Friends/Family/Others (Outside Sources) for Residents", dated 01/01/17, was provided by the Administrator on 11/16/18 at 02:02 P.M. The policy indicated "...Foods or beverages brought in from the outside will be labeled and dated with the resident's name, room number and the date the item was brought into the facility for consumption/storage..."

3.1-21(i)(3)

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.

§483.70(i) Medical records.

§483.70(i)(1) In accordance with accepted determination for ongoing monitoring and/or changes to the QA meeting. If needed, an action plan will be developed by the committee. Any action plan will be followed weekly by the administrator until resolved.
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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 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.

Based on record review and interview, the facility failed to ensure electronic health records contained accurate and complete documentation related to a change in a resident's code status. This deficient practice effected 1 of 1 residents reviewed for death. (Resident 61)

Findings include:

The clinical record for Resident 61 was reviewed on 11/14/18 at 12:00 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 07/16/18, indicated the resident was severely cognitively impaired. The resident required extensive assistance with ADLs (Activities of Daily Living). Diagnoses included, but were not limited to, heart failure, diabetes, and dementia.

A Progress Note, dated 09/27/2018, indicated Resident 61 had expired that evening.

Orders in the electronic health record at the resident's time of death included an open ended order, with a start date of 08/07/18, that indicated...
A document in the resident's chart titled "Indiana Physician Orders for Scope of Treatment (POST)" form, with a prepared date of 09/23/18, indicated the resident wished to be designated as a DNR (Do Not Attempt Resuscitation). The document was signed by the physician, and a note on the bottom of the form indicated verbal consent for the code status of DNR was obtained from the POA (Power of Attorney) and was witnessed by three nurses.

During an interview, on 11/15/18 at 09:30 A.M., the Director of Nursing indicated Resident 61's code status had changed a few times in the last several weeks prior to her death. The resident's POA indicated the resident's code status should be a DNR. The resident's code status should have been updated in the electronic health record to reflect that she was a DNR.

The current facility policy titled "Advance Directives Policy and Procedure", dated 01/01/17 was provided by the Administrator on 11/16/18 at 03:31 P.M. The policy indicated, "...advance directives...will be obtained and incorporated in the resident medical record..."

3.1-50(a)(1)
WATERS OF BATESVILLE, THE
958 E HWY 46
BATESVILLE, IN 47006

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER

X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

X3) DATE SURVEY COMPLETED

11/16/2018

IDENTIFICATION NUMBER

155233

SUMMARY STATEMENT OF DEFICIENCY

(Each deficiency must be preceded by full regulatory or LSC identifying information)

PREFIX

TAG

ID

PREFIX

TAG

IDENTIFICATION NUMBER

155233

SUMMARY STATEMENT OF DEFICIENCY

483.75(g)(2)(ii)

QAPI/QAA Improvement Activities

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;

Based on observation, interview, and record review, the facility failed to adequately monitor the effectiveness of a quality assessment performance improvement project related to food temperatures and meal service. This deficient practice had the potential to affect 58 of 59 residents who would dine in their room related to appropriate meal temperatures.

Findings include:

During an observation with the Dietary Manager, on 11/14/18 at 12:25 P.M., of the last meal tray on the ICF (Intermediate Care Facility) hallway cart, the following temperatures were observed:

- Salisbury Steak - 108 degrees Fahrenheit
- Mechanical soft Salisbury steak - 100 degrees Fahrenheit
- Puree Salisbury steak - 104 degrees Fahrenheit
- Company Potatoes - 112 degrees Fahrenheit
- Puree Company Potatoes - 104 degrees Fahrenheit
- Broccoli - 110 degrees Fahrenheit
- Puree broccoli - 100 degrees Fahrenheit

Due to the potential for food safety concerns, it is the intention of this facility to ensure that quality assessment and assurance committee develops and implements appropriate plans of action to correct identified deficiencies. Further, to implement these action plans with the outcome being substantial compliance. Action Taken: Acceptable food temperatures per policy and regulation as well as meal satisfaction are being maintained day to day in the facility. Others Identified: Residents who consume food prepared in the dietary kitchen have the potential to be affected by this finding. Systems in Place: Regional team will review the QAPI process with the IDT (interdisciplinary team) to include identifying opportunities for improvement, preparing an action plan or PIP (performance improvement plan), setting timelines for achieving those

COMPLETION DATE

12/16/2018

F 0867

F867-D

until resolved.
of the time when he gets his tray the food is cold.

During an interview, on 11/13/18 at 10:03 A.M., Resident 16 indicated she eats in her room and when she gets her tray her hot foods are cold.

During an anonymous interview, on 11/14/18 at 03:24 P.M., a resident indicated sometimes the food was really cold. The facility got a new meal cart but the food still wasn't hot. It was just warm now. No staff members had followed up with the resident to see if the food was warmer or if things had gotten better.

