STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING 00 B. WING	07/11/2016

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00203347. This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. This visit was in conjunction with the PSR to Complaint IN00201205 completed on 6/2/2016. Complaint IN00203347 - Substantiated. Federal/State deficiencies related to the allegations are cited at F225, F226 and F323. Survey dates: July 6, 7, 8, 9, 10, and 11, 2016 Facility number: 000478 Provider number: 155494 AIM number: 100290430 Census bed type: SNF/NF: 84 Total: 84 Census payor type: Medicare: 6 Medicaid: 71 Other: 7	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is: **August 2, 2016**	

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

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	Total: 84 Sample: 3 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 34233 on July 13, 2016.			
F 0225 SS=J Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all			

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	alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on observation, interview and record review, the facility failed to ensure staff immediately reported, to the Administrator, an observation of a sexual encounter between two cognitively impaired residents for 2 of 3 residents reviewed for sexual misconduct. (Resident #G and Resident #H) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 6/22/16 at 3:30 a.m. when two staff members observed a sexual encounter between two cognitively impaired residents (Resident #G and Resident #H) and failed to immediately notify the Administrator of the incident. The Health Facility Administrator, Regional Director, Director of Nursing, and Assistant Director of Nursing were notified of the Immediate Jeopardy on 7/7/16 at 4:47 p.m. The Immediate Jeopardy was	F 0225	**F-225** It is the policy of the facility to ensure that the Administrator is immediately notified of any incident of abuse or alleged abuse including any observed sexual encounter between two cognitively impaired residents. Resident H is safe and not accessible to any physical encounter of any kind with Resident G. Resident G has been hospitalized and is being treated for sexual behavior control with success. This treatment will be on going and regularly assessed for efficacy. Resident G is in a private room in close proximity to the nurses's station. Resident G is on every 15 minute checks from the time he retires for the evening until he arises for breakfast. This is 7 p.m. to 7:00 a.m. Residents who reside in the facility's Onyx Unit could have the potential to be affected by this finding. Residents with cognitive and/or physical deficits could have a greater potential to be	08/02/2016

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	removed on 7/11/16, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: The clinical record for Resident #G was reviewed on 7/6/16 at 10:05 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, anxiety, affective mood disorder, and inappropriate sexual behavior. The MDS (Minimum Data Set) quarterly assessment, dated 5/6/16, indicated Resident #G had severe cognitive impairment with a BIMS (Brief Interview of Mental Status) score of 1. The clinical record for Resident #H was reviewed on 7/6/16 at 11:15 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, psychosis, depression and insomnia. The MDS quarterly assessment, dated 6/9/16, indicated Resident #H had severe cognitive impairment with a BIMS score of 3. On 7/6/16 at 9:50 a.m., Resident #G was observed ambulating independently in the Onyx dining room.		affected by this finding. An audit was conducted to identify the residents who reside in the facility and who have a sexual concern/behavior diagnosis or any resident who is care planned for inappropriate sexual comments or behaviors to see that they have appropriate interventions in place to address and manage and control the issue. At the daily CQI meetings, any behaviors documented or reported since the last CQI meeting will be discussed and addressed according to facility policy and procedure. This will include any needed assessments/notification/interviews/investigating/interventions/careplanning/monitoring and follow up. The SSD/Designee will spearhead this review and it will be ongoing. Any residents admitted with behaviors or from a Behavioral Unit will be reviewed in the CQI meeting prior to the resident's arrival to discuss proper and safe placement for this resident as well as all other residents. Further, the SSD/Designee will make a note on these residents daily for at least 30 days as related to their behavioral diagnosis or concern. Residents admitted with a diagnosis of a sexually related behavior will have an onsite assessment by the appropriate facility staff prior to admission to the facility. Any resident with an	

