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	02/24/2017

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00217784 and IN00217668. Complaint IN00217668 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00217784 - Unsubstantiated due to lack of sufficient evidence, Survey dates: February 20, 21, 22, 23 and 24, 2017 Facility number: 000478 Provider number: 155494 AIM number: 100290430 Census bed type: SNF/NF: 69 Total: 69 Census payor type: Medicare: 9 Medicaid: 43 Other: 17 Total: 69	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. It is the practice of this facility and it's staff to promote at all times the practices and care that enhance the individuality and dignity of our residents. The facility respectfully request desk review.	

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

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	Sample: 4 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 3, 2017.			
F 0241 SS=D Bldg. 00	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. Based on observation, interview and record review, the facility failed to ensure the provision of privacy during 1 of 3 observations of incontinence care (Resident 55). Findings include: On 02/22/17 at 1:23 p.m., Resident 55 was provided incontinence care by CNAs	F 0241	**F-241** It is the policy of the facility to ensure that privacy is provided whenever appropriate to include during any personal and/or private care such as incontinence care. Resident #55 has privacy provided when	03/24/2017

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	(Certified Nursing Assistant) 1 and 2. Neither CNA closed the privacy curtains on the entire length of the resident's side of the room. The roommate's privacy curtains were closed with a three inch gap. Resident 55's curtains were open at the foot of the resident's bed, from the wall with the window to the roommate's privacy curtains, at the track intersection. During an interview on 02/23/17 at 2:43 p.m., the DON (Director of Nursing), indicated when providing resident care the staff should knock before entering a resident's room, pull the outside curtains shut, and close the privacy curtains around the bed between residents. On 02/24/17 at 8:35 a.m., the ADON (Assistant Director of Nursing) provided a copy of the Conduct Between Staff and Residents...Dignity Based Policy, which indicated, but was not limited to, the following: "... Privacy will be maintained at all times for the residents. This includes during ADL [Activity of Daily Living] care such as bathing, dressing and peri [perineal] care with the resident room/shower room door or curtain as well as the bathroom door closed during care and/or toileting..." 3.1-3(t)		personal care including incontinence care is performed for the resident. Residents who reside in the facility and who receive assistance with incontinence care have the potential to be affected by this finding. A targeted list of residents who require assistance with incontinence care was compiled by the IDT (Interdisciplinary Team). The DON/Designee will monitor 10 of these residents 3 days weekly on various shifts and to include some weekend days to see that the residents are afforded privacy as well as proper technique with regards to required infection control practices during the time that incontinence care is being administered. Any concerns or breaches will be prevented and/or addressed and corrected as observed. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved.	

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			Afterwards, this monitoring will continue for 10 residents at least 1 day weekly for at least 6 months to ensure ongoing compliance. After that, random monitoring will occur ongoing. At an in-service held 3\7\17, for nursing staff the following was reviewed: A.) Resident Rights B) Dignity--with emphasis on providing privacy and also proper use of privacy curtains/doors C,) Incontinence Care--with emphasis on technique (male and female) as related to Infection Control Policies and Procedures. D.) Questions and Answers Any staff who fail to comply with the points of the in-service will be further educated and/or progressively	

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			disciplined as appropriate. At the monthly Quality Assurance meetings, the results of the monitoring by the DON/Designee will be reviewed. Any concerns will have been prevented and/or addressed and corrected as observed. Any patterns will be identified and if necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored weekly by the Administrator until resolution.	
F 0364 SS=E Bldg. 00	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature;			

