

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630
--	--

(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
F0000	<p>This visit was for the Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00111137.</p> <p>Complaint IN00111137- Unsubstantiated, due to lack of evidence.</p> <p>Survey Dates: August 13,14,15,16, 17, and 20,2012</p> <p>Facility number: 000245 Provider number: 155354 AIM number: 100290800</p> <p>Survey team: Vickie Ellis, RN -TC Barb Fowler, RN Amy Wininger, RN Diane Hancock, RN</p> <p>Census bed type: SNF/NF 108 Total: 108</p> <p>Census Payor type: Medicare: 8 Medicaid: 78 Other: 22 Total: 108</p> <p>These deficiencies reflect state findings cited in accordance with 410</p>	F0000	Preparation and or execution of this Plan of Correction general, or any other corrective action set forth herein, in particular, does not constitute an admission or agreement by Newburgh Healthcare of the facts alleged or the conclusions set forth in the Statement of Deficiencies. The Plan of Correction and specific corrective actions are prepared and/ or executed solely because of provisions of federal and / or State law.	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
	IAC 16.2. Quality review completed on August 23, 2012 by Bev Faulkner, RN				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630
--	--

(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
F0272 SS=E	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview and record review, the facility failed to ensure 3 of 3 sampled residents were comprehensively assessed for dental status, in the sample of 4 who met the</p>	F0272	I. CORRECTIVE ACTION1.) Resident # 117 will have an updated Dental Assessment completed. The plan of care will be updated according to the findings.2.) The assessor	09/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
	<p>criteria, and 1 of 3 sampled residents were comprehensively assessed for vision, in the sample of 27 who met the criteria. (Residents #117, #107, #7, #106)</p> <p>Findings include:</p> <p>1. On 8/14/12 at 9:10 a.m., Resident #117 was observed lying in bed. She was observed to have sporadic missing lower teeth with large spaces between existing teeth.</p> <p>Resident #117's clinical record was reviewed on 8/15/12 at 10:06 a.m. The resident's diagnoses included, but were not limited to, atrial fibrillation, esophageal reflux, vitamin D deficiency, vascular dementia, hypertension, hypothyroidism, hyperlipidemia, malaise and fatigue. The resident was admitted on 11/3/10.</p> <p>The annual Minimum Data Set [MDS] assessment, dated 10/31/12, indicated under Oral/Dental Status, there were no dental problems identified.</p> <p>2. Resident #106's clinical record was reviewed on 8/15/12 at 1:45 p.m. The resident's diagnoses included, but were not limited to, late effect</p>		<p>followed the RAI manual instructions which tells the assessor to " Observe whether the resident used eye glasses or other vision aides during the vision test (B1000) ".The RAI manual further states to "code "yes" if corrective lenses or other visual aides were used in the assessment or "no" if visual aides were not used. In this assessment, resident # 106 completed the assessment without the use of corrective lenses or visual aides.Resident # 106 will be reviewed and the progress note updated to reflect the results of the assessment. The progress note will also include the resident's use of corrective lenses as desired. The plan of care will be updated according to the progress note.3.) Resident #7 Will have an updated Dental Assessment and the careplan updated according to the findings. Resident # 7 does receive a mechanical soft diet.4.) Resident # 4 will have an updated Dental assessment and the care plan updated according to the findings.II. OTHERS HAVING THE POTENTIAL TO BE AFFECTEDa. All residents will have an updated Dental Assessment and the careplan updated according to the findings.b. The visual assessment will be reviewed for all residents for clarity of the assessments and progress notes.III. MEASURES / SYSTEMIC CHANGESa. The</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
	<p>hemiplegia, aphasia, malignant hypertension, coronary atherosclerosis, diabetes mellitus, hypothyroidism, peptic ulcer disease, cardiomegaly, anxiety state, cerebrovascular disease.</p> <p>The resident's Minimum Data Set [MDS] assessment, dated 7/23/12, indicated the resident's vision was impaired. Regarding corrective lenses, the MDS indicated the resident did not have any. The notes related to the vision assessment indicated, "[Resident] does need large print materials for reading. [Resident's name] should continue to read as desired. Staff should provide large print materials to [resident's name] if requested. Vision should not interfere with daily activities."</p> <p>On 8/15/12 at 9:22 a.m., the resident was observed in her room. She indicated, "I see okay with these glasses."</p> <p>Social Service Progress Notes, dated 7/22/12, indicated the resident had impaired vision with no corrective lenses.</p> <p>3. An observation was made of Resident #7 on 8/13/12 at 2:56 p.m. The Resident had no top teeth or dentures and some broken natural lower teeth. At the time of</p>		<p>Dental Assessment will be updated and implemented to clarify areas of concern and need for a dental referral.b. Licensed Nursing staff will be inserviced to the updated Dental Assessment and the procedure to follow.c. CNA's will be inserviced to include reporting of dental concerns e.g. oral problems, lesions, lost or loose dentures etc.IV. MONITORINGThe MDS Coordinator will monitor the dental and visual assessments with each MDS that is due on an ongoing basis. A summary of findings will be submitted at the Quarterly Quality Assurance Committee Meeting. If there are no findings after three (3) months, then the summary will be discontinued. The monitor will remain ongoing. If findings are noted then this information will be submitted to the Quality Assurance Committee for system review and revisions.V. COMPLETION DATE September 19, 2021</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630
--	--