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	The ISDH (Indiana State Department of Health) reportable, dated 6/22/16, included, but was not limited to, the following: "...Incident Date: 06/22/2016...Incident Time: 03:30AM...Residents Involved... [Resident #H's name]...Diagnosis: Dementia...[Resident #G's name]...Diagnosis: Dementia with behaviors...Brief Description of Incident...6/22/2016 Resident, [Resident #G] was noted in the bed with... roommate when the C.N.A. [Certified Nursing Assistant] went in to check on the residents. She noted [Resident #G] lying behind resident and when she got closer, [Resident #G] had... hand stretched across [Resident #H's] waste [sic] and touching [Resident #H's] hip and groin area...Follow up added - - 6/27/2016 Upon investigation, the following was noted: At approx. [approximately] 3:30 am, June 22, 2016, [CNA #8] went into [room number] to check on [Resident #G] and [Resident #H]. Upon entering, she discovered that [Resident #G] was in [Resident #H's] bed, lying behind...[Resident #G] was noted to be pulling at [Resident #H's] brief/pull up. [CNA #8] attempted to redirect resident...became combative. She then went to the doorway to summon [CNA #7] to help her. They immediately went together and separated them. [CNA		on set of sexual behavior will be immediately be placed on 1:1 supervision until treated and the behavior is controlled. Note: Residents newly admitted or readmitted with a sexually related diagnosis will be on “every 15 minute checks” supervision for a period of time until it can be determined that the treatment plan in place is adequate and is producing desired outcome. This will be assessed and determined (that “every 15 minute checks” are no longer necessary) by a physician’s order or by lab testing for therapeutic levels being achieved, and then a physician’s order to discontinue the checks every 15 minutes based on the lab results. Going forward, the facility will conduct their weekly Behavior Management meeting at which behaviors of the targeted residents who have behaviors will be reviewed. Any needed changes in the care plans will be made based on discussion within the IDT (Interdisciplinary Team)as related to behaviors over the previous week. Efficacy of current interventions including medications will be any recommendations for medication changes or GDRs. Any appropriate notifications will be made as indicated based on the results of the meeting activity. The SSD/Designee will spearhead this meeting. All staff were in-service don the following:	

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	#7] noted that [Resident #H's] brief was pulled down on one side and [Resident #G] was touching [Resident #H] on leg/groin area...The CNAs [sic] reported to the night shift nurse [LPN [Licensed Practical Nurse] #9] that [Resident #G] was found in bed with [Resident #H] and was noted to be rubbing...leg/hip area...." The written statement from RN (Registered Nurse) #4, untimed and undated, included the following: "At around 0700 [7:00 a.m.] during shift report, the night shift nurse stated that [Resident #G] was behind [Resident #H]. [Resident #G] was pulling on...brief [plus sign] [and] rubbing [Resident #H's] thigh." The written statement from CNA #8, undated and untimed, included, but was not limited to, the following: "...At around 4 am [sic] [4:00 a.m.] we began to start rounds and I opened the door to [Resident #G's] [plus sign] [and] [Resident #H's] room. When I opened the door [sic] [Resident #G] had...pants off w [with]/nothing on but a shirt and was laying behind [Resident #H] w[with]/...cheek against [Resident #H's] butt. [Resident #G] was pulling on [Resident #H's] pull up as I was telling...to stop and get up...I stepped in the hallway to get [CNA #7] to come in		1.Resident Rights 2.Abuse Policy 3.Reporting witnessed Abuse or Alleged Abuse or an incident of Abuse or Alleged Abuse that is reported to you 4.Any with behaviors or from a Behavioral Unit will be reviewed in the CQI meeting prior to the resident's arrival to discuss proper and safe placement for this resident and all other residents—Further, the SSD/Designee will make a note on these residents daily for at least 30 days as related to their behavior diagnosis 5.Residents admitted from an acute Behavioral Facility will have onsite assessments prior to admission to the facility 6.Residents admitted with a diagnosis of a sexual related behavior will have onsite assessments prior to admission to the facility 7.Any resident with an onset of sexual behavior will be immediately placed on 1:1 supervision until treated and the behavior is controlled 8.NOTE: Those staff specifically involved in this incident were individually educated and/or counseled as appropriate. Any staff who fail to comply with the points of this in-servicing will be further educated and/or progressively disciplined as indicated. At the monthly Q.A.meetings, the results of the Behavior Management	