During an interview, on 11/16/18 at 04:45 P.M., the Administrator indicated the facility had routine quality improvement areas they worked on in addition to anything new that would come up or any resident council concerns. They had been working on issues with cold food temperatures.

The August 2018 Resident Council Meeting minutes indicated new concerns identified in resident council included a concern of "[meal] trays sitting on food carts not being passed in a timely manner". The Resident Council Action Form indicated the concern was that trays were sitting on food carts too long sometimes and the food was cold. The response or resolution to the concern was that they split up ICF food trays onto two carts so both could be passed at the same time.

The September 2018 Resident Council Meeting minutes indicated new concerns identified in resident council included a concern that breakfast was cold. The Resident Council Action Form indicated the concern was that residents stated the breakfast carts were sitting while nursing staff got the residents up, leaving them with cold food.
The response or resolution to the concern was that staff would monitor hall carts daily for two weeks and management staff would assist with serving trays. Staff would also offer residents that ate in their rooms the choice to eat in the main dining room.

The PIP (Performance Improvement Project) Project Documentation Form, dated 09/03/18 through 10/31/18, for the project titled "Hall Trays" identified the goal in measurable terms as "Resident Meal Satisfaction". Resident interviews would be the source used to obtain the measure. Resident interviews without negative feedback would be used to compare the measures. Interventions noted included a "new cart, dividing the trays for specific hallways, organize trays by room numbers, and encourage residents to take meals in the dining room". A note indicated improvement had been made and there was a decrease in resident concerns related to food temperatures.

The PIP Project Documentation Form for the project titled "Meal Times", dated 10/01/18 through 11/01/18, identified the goal in measurable terms as "No late meals" and indicated meal observations would be the source used to obtain the measure. Previous month's resident and staff feedback would be used to compare the measures. Interventions noted included "educated staff on time line expectations, new clock visible from window. Documented timeline and adjusted times to meet deadlines, per resident council vote. Set timers to keep staff aware of tasks completed timely. Frequent follow throughout the day to ensure assistance from IDT is available. Two dietary managers provided additional training. Dietician assisting with performance improvement ideas".
There was no additional documentation provided related to the monitoring of hall cart food temperatures and resident satisfaction with meal services.

During an interview on 11/16/18 04:23 P.M., the Administrator indicated staff had been monitoring the meal service and asked the residents if the food temperatures had improved, but could provide no auditing tools or documentation of any monitoring they had done since this concern was identified in resident council. They should have documented interviews and the responses of the residents.

The current, undated facility policy titled "QAPI [Quality Assurance and Performance Improvement Program] Plan..." was provided by the Director of Nursing on 11/16/18 at 04:50 P.M. The policy indicated "...QAPI will be utilized to make decisions based on data, which includes input...from residents...will set goals and measure progress through QAPI..."

The current, undated facility policy titled "Monitoring Food Temperatures for Meal Service" was provided by the Director of Nursing on 11/16/18 at 05:16 P.M. The policy indicated "...If hot foods are not 135 degrees Fahrenheit or higher when checked, they will be reheated to at least 135 degrees Fahrenheit..."

3.1-52(b)(2)

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

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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 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
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

#### IDENTIFICATION NUMBER
155233

#### DATE SURVEY COMPLETED
11/16/2018

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<td><strong>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</strong></td>
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<td><strong>(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</strong></td>
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<td><strong>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</strong></td>
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<td><strong>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</strong></td>
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<td><strong>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</strong></td>
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<td><strong>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</strong></td>
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<td>Based on observation, interview, and record review, the facility failed to ensure appropriate infection control guidelines were followed related to indwelling urinary catheter care. This deficient practice effected 1 of 3 residents reviewed for indwelling urinary catheters. (Resident 32)</td>
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Findings include:

On 11/14/18 at 02:13 P.M., Resident 32 was observed in his bed. The bed was in a low position and the indwelling urinary catheter drainage bag was noted to be attached to the right

**Action Taken:**
- a) Resident 32 has his urinary drainage bag positioned at all times in a way so as not to touch the floor.
- Others identified: Residents who have urinary catheters have the potential to be affected by this
side of the bed. The drainage bag was resting directly on the floor.

On 11/15/18 at 02:44 P.M., Resident 32 was observed in his bed. The bed was in a low position and the indwelling urinary catheter drainage bag was noted to be attached to the right side of the bed. The drainage bag was resting directly on the floor.

On 11/16/18 at 01:13 P.M., Resident 32 was observed in his bed. The bed was in a low position and the indwelling urinary catheter drainage bag was noted to be attached to the right side of the bed. The drainage bag was resting directly on the floor.

Resident 32's clinical record was reviewed on 11/15/18 at 03:00 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 10/04/18, indicated the resident was severely cognitively impaired and was totally dependent on staff for toileting. Diagnoses included, but were not limited to, malnutrition, septicemia, and neurogenic bladder. The resident had an indwelling urinary catheter and a urinary tract infection within the last 30 days prior to the assessment.