(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
	<p>the observation an interview was conducted and Resident #7 indicated she couldn't eat hard things because they hurt her mouth.</p> <p>An annual Minimum Data Set [MDS] assessment for Resident #7, dated 6/18/12, and a quarterly MDS assessment, dated 3/19/12, were reviewed on 8/14/12 at 8:45 a.m. The oral/dental status was not documented as completed for eight statements related to oral/dental status listed, as none were checked as applicable to the resident.</p> <p>A review of Resident #7's medical record was done on 8/14/12 at 10:00 a.m. A document titled Admission Assessment and dated 10/30/08 indicated Resident #7 had some lower teeth which were in poor condition, and no upper teeth.</p> <p>In an interview on 8/16/12 at 2:11 p.m., with the MDS coordinator, the MDS coordinator indicated she doesn't personally assess residents herself. "She goes by the floor nurses assessment, and until August 1 there was not an oral assessment done, so she does not code oral on the MDS."</p> <p>A document provided by the Director of Nursing [DoN] on 8/20/12 at 2:05 p.m.,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
	<p>titled Resident Assessment Instrument and dated October 2010 indicated "a comprehensive assessment of a resident's needs shall be made within fourteen days of the resident's admission and quarterly."</p> <p>4. Review of Resident # 107's clinical record on 8/14/12 at 9:35 a.m., indicated Resident #107 was admitted on 4/30/10. The resident's diagnosis included, but was not limited to, essential hypertension, status post left hip nailing, benign prostatic hypertrophy, macular degeneration, and senile dementia. The quarterly MDS [Minimum Data Set], dated 7/9/12, indicated Resident #107 did not have any dental issues.</p> <p>On observation of Resident #107 on 8/13/12 at 3:30 p.m., the resident was lying in his bed. The resident had no dentures and very few of his own teeth. On observation on 8/14/12 at 10:30 a.m., Resident #107 was observed to be sitting in his chair in the activity room. The resident did not have dentures.</p> <p>The Admission Assessment [resident had been to the hospital], completed on 8/2/12, indicated Resident #107 was admitted with his own teeth (few) which were in poor condition. The Admission Assessment did not indicate the resident</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
	<p>had any dentures or partial plates.</p> <p>A care plan, which was located in the MDS office, dated 8/20/12, and obtained on 8/20/12 at 11:35 a.m. from QMA [Qualified Medication Aid] #1, indicated Resident #107 had a upper partial, 5 teeth on the top and 5 teeth on the bottom. The care plan indicated the resident would be monitored for loose, missing, or carious teeth, poor fitting or broken dentures.</p> <p>Interview with LPN #4, on 8/20/12 at 11:20 a.m., indicated Resident #107 had a bottom partial and his own teeth on top. She indicated on July 31, 2012, she had to count the resident's teeth for the MDS nurse.</p> <p>3.1-31(c)(9)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview and record review, the facility failed to ensure a care plan was developed for a change in range of motion, for 1 of 3 sampled residents reviewed for range of motion in the sample of 15 who met the criteria. (Resident #106)</p> <p>Finding includes: Resident #106 was observed on 8/13/12 at 10:28 a.m. She indicated, during the observation, she had some discomfort and difficulty moving her right shoulder.</p>	F0279	<p>I. CORRECTIVE ACTION Resident # 106 will receive and updated Range of Motion Assessment and will have the care plan updated according to the findings. II. OTHERS HAVING THE POTENTIAL TO BE AFFECTED The Range of Motion Assessments and related careplans will be reviewed for all residents and corrected / updated as needed. III. MEASURES / SYSTEMIC CHANGES The MDS Coordinator will review the assessments as they are due / completed and collaborate with the unit managers and charge nurses. IV.</p>	09/19/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
	<p>Resident #106's clinical record was reviewed on 8/15/12 at 1:45 p.m. The resident's diagnoses included, but were not limited to, late effect hemiplegia, aphasia, malignant hypertension, coronary atherosclerosis, diabetes mellitus, hypothyroidism, peptic ulcer disease, cardiomegaly, anxiety state, cerebrovascular disease.</p> <p>The resident had a significant change Minimum Data Set [MDS] assessment, dated