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	Based on observation, interview and record review, the facility failed to ensure hot beverages were maintained at an acceptable serving temperature related to coffee for 4 of 5 residents interviewed. (Resident 95, 96, 89, & 75) Findings include: During an observation on 02/23/2017 at 12:45 p.m., the coffee temperature was tested on the secure unit, with the Dietary Manager. The coffee was found to be at 123.9 degrees. On 02/23/2017 at 1:22 p.m., the review of the resident council minutes for July, 2016 indicated residents complained of coffee being too cold. The Dietary Manager noted a new coffee system was to be installed. The resident council minutes, on July 22, 2016, revealed coffee temperatures were to be monitored daily after the new "coffee system" was installed. Review of the coffee temperature logs, indicated the coffee temperatures were below 130 degrees for the following days in the months of July, August, and September 2016: July, 2016 logged coffee temperatures were below 130 degrees for nine out of	F 0364	**F-364** It is the policy of the facility to ensure that hot beverages are served at temperatures acceptable to the residents but yet "safe" and according to the temperature policy parameters as well. Residents #95, #96, #89 and #75 are receiving their coffee at a temperature that is acceptable to them as well as within the temperature policy parameters. Residents who drink hot beverages (coffee in particular) have the potential to be affected by this finding. The DM (Dietary Manager)/Designee will monitor coffee from the new coffee system every 4 hours from the time it is offered to the dining room before breakfast until the dietary department discontinues coffee service	03/24/2017

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	31 days. August, 2016 logged coffee temperatures were below 130 degrees for two out of 31 days. September, 2016 logged coffee temperatures were below 130 degrees for five out of 30 days. During an interview on, 02/24/2017 at 9:50 a.m., the following residents were interviewed regarding the temperature of the coffee: Resident 95 indicated the coffee, "it's not real hot." The resident was alert and oriented to person, place, and time. Resident 96 indicated the coffee was, "not very warm." Review of the resident's Admission MDS assessment, dated 01/11/2017, indicated the resident was alert and oriented with a BIMS score of 13. Resident 89 indicated the coffee was, "not very warm." The resident was alert and oriented to person, place, and time. Resident 75 indicated the coffee was, "not very warm." Review of the resident's Admission MDS assessment, dated 02/01/2017, indicated the resident		from the dining room/dietary department as part of the post evening meal cleaning and storage process. This temperature checking will include checking the setting of the temperature dial as well as taking the temperature of the coffee itself. This dual monitoring will be documented. Should the coffee be found to be below 130 degrees an adjustment will be made and it will be rechecked every 15 minutes until it reaches and maintains an acceptable temperature. This too will be documented. Any concerns not resolved by a dial adjustment by authorized dietary staff will be reported to the maintenance staff to be addressed as found. As with any appliance, should the coffee system machine be found to be faulty in any way it will be unplugged and taken out of service until repaired or replaced. Additionally,	

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	was alert and oriented with a BIMS score of 15. On 02/24/2017 at 9:30 a.m., the Dietary Manager provided a copy of the facility policy " Precautions for Handling Hot Beverages" which indicated, but was not limited to, the following : "...suggested monitoring procedure is as follows: ...the serving temperature of 130 degrees F[fahrenheit] to 140 degrees F". 3.1-21(a)(2)		residents who drink hot beverages (coffee in particular) will be interviewed by the Dietary Manger/Designee at the rate of 10 interviewable residents 3 days weekly on various shifts and to include some weekend days to ensure that they are content with the temperature of their coffee as served. Any concerns will be addressed as found. This dual monitoring will continue until 4 consecutive weeksof zero negative findings is achieved. Afterwards, the monitoring will continue each shift for the coffee temps and 10 residents weekly for the satisfaction with the coffee temps for a period of time not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur ongoing. At an in-service held for all staff on 3\7\17 the following was reviewed:	

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			A.) Resident Rights/Dignity B.) Meal Service—Coffee Service C.) Preferences—Honoring preferences D.) What to do/who to tell if a resident complains about the temperature of a "hot" beverage E.) Discussion Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings the results of the monitoring by the Dietary Manager/Designee will be reviewed. Any concerns will have been addressed. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plans will	

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			be monitored by the Administrator until resolved.	
F 0441 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (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 (facility assessment implementation is Phase 2); (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			

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	precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview and record review, the facility failed to ensure staff followed infection control practices per policy when providing incontinence care for 3 of 3 residents reviewed for incontinence care. (Residents 39, 30, and	F 0441	F-441 It is the policy of the facility to ensure that staff follow infection control practices per policy when providing incontinence care for	03/24/2017