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	and help me. When she came in to help me [sic] [Resident #G] had pulled [Resident #H's] pull up down slightly at an angle and ...butt was exposed. [Resident #G] was rubbing on...leg and butt/groin area...The nurse was then notified of the situation and said she would document...." The written statement from CNA #7, dated 6/22/16 and untimed, included, but was not limited to, the following: "Around 3:30 a.m. [Resident #G] was got [sic] toileted and layed [sic] down in...own bed. 4:00 a.m. [sic] [CNA #8] went and checked on [Resident #G] to make sure...wasn't going into other resident [sic]. [CNA #8] yelled at me while I was standing at the nurse [sic] station to help her with [Resident #G]. I walked in [Resident #G's] room and I found [Resident #G] naked beside [Resident #H] with...pull up half way down while [Resident #G] touching [Resident #H's] private parts. [Resident #G] was awake when doing what...was doing. Me and [CNA #8] got [Resident #G], put...clothes on and sent...to the dining room...." The written statement from from the Director of Nursing (DON), indicated as verbal confirmation per telephone conversation to RN #9, dated 6/22/16 and		meetings will be reviewed. Further, all reportable incidents since the last Q.A. meeting will be reviewed. Additionally, all new/readmissions will be reviewed to see that all proper meds/treatments are in place to address any known or diagnosed behaviors. Any patterns will be identified. If necessary an Action Plan will be written by the committee. Any Action Plan will be monitored weekly by the Administrator until resolution. NOTE: There will be a member of the Corporate Regional Team in the facility until substantial compliance is achieved for oversight and supervision at least 3 days weekly to ensure ongoing compliance. The Facility is contesting the validatity of the citation, we are requesting and IDR at this time.	

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	untimed, included, but was not limited to, the following: "The nurse on Onyx night shift, noted [CNA #7 and CNA #8], bringing [Resident #G] out in the hallway. The CNA's reported to [RN #9] that they had seen [Resident #G] [was with a line through it] in bed behind [Resident #H]. [Resident #H] had no pants on but he did have a pull up on. [Resident #H] was facing the wall while abed. [Resident #G] was noted to be pulling [Resident #H's] brief at the waist. [RN #9] was unsure if [Resident #G] was (in or out of bed), [sic] [RN #9] told [DON] the CNA's yelled "stop that" when they saw the resident rubbing on hip...[RN #9] did not witness...." The written statement from CNA #5, dated 6/22/16 and untimed, included, but was not limited to, the following: "I [sic] [CNA #5] was reported...on 6-22-16 By [sic] C.N.A.s [sic] working on onyx that [Resident #G] laying behind [Resident #H]. With [sic] all his clothes off and brief off. [Resident #G] had [Resident #H's] brief off. [Resident #G] was rubbing [Resident #H's] buttox [sic] [buttocks] and his genitalia, they [sic] said they removed [Resident #G] from [Resident #H's] bed and they reported this to nurse...." The written statement from CNA #6,			

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	dated 6/22/16 and untimed, included, but was not limited to, the following: "I [CNA #6] was reported this on 6-22-16, By [sic] the night shift CNA working on onyx that [Resident #G] was laying behind [Resident #H] with all his clothes off and brief was off [sic] [Resident #G] had [Resident #H's] brief off [sic] [Resident #G] was rubbing [Resident #H's] buttox [sic] [buttocks] and his genetalia [sic]...They said they reported this to there [sic] [their] nurse...." The nurses note, dated 6/22/16 at 9:09 a.m., included, but was not limited to, the following: "ADON [Assistant Director of Nursing] summoned me into his office to report to me that [RN #4] had just reported to him that his CNA's [CNA #5 and #6] got in report that [Resident #G] was noted in the bed with his roommate and touching him inappropriately with his hands...." During an interview on 7/7/16 at 2:20 p.m., the Administrator indicated CNA #7 and CNA #8 did not tell the nurse the specifics of the incident, only that (Resident #G) was in bed with (Resident #H). The Administrator indicated CNA #7 and CNA #8 told RN #9 (Resident #G) was not sleeping so they were bringing (Resident #G) to the dining room and RN #9 indicated she would			

