| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155494 | A. BUILDING 00<br>B. WING | 05/27/2015 |

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| WATERS OF SCOTTSBURG, THE | 1350 N TODD DR<br>SCOTTSBURG, IN 47170 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00174262 and Complaint IN00173870.<br><br>Complaint IN00174262 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Complaint IN00173870 - Substantiated. Federal/State deficiencies related to the allegations are cited at F224.<br><br>Survey dates: May 26 and 27, 2015<br><br>Facility number: 000478<br>Provider number: 155494<br>AIM number: 100290430<br><br>Census bed type:<br>SNF/NF: 87<br>Total: 87<br><br>Census payor type:<br>Medicare: 11<br>Medicaid: 68<br>Other: 8<br>Total: 87<br><br>Sample: 7<br><br>This deficiency also reflects State | F 0000 | | |

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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| | findings cited in accordance with 410 IAC 16.2-3.1. | | | |
| F 0224 SS=E Bldg. 00 | 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN<br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br>Based on record review and interview, the facility failed to ensure residents were protected from unauthorized photographs being taken. This deficient practice affected 4 of 4 residents reviewed for unauthorized photographs. (Residents #B, #C, #D, and #E)<br><br>Findings include:<br><br>During an interview on 5/26/15 at 9:45 a.m., and again on 5/27/15 at 10:30 a.m., the Facility Administrator indicated she had received two anonymous calls on 5/15/15. The anonymous callers indicated they had been sent pictures via (name of mobile conversation site - used to take a picture and add a caption) of what appeared to be several residents in the facility. The callers indicated the photos had been sent by two possible members of the facility's nursing staff. After the first call on 5/15/15, the Administrator started an immediate | F 0224 | **The Waters of Scottsburg**<br>**POC for complaint IN00173870, 05/27/2015.** 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 its' staff to promote at all times the practices and care that enhance the individuality and dignity of our residents. **F 224- Facility failed to ensure residents were protected from unauthorized photographs being taken.**<br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents were assessed for mental/emotional disturbance by | 06/15/2015 |

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| | investigation into the allegations. The Administrator indicated that the police were notified and a report was filed. She also indicated three CNA's (Certified Nursing Assistants) were suspected of posting the pictures and were suspended pending the outcome of the investigation.<br><br>Interviews were conducted on 5/18/15 and 5/19/15 by facility staff with residents who were deemed alert and oriented. Eight of the interviewed residents indicated staff were frequently seen on their cell phones and were observed taking pictures throughout the facility, including of the residents. They also indicated they had concerns with staff taking these pictures. Resident #E indicated on 5/19/15 (no time given) that staff did take her picture one day and she was not happy that they did so.<br><br>During the course of the facility's investigation between 5/15/15 and 5/21/15, it was determined CNA #1 was not involved in the alleged incident with the pictures.<br><br>On 5/15/15 at 2:15 p.m., the Administrator and Social Worker interviewed CNA #3 about taking pictures of the residents. CNA #3 admitted she had taken pictures of the residents in the past but nothing | | Social Services, related to pictures being taken with no negative findings noted. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents in the facility had the potential to be affected by the finding. The resident who voiced displeasure at having her photo taken was assured that the facility prohibits this type of activity (unauthorized picture taking) and that should not have happened. Further, measures that were in place to prohibit such activities have been reinforced and that should never happen to her again. This resident was satisfied with the facility's efforts and explanation to her. What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur? 1) All staff educated on the addendum to the cell phone policy expectations. 2)The administrator added an addendum to the expectation of current cell phone policy to further restrict use of cell phones in resident care areas, to include: Cell phones are to be kept in a secure area and not used unless on break and used only in a private, non-residential area. Nurses that need to text physicians to request a call are to use their phones in the med room only. 3) Any staff who fail to | |

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| | inappropriate. The CNA indicated that she knew she was not supposed to take any pictures as it went against HIPAA (Health Insurance Portability and Accountability Act). She indicated she took the pictures because the residents were like family to her, as she spent so much time with them. She indicated to the Administrator that the residents she took pictures of were all alert and oriented and had given their " consent " to have their picture taken. The residents in the pictures allegedly taken by CNA #3, however, were not cognitively capable of giving their consent and did not have " official consent " on file with the facility.<br><br>On 5/15/15 at 2:24 p.m., the Administrator and the Social Worker interviewed CNA #2 about taking pictures of the residents. CNA #2 indicated she and CNA #3 went into Resident #C's room to change her clothes and found the resident kneeling on the floor, in front of her chair, with her head resting in the chair. CNA #3 took a picture of the resident on (name of mobile conversation site-used to take photo's and video's and add captions) and sent it for public view. This picture was sent with an inappropriate message typed as a caption on the picture. | | comply with the points of the inservice will be disciplined up to and including probable termination. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? 1) Interviewable residents to be interviewed 5 days/week by department leaders via our current “Gaurdian Angel” rounds about concerns with cell phone usage and/or picture taking by staff. Outcomes to be reviewed in our daily Stand-up meeting, QA, and addressed according to policy. 2) DON or designee to audit through daily rounding on varying shifts 5 days/week x 1 month, 3 days/week x 2 months, 2days/week x 2 months and 1 day/week x 1 month or until 100% compliance obtained for 6 consecutive months. Results to be reviewed in QA monthly. Date of compliance with this POC is Monday, June 15, 2015. IDR Request: We are questioning the scope and severity related to the number of residents/staff members involved in this circumstance. | |