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	55) Findings include: 1. On 02/22/17 at 9:25 a.m., Resident 39 received incontinence care by CNA (Certified Nursing Assistant) 4 and CNA 3. The CNAs removed the resident's pants and soiled brief at the toilet. The resident indicated her brief was wet, but she could not urinate right now. The soiled brief was removed. CNA 4 obtained wipes, applied peri (perineal) spray, and cleaned the labial area per policy. The resident was asked to slide forward on the toilet seat. Another wipe was obtained and the resident's rectal area was cleaned using a back to front motion, folding between each swipe for a total of 3 folds. Stool was observed on the wipe. Another wipe was obtained and, using a back to front motion, the rectal area was wiped again. 2. On 02/22/17 at 10:12 a.m., Resident 30 received incontinence care by CNAs 4 and 3. The brief was unfastened and lowered. The labial area was cleaned per policy. The resident was rolled onto her left side. CNA 3 cleaned the rectal area with one wipe and peri wash, using a back to front (rectum to vagina) motion. She obtained another wipe and swiped the rectal area, using a back to front		residents. Residents #39, #30 and #55 receive incontinence care by staff who are following infection control practices per policy as the care is being rendered. Residents who require assistance from staff for incontinence care have the potential to be affected by this finding. Resident #55 has privacy provided when personal care including incontinence care is performed for the resident. Residents who reside in the facility and who receive assistance with incontinence care have the potential to be affected by this finding. A targeted list of residents who require assistance with incontinence care was compiled by the IDT (Interdisciplinary Team). The DON/Designee will monitor 10 of these residents 3 days weekly on various shifts and to include some weekend days to see that the residents are afforded privacy as well as proper technique with regards to required infection control practices during the time that	

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	motion. Another wipe was obtained and the rectal area was swiped twice, using a back to front motion, folding between swipes. 3. On 02/22/17 at 1:23 p.m., Resident 55 received incontinence care by CNAs 1 and 2. CNA 1 obtained 3 wipes and applied peri wash. He swiped the creases to the right and left sides of the penis, with 6 swipes on the same area of the wipes. He obtained 3 clean wipes, applied peri wash, and swiped the creases again 3 times, with the same area on the wipes. He obtained 3 clean wipes, applied peri wash, and swiped the penis 2 times with the same area on the wipes down the shaft of the penis. He folded the wipes and cleaned the penis, with 3 swipes on the same area of the wipe. The resident was rolled onto his right side. Stool was observed on the rectal area. CNA 1 obtained clean wipes and swiped some of the stool from the rectal area. He obtained wipes, sprayed them with peri wash, swiped twice with the same area on the wipe, folded the wipes, swiped 4 times with the same area of the wipe, folded the wipes, swiped again. He obtained wipes, sprayed them with peri-wash, and swiped the rectal area 5 times with one area on the wipe. He obtained fresh wipes, swiped the rectal area 2 times with the same area on the		incontinence care is being administered. Any concerns or breaches will be prevented and/or addressed and corrected as observed. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, this monitoring will continue for 10 residents at least 1 day weekly for at least 6 months to ensure ongoing compliance. After that, random monitoring will occur ongoing. At an in-service held 3\7\17, for nursing staff the following was reviewed: A.) Resident Rights B) Dignity--with emphasis on providing privacy and also proper use of privacy curtains/doors C,) Incontinence Care--with emphasis on technique (male and female) as related to Infection Contol policies and procedures D) Questions and Answers Any staff who fail to comply with the points of the	

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	wipe, folded and swiped 2 times with the same area then folded and swiped 2 times with the same area of the wipe. Particles of stool were observed still on the resident's buttocks when CNA 1 placed a clean brief under the resident. During an interview on 02/22/17 at 9:43 a.m. with CNA 4, she indicated to perform pericare: she would remove the brief then wash the folds, sides, and middle. Clean with a front to back motion. During an interview on 02/23/17 at 2: p.m., the DON (Director of Nursing), indicated for incontinence care the staff should clean from front to back, meaning from the top of the labia down to the anus and throw the wipe away after each swipe. They should clean from the vagina back and not toward the vagina or urethra. On 02/22/17 at 9:51 a.m., the DON provided a copy of the Incontinence Care Policy and Procedure which indicated, but was not limited to, the following: "...the facility to ensure that resident's [sp] receive as much assistance as needed for cleansing the perineum and buttocks after an incontinent episode or with routine daily care...Cleanse peri-area and buttocks with cleansing agent wiping		in-service will be further educated and/or progressively disciplined as appropriate. At the monthly Quality Assurance meetings, the results of the monitoring by the DON/Designee will be reviewed. Any concerns will have been prevented and/or addressed and corrected as observed. Any patterns will be identified and if necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored weekly by the Administrator until resolution.	