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	watch him/her. The Administrator indicated the day shift CNA's got report from the night shift CNA's, and the day shift CNA's further questioned the night shift CNA's about the incident. The Administrator indicated the day shift CNA's reported the incident to RN #4, the day shift nurse, who reported it to the ADON, who then, reported it to her. During an interview on 7/7/16 at 2:25 p.m., the DON indicated there was a communication breakdown between staff and management. The clinical record lacked documentation of the initial incident that occurred between Resident #G and Resident #H on 6/22/16 at approximately 3:30 a.m. until the next shift began, at approximately 7:00 a.m. On 7/6/16 at 10:05 a.m., the Administrator provided a copy of the document titled, "Resident Rights". It included, but was not limited to, the following: "As a resident of this facility, you have the right to a dignified existence...The facility will protect and promote your rights as designated below...You have the right to be free from...sexual abuse...Staff Treatment...The facility must implement procedures that protect you...."			

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	On 7/7/16 at 2:04 p.m., the Business Office Manager provided a current copy of the document titled, "Abuse Prevention Program". It included, but was not limited to, the following: "....Policy...This facility will not tolerate resident abuse or treatment by anyone, including staff members, other residents...All personnel must promptly report any incident or suspected incident of resident abuse...Procedure...Any alleged violations involving...abuse...MUST be reported to the Administrator and Director of Nursing...Additionally, the person(s) observing an incident of resident abuse or suspecting resident abuse must IMMEDIATELY report such incidents to the Charge Nurse...The Charge Nurse will immediately report the incident to the Administrator...." The Immediate Jeopardy that began on 6/22/16 was removed on 7/11/2016 at 4:45 p.m. when the facility completed staff education/inservices on resident rights, abuse policy, reporting witnessed abuse or alleged abuse and residents who require 1:1 supervision of any onset of sexual behaviors. The Immediate Jeopardy was removed on 7/11/16, but noncompliance remained at the lower scope and severity of isolated, no actual			

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	harm with potential for more than minimal harm that is not immediate jeopardy because not all staff had been educated on resident rights, abuse policy, reporting witnessed abuse and residents who require 1:1 supervision of any onset of sexual behaviors. This Federal tag relates to Complaint IN00203347 3.1-28(c)			
F 0226 SS=J Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record, the facility failed to follow policy and procedure on abuse when staff observed a sexual encounter between two cognitively impaired residents (Resident #G and Resident #H) and failed to immediately notify the Administrator. This deficient practice had the potential to affect 1 of 3 sampled residents (Resident H) on a secured unit of 23 residents. This deficient practice resulted in an Immediate Jeopardy. The Immediate	F 0226	**F-226** It is the policy of the facility to ensure that the Administrator is immediately notified of any incident of abuse or alleged abuse including any observed sexual encounter between two cognitively impaired residents. Residents who reside in the facility could have the potential to be affected by this finding. NOTE: The in-servicing and monitoring and follow up for this F-tag is included in the response for F-225. NOTE: There will be a member of the CorporateRegional Team in the facility until substantial	08/02/2016