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| | During the interview on 5/15/15 at 2:24 p.m., CNA #2 also indicated she took a picture of herself and Resident #A and posted it on (name of mobile conversation site-used to take photo's and video's and add captions) telling everyone she loved this lady. CNA #2 also admitted to taking a video of Resident #D while she cursed and called people names and posted it online. She also indicated she took a picture of herself with Resident #E, but did not post this picture on the website. The date and time the picture was taken was not indicated.<br><br>CNA #2's employee personnel record was reviewed on 5/26/15 at 2:00 p.m. The record indicated the CNA had received a written warning on 5/12/15 - 3 days before the 5/15/15 incident - for taking a picture of herself and another CNA in the shower room during work time. This picture was then posted on (name of a social networking site).<br><br>Review of the personnel files indicated both, CNA #2 and CNA #3 signed employment documents indicating they had read and understood the facility's Social Media Policy, Abuse Policy, Resident Rights, Cell Phone Usage Policy and Code of Conduct when hired on 3/23/15 and 12/19/14, respectively. | | | |

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| | On 5/27/15 at 11:30 a.m., the Staff Development Coordinator presented a copy of an inservice given on 5/8/15. Among the topics included in the inservice, were "Media Relations", which prohibited staff from making comments via print or Internet without approval and "Use of Personal Cell Phones", which strictly prohibited cell phones being used to take pictures or videos of residents and also prohibited use of phones, in any manner, while providing resident care.<br><br>1. Review of the clinical record for Resident #B on 5/26/15 at 10:17 a.m., indicated the resident had diagnoses which included, but were not limited to, psychosis, bipolar disorder single manic episode, dementia with behavior disturbance and alcohol dependence.<br><br>The Quarterly Minimum Data Set (MDS) Assessment, dated 5/13/15, indicated the resident scored a 10 out of 15 on her Brief Mental Interview Status (BIMS) - good recall with cues but poor orientation to time and day and was occasionally disruptive with yelling/calling out.<br><br>2. Review of the clinical record for Resident #C on 5/26/15 at 10:00 a.m., indicated the resident had diagnoses which included, but were not limited to, bipolar disorder, infantile cerebral palsy, | | | |

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| | and anoxic brain damage.<br><br>The Admission MDS Assessment, dated 3/25/15, indicated the resident scored an 8 out of 15 on her BIMS-moderate impairment in long and short term memory with poor recall and behaviors such as throwing self on floor and throwing things at others, pilfering in other residents' drawers, and yelling out.<br><br>3. Review of the clinical record for Resident #D on 5/26/15 at 10:20 a.m., indicated the resident had diagnoses which included, but were not limited to, bipolar disorder, dementia and depressive disorder.<br><br>The Quarterly MDS Assessment, dated 3/20/15, indicated the resident scored an 8 out of 15 on her BIMS-moderate impairment in long and short term memory with poor recall and had episodes of cursing at staff.<br><br>4. Review of the clinical record for Resident #E on 5/26/15 at 10:35 a.m., indicated the resident had diagnoses which included, but were not limited to, paranoid schizophrenia.<br><br>The Annual MDS Assessment, dated 4/15/15, indicated the resident scored a 9 out of 15 on her BIMS-moderate | | | |

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| | impairment in long and short term memory with poor recall and had episodes of physical behaviors towards others.<br><br>During the interview with the Administrator on 5/27/15 at 10:30 a.m., she indicated the four residents identified in the investigation were not fully capable of giving informed consent to have their pictures taken.<br><br>Resident #B was hospitalized (unrelated) the morning of 5/26/15 and was unable to be interviewed. Interviews were attempted with Residents #C, #D and #E also on 5/26/15 between 11:00 a.m., and 2:00 p.m., but responses were not in context with questions asked regarding the pictures taken of them.<br><br>During an interview with Resident #B's family member on 5/26/15 at 8:00 p.m., she indicated that she was aware residents had their pictures taken without their consent, but did not indicate if the resident was bothered by it.<br><br>In interviews with LPN's #1 and #2 (Licensed Practical Nurse), CNA's #1 and #2, Housekeeper #1, and the Housekeeping Supervisor on 5/26/15 between 10:30 a.m., and 2:00 p.m., and with the Administrator and the Director | | | |

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| | of Nursing on 5/27/15 between 10:00 a.m. and 11:00 a.m., they were able to describe "Abuse" and considered taking any residents' pictures without approval, especially inappropriate ones, to be a form of abuse. They indicated inservices were provided to all staff at the time of hire and periodically, on "Cell Phone Usage", "Picture Taking of Residents" and "Social Media".<br><br>This Federal Tag is related to Complaint IN00173870.<br><br>3.1-28(a) | | | |