During an interview on 11/16/18 at 01:48 P.M., CNA 4 indicated catheter drainage bags were not supposed to touch the floor, but when Resident 32's bed was in the lowest position, the drainage bag touched the floor. She did not know what they could do to prevent the drainage bag from touching the floor. She could have placed a towel on the floor under the catheter drainage bag.

The current, undated, facility policy titled "Catheters" was provided by the Administrator on 11/16/18 at 03:31 P.M. The policy indicated "...a finding. Systems in place: a) DON/Designee in-serviced nursing staff on infection control guidelines related to indwelling urinary catheter care on 12/3/18. Failure to comply with in-service points will result in further in-serviceing and or progressive disciplinary action as indicated. Monitoring: a) DON/Designee will monitor catheter bags 3 days a week for 12 weeks, 2 days a week for 8 weeks, and 1 day a week for 4 weeks. Random monitoring will occur ongoing. B) Administrator/Designee will review all audits/proficiencies as completed in daily QA stand up meeting. Any issues will be immediately addressed and corrected. C) Results/issues identified will be discussed with IDT at monthly QA meeting and with the Medical Director and the Quarterly QA meeting and/or as needed for determination for ongoing monitoring and/or changes to the QA meeting. If needed, an action plan will be developed by the committee. Any action plan will be followed weekly by the administrator until resolved.
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<td>F 9999</td>
<td>resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections...ongoing care and catheter removal protocols that adhere to professional standards of practice and facility policy and procedure with adherence to infection prevention and control techniques...&quot;</td>
<td>F 9999</td>
<td>It is the intent of this facility to ensure each employee has appropriate tuberculin testing. Action Taken: a) employees identified underwent tuberculin retesting. B) An audit of all current employee files was conducted to ensure tuberculin testing was completed and read timely. B) Nursing staff in-serviced on tuberculin testing and reading procedures by DON/Designee on 12/4/18.</td>
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<td>3.1-14 PERSONNEL</td>
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<td>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1)At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection.</td>
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| (X3) DATE SURVEY | 11/16/2018 |
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 155233

MULTIPLE CONSTRUCTION
A. BUILDING 00
B. WING 00

DATE SURVEY COMPLETED: 11/16/2018

NAME OF PROVIDER OR SUPPLIER
WATERS OF BATESVILLE, THE
958 E HWY 46
BATESVILLE, IN 47006

ID: 155233
PREFIX: W
TAG: 00

SUMMARY STATEMENT OF DEFICIENCY
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID: 155233
PREFIX: W
TAG: 00

A form indicated CNA (Certified Nurse Aide) 7's most recent second step tuberculin skin test had been administered on 09/21/18 at 03:00 P.M., and read on 09/26/18 at 10:45 A.M.

A form indicated QMA (Qualified Medication Aide) 8's most recent annual tuberculin skin test had been administered on 03/29/18 at 02:16 P.M., and read on 04/01/18 at 04:18 P.M.

A form indicated LPN (Licensed Practical nurse) 9's most recent annual tuberculin skin test had been administered on 06/12/18 at 02:00 P.M., and read on 06/15/18 at 04:00 P.M.

A form indicated RN 10's most recent annual tuberculin skin test had been administered on 03/05/18 at 01:30 P.M., and read on 03/08/18 at 03:00 P.M.

During an interview, on 11/13/18 at 02:11 P.M., the DON (Director of Nursing) indicated PPD's should be read within 48 to 72 hours.

The Tuberculin testing serum manufacture's insert was provided by the DON on 11/05/18 at 03:25 P.M., The insert indicated, "...The area of induration reflects DTH activity. In most

This rule is not met as evidenced by:

Based on record review and interview, the facility failed to ensure each employee had appropriate tuberculin testing. This affected 4 of 10 staff members reviewed for employee records. (CNA 7, LPN 9, QMA 8, and RN 10)

Findings include:

Monitoring: A review of all new employees files will be conducted to ensure timely TB testing is completed prior to first day of employment. Listing of current employees with annual TB testing requirements will be maintained by BOM and notifications made when necessary. Department heads will be a second check as far as making sure that employees in their department have timely and acceptable TB testing results prior to working around residents. Any staff member who fails to comply will not be scheduled to work until the issue is resolved. A review of TB testing documentation in new employee files will be conducted at monthly QA meeting. Any issues will be addressed and corrected. Results and issues identified will be discussed with IDT at monthly QA meeting and with the Medical Director and the Quarterly QA meeting and/or as needed for determination for ongoing monitoring and/or changes to the QA meeting. If needed, an action plan will be developed by the committee. Any
<table>
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<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
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<td>PREFIX</td>
<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>TAG</td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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**WATERS OF BATESVILLE, THE**

**958 E HWY 46**

**BATESVILLE, IN 47006**

Tuberculin-sensitive individuals, the delayed hypersensitivity reaction is evident 5-6 hours after administration of tuberculin skin test and is maximal 48-72 hours...

Action plan will be followed weekly by the administrator until resolved.