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	Jeopardy began on 6/22/16 at 3:30 a.m. when two staff members observed a sexual encounter between two cognitively impaired residents (Resident #G and Resident #H) and failed to immediately notify the Administrator of the incident. The Health Facility Administrator, Regional Director, Director of Nursing, and Assistant Director of Nursing were notified of the Immediate Jeopardy on 7/7/16 at 4:47 p.m. The Immediate Jeopardy was removed on 7/11/2016 at 4:45 p.m., but noncompliance remained at the lower scope and severity of widespread, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: The ISDH (Indiana State Department of Health) reportable, dated 6/22/16, included, but was not limited to, the following: "...Incident Date: 06/22/2016...Incident Time: 03:30AM...Residents Involved... [Resident #H's name]...Diagnosis: Dementia...[Resident #G's name]...Diagnosis: Dementia with behaviors...Brief Description of Incident...6/22/2016 Resident, [Resident #G] was noted in the bed with... roommate when the C.N.A. [Certified		compliance is achieved foroversight and supervision at least 3 days weekly to ensure ongoing compliance. The facility is contesting the validity of this citation, we are requesting an IDR at this time	

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	155494	A. BUILDING 00 B. WING	07/11/2016

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	Nursing Assistant] went in to check on the residents. She noted [Resident #G] lying behind [Resident #H] and when she got closer, [Resident #G] had... hand stretched across [Resident #H] waste [sic] and touching [Resident #H] hip and groin area...Follow up added - - 6/27/2016 Upon investigation, the following was noted: At approx. [approximately] 3:30 am, June 22, 2016, [CNA #8] went into [room number] to check on [Resident #G] and [Resident #H]. Upon entering, she discovered that [Resident #G] was in [Resident #H] bed, lying behind...[Resident #G] was noted to be pulling at [Resident #H] brief/pull up. [CNA #8] attempted to redirect resident...became combative. She then went to the doorway to summon [CNA #7] to help her. They immediately went together and separated them. [CNA #7] noted that [Resident #H] brief was pulled down on one side and [Resident #G] was touching [Resident #H] on leg/groin area...The CNAs [sic] reported to the night shift nurse [LPN (Licensed Practical Nurse) #9] that [Resident #G] was found in bed with [Resident #H] and was noted to be rubbing...leg/hip area...." The written statement from CNA #8, undated and untimed, included, but was not limited to, the following: "...At around 4 am [sic] [4:00 a.m.] we began			

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	to start rounds and I opened the door to [Resident #G's] [plus sign] [and] [Resident #H's] room. When I opened the door [sic] [Resident #G] had...pants off w [with]/nothing on but a shirt and was laying behind [Resident #H] w[with]/...cheek against [Resident #H's] butt. [Resident #G] was pulling on [Resident #H's] pull up as I was telling...to stop and get up...I stepped in the hallway to get [CNA #7] to come in and help me. When she came in to help me [sic] [Resident #G] had pulled [Resident #H's] pull up down slightly at an angle and ...butt was exposed. [Resident #G] was rubbing on...leg and butt/groin area...The nurse was then notified of the situation and said she would document...." The written statement from CNA #7, dated 6/22/16 and untimed, included, but was not limited to, the following: "Around 3:30 a.m. [Resident #G] was got [sic] toileted and layed [sic] down in...own bed. 4:00 a.m. [sic] [CNA #8] went and checked on [Resident #G] to make sure...wasn't going into other resident [sic]. [CNA #8] yelled at me while I was standing at the nurse [sic] station to help her with [Resident #G]. I walked in [Resident #G's] room and I found [Resident #G] naked beside [Resident #H] with...pull up half way			

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	down while [Resident #G] touching [Resident #H's] private parts. [Resident #G] was awake when doing what...was doing. Me and [CNA #8] got [Resident #G], put...clothes on and sent...to the dining room...." The written statement from RN #9, indicated as verbal to the DON (Director of Nursing), dated 6/22/16 and untimed, included, but was not limited to, the following: "The nurse on Onyx night shift, noted [CNA #7 and CNA #8], bringing [Resident #G] out in the hallway. The CNA's reported to [RN #9] that they had seen [Resident #G] [was with a line through it] in bed behind [Resident #H]. [Resident #H] had no pants on but he did have a pull up on. [Resident #H] was facing the wall while abed. [Resident #G] was noted to be pulling [Resident #H's] brief at the waist. [RN #9] was unsure if [Resident #G] was (in or out of bed), [sic] [RN #9] told [DON] the CNA's yelled "stop that" when they saw the resident rubbing on hip...[RN #9] did not witness...." The written statement from CNA #5, dated 6/22/16 and untimed, included, but was not limited to, the following: "I [sic] [CNA #5] was reported...on 6-22-16 By [sic] C.N.A.s [sic] working on onyx that [Resident #G] laying behind [Resident			