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	from front of perineum toward rectum. Use separate area of cloth for each stroke. Turn resident side to side to cleanse entire affected area as needed...Dry peri area and buttocks from front to back..." 3.1-18 (a)			
F 9999 Bldg. 00	3.1-14 Personnel (k) There shall be organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Resients' rights (2) Prevention and control of infection (3) Fire prevention (4) Safety and accident prevention (5) Needs of specialized populations served (6) Care of cognitively impaired residents (l) The frequency and content of inservice education and training programs shall be in accordance with skills and knowledge of the facility personnel as follows: For nursing personnel, this shall include at least twelve (12) hours of in-service per calendar year and six (6) hours of	F 9999	**9999** It is the policy of the facility to provide an organized ongoing in-service education and training program in advance for all personnel. The training includes all required topics as well as the required number of in-service/training hours for nursing and non-nursing staff as per state/federal regulation. The facility has a calendar with required in-services listed. All staff have been in-serviced on required in-service topics for their position and are current as related to their last anniversary date to present.	03/24/2017

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	02/24/2017

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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	in-service per calendar year for non-nursing personnel. This rule is not met as evidenced by: Based on interview and record review the facility failed to conduct employee in-services and update the in-service records. Findings include: During an interview on 2/24/17 at 1:30 p.m., LP (Licensed Practical Nurse) 1 indicated "The AMA (Qualified Medication Aide) 1 sets up the in-service information and the DON (Director of Nursing) does the in-service. I am not sure who keeps the records up to date like the license book." On 2/24/17 at 1:45 p.m., during an interview with the Administrator, she indicated "Our census went down from 80 residents to 60 residents and we had to make cuts in staffing. The ADN (Assistant Director of Nursing) and the DON are now responsible for the in-services. Up until about a month ago, RN 1 did-service records, but she has gone back to working the floor. The license book was in the business office and the book should have all updated license in it. We go by the state		Staff who work in the facility as well as the residents whom they are caring for have the potential to be affected by this finding. Going forward, newly hired staff will receive the required in-servicing/training as per state/federal guidelines for newly hired individuals via the orientation process. Each staff member has a personal in-service tracking record that will be updated as any in-service or training is attended by that individual. This will be in addition to the In-service sign-in sheet that the presenter of any given in-service keeps which states the topic(s), presenter, date, time started, time ended, text of material as well as signatures of all attendees. Department Heads will track the individual in-servicing/training records	

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	regulations for our in-service requirements." On 2/24/17 at 2:10 p.m., a review of the Proposed Disservice Calendar indicated, but was not limited to, in-services for Abuse/Neglect are done semi-annually in February and August, and the Dementia in-service was scheduled for January and September. Resident Rights was not scheduled on the in-service calendar. A review of the employee in-service records indicated no in-services were conducted for the dates scheduled in August 2016, and September 2016, January 2017, and February 2017.		of their department's staff. On an annual basis, 30-60 days prior to each staff member's anniversary date, they will be notified of any outstanding in-service/training requirements they might have. Each staff member will be responsible to attend offered in-services/training in order to meet their individual requirement. Staff with outstanding in-service requirements on the date of their anniversary will be removed from the schedule until their in-service obligation is met. At the monthly Quality Assurance meetings as part of the agenda the facility annual In-service Calendar will be reviewed. Any updates or changes in keeping with compliance will be done. Further, Department Heads will bring their staff's in-service records so that any	

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			outstanding in-service needs can be identified. A plan on when these needed in-services will be offered will be discussed. Department Heads will notify their staff of any needed in-services and when they will be offered. These offerings will be posted. Any staff who fail to comply with the in-service requirements will be removed from the schedule until their requirement is met. The Administrator/Designee will globally monitor this process monthly at the QA meetings for a period of not less than 6 months to ensure ongoing compliance. After that, it will continue to part of the QA agenda ongoing.	