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	#H]. With [sic] all his clothes off and brief off. [Resident #G] had [Resident #H] brief off. [Resident #G] was rubbing [Resident #H] buttox [sic] [buttocks] and his genitalia, they [sic] said they removed [Resident #G] from [Resident #H] bed and they reported this to nurse...." The written statement from CNA #6, dated 6/22/16 and untimed, included, but was not limited to, the following: "I [CNA #6] was reported this on 6-22-16, By [sic] the night shift CNA working on onyx that [Resident #G] was laying behind [Resident #H] with all...clothes off and brief was off [sic] [Resident #G] had [Resident #H's] brief off [sic] [Resident #G] was rubbing [Resident #H's] buttox [sic] [buttocks] and...genetalia [sic]...They said they reported this to there [sic] [their] nurse...." The nurses note, dated 6/22/16 at 9:09 a.m., included, but was not limited to, the following: "ADON [Assistant Director of Nursing] summoned me into his office to report to me that [RN #4] had just reported to him that his CNA's [CNA #5 and #6] got in report that [Resident #G] was noted in the bed with his roommate and touching him inappropriately with his hands...."			

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	During an interview on 7/7/16 at 2:20 p.m., the Administrator indicated CNA #7 and CNA #8 did not tell the nurse the specifics of the incident, only that (Resident #G) was in bed with (Resident #H). The Administrator indicated CNA #7 and CNA #8 told RN #9 (Resident #G) was not sleeping so they were bringing (Resident #G) to the dining room and RN #9 indicated she would watch him/her. The Administrator indicated the day shift CNA's got report from the night shift CNA's, and the day shift CNA's further questioned the night shift CNA's about the incident. The Administrator indicated the day shift CNA's reported the incident to RN #4, the day shift nurse, who reported it to the ADON, who then, reported it to her. The Administrator indicated she and the Director of Nursing were not notified when the incident occurred. The clinical record lacked documentation regarding the incident, when it occurred, on 6/22/16 at 3:30 a.m. until the next shift began at approximately 7:00 a.m. The clinical record also lacked documentation of the notification of the Administrator and/or Director of Nursing regarding the incident, when it occurred, on 6/22/16 at 3:30 a.m.			

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	On 7/7/16 at 2:04 p.m., the Business Office Manager provided a current copy of the document titled, "Abuse Prevention Program". It included, but was not limited to, the following: "....Policy...All personnel must promptly report any incident or suspected incident of resident abuse...Procedure...Any alleged violations involving...abuse...MUST be reported to the Administrator and Director of Nursing...Additionally, the person(s) observing an incident of resident abuse or suspecting resident abuse must IMMEDIATELY report such incidents to the Charge Nurse...The Charge Nurse will immediately report the incident to the Administrator...." The Immediate Jeopardy that began on 6/22/16 was removed on 7/11/2016 at 4:45 p.m. when the facility completed staff education/inservices on resident rights, abuse policy, reporting witnessed abuse or alleged abuse and residents who require 1:1 supervision of any onset of sexual behaviors. The Immediate Jeopardy was removed on 7/11/16, but noncompliance remained at the lower scope and severity of widespread, no actual harm with potential for more than minimal harm that is not immediate jeopardy because not all staff had been educated on resident rights, abuse policy,			

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	reporting witnessed abuse and residents who require 1:1 supervision of any onset of sexual behaviors. This Federal tag relates to Complaint IN00203347 3.1-28(a)			
F 0323 SS=J Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to provide adequate supervision to prevent, the potential for, additional sexual encounters to occur, after a resident (Resident #G) returned from a behavioral hospital stay related to sexual misconduct towards another resident (Resident #H). This deficient practice had the potential to affect 1 of 3 sampled residents (Resident H) on a secured unit of 23 residents. This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 6/22/16 at 3:30 a.m.	F 0323	**F-323** It is the policy of the facility to ensure that residents reside in an environment that is as free of accident hazards as possible and that each resident receives adequate supervision and assistive devices to prevent accidents. Resident H is safe and to any physical encounter of any kind with Resident G. Resident G has been hospitalized and is being treated for sexual behavior control with success. The treatment will be ongoing and regularly assessed for efficacy. Resident G is in a private room in close proximity to the nurses' station. Resident G is on every 15 minute checks from the time he retires in the evening	08/02/2016

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	when two staff members observed a sexual encounter between two cognitively impaired residents (Resident #G and Resident #H) and failed to provide adequate supervision to prevent, the potential for, additional sexual encounters to occur, after a resident returned from a behavioral hospital stay related to sexual misconduct towards another resident. The Health Facility Administrator, Regional Director, Director of Nursing, and Assistant Director of Nursing were notified of the Immediate Jeopardy on 7/7/16 at 4:47 p.m. The Immediate Jeopardy was removed on 7/11/2016 at 4:45 p.m., but noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: The ISDH (Indiana State Department of Health) reportable, dated 6/22/16, was reviewed on 7/6/16 at 11:00 a.m. It included, but was not limited to, the following: "...Incident Date: 06/22/2016...Incident Time: 03:30AM...Residents Involved... [Resident #H's name]...Diagnosis: Dementia...[Resident #G's name]...Diagnosis: Dementia with		until he arises for breakfast. This is 7 p.m to 7 a.m. Residents who reside on the Onyx Unit could have had the potential to be affected by this finding. Residents who are newly admitted or readmitted with a sexually related diagnosis will be on “every 15 minute checks” supervision for a period of time until it can be determined that the treatment plan in place is adequate and is producing desired outcome. This will be assessed and determined (that“every 15 minute check” are no longer necessary) by a physician’s order or by lab testing for therapeutic levels being achieved, and then a physician’s order to discontinue the checks every 15 minutes based on the lab results. NOTE: The in-servicing monitoring and follow up for this F-tag is included in the response for F-225 NOTE: There will be a member of the Corporate Regional Team in the facility until substantial compliance is achieved for oversight and supervision at least 3 days weekly to ensure ongoing compliance. The facility is contesting the validity of the citation, we are requesting an IDR	

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	behaviors...Brief Description of Incident...6/22/2016 Resident, [Resident #G] was noted in the bed with... roommate when the C.N.A. [Certified Nursing Assistant] went in to check on the residents. She noted [Resident #G] lying behind resident and when she got closer, [Resident #G] had... hand stretched across [Resident #H's] waste [sic] and touching [Resident #H's] hip and groin area...Type of Preventative Measures Taken..[.Resident #G] was moved into a different room where...will return upon readmission...." On 7/6/16 at 9:46 a.m., during initial tour, Resident #G's name and Resident #H's name were observed to be posted on the wall by the door of the same room. On 7/6/16 at 9:50 a.m., Resident #G was observed ambulating independently on the Onyx unit. During an interview on 7/6/16 at 10:46 a.m., CNA #6 indicated Resident #G and Resident #H resided in the same room. During an interview on 7/6/16 at 12:00 p.m., the Administrator indicated the facility just realized Resident #G and Resident #H were residing in the same room. The Administrator indicated Resident #G was moved to a different			

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	room the day the incident occurred, prior to discharge to the behavioral hospital. The Administrator indicated RN (Registered Nurse) #4, per their phone conversation, felt it was okay to readmit Resident #G to his original room with Resident #H. The Administrator further indicated RN #4 stated since Resident #G was sent out and treated and Resident #H's POA (Power of Attorney) was okay with Resident #G returning to the same room, there was no issue. The Administrator also indicated RN #4 should not have made that decision without consulting management. The Administrator indicated Resident #G and Resident #H were now in separate rooms. During an interview on 7/6/16 at 12:04 p.m., the DON (Director of Nursing) indicated there was a communication problem regarding the resident's room change. During an interview on 7/6/16 at 4:48 p.m., the Vice President of Clinical Operations indicated Resident #G did not return to the facility with any orders for 15 minute monitoring checks and also indicated Resident #G was not having any behaviors at the time of hospital discharge on 6/27/16. The Social Service note, dated 7/7/16 at			

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	1:48 p.m., included, but was not limited to, the following: "F/U [follow up] on adjustment to room change this am [sic] [a.m.] when observed [Resident #G] in the DR [dining room] [sic] mood pleasant & [and] calm. Upon making rounds later in the AM to unit [sic] observed...name on old room with old roommate. Upon speaking with staff [sic] was informed [Resident #G] was moved back into old room upon return from the hospital...." During a interview on 7/7/16 at 2:15 p.m., the Social Services Director (SSD) indicated, on 6/22/16, only bodies were moved, not belongings. The SSD indicated, for whatever reason, someone took it upon themselves to put Resident #G back in his/her original room. The SSD indicated she did not know why the personal belongings were not moved on 6/22/16. The clinical record for Resident #G was reviewed on 7/6/16 at 10:05 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance and inappropriate sexual behavior. The clinical record for Resident #H was reviewed on 7/6/16 at 11:15 a.m. Diagnosis included, but was not limited to, dementia with behavior disturbance.			

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	The nurses note, dated 6/27/16 at 6:48 p.m., included, but was not limited to, the following: "Resident [Resident #G] returned to facility from [name of behavior hospital]...Making frequent statements such as "we love you". Stated to the female CNA [sic] "sit on my head" while being weighed...." The nurses note, dated 6/28/16 at 5:14 a.m., included, but was not limited to, the following: "Resident [Resident #G] has been resting quietly...No inappropriate sexual comments or advances;...was repeating the word "balls" over and over...." The IDT (Interdisciplinary Team) note, dated 6/28/16 at 11:24 a.m., included, but was not limited to, the following: "...Resident [Resident #G] was sent to behavior for sexual behaviors...now on Climara [medication used for sexual behaviors] to prevent further sexual behaviors...." The IDT note, dated 7/1/16 at 2:04 p.m., included, but was not limited to, the following: "IDT team met for weekly behavior meeting. Team reviewed & [and] discussed behavior charted by nursing. [Resident #G] was being verbally sexually inappropriate...."			

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The June 2016 Behavior Monthly Flowsheet indicated Resident #G had a sexual behavior on 6/28/16.

The clinical record indicated behavior monitoring was tracked once per 12 hour shift. The behavior tracking logs for sexual behaviors/remarks were left blank on 6/30/16, 7/1/16, 7/2/16 and 7/4/16. The behavior tracking log for July 2016 also indicated to begin tracking signs of sexual behavior on 7/7/16.

The clinical record lacked any documentation of increased monitoring and preventative measures for Resident #G to ensure the safety of Resident #H and other residents residing on Onyx.

The Immediate Jeopardy that began on 6/22/16 was removed on 7/11/2016 at 4:45 p.m. when the facility completed staff education/inservices on resident rights, abuse policy, reporting witnessed abuse or alleged abuse and residents who require 1:1 supervision of any onset of sexual behaviors. The Immediate Jeopardy was removed on 7/11/16, but noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy because not all staff had been

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	educated on resident rights, abuse policy, reporting witnessed abuse, and residents who require 1:1 supervision of any onset of sexual behaviors. This Federal tag relates to Complaint IN00203347 3.1-45(a)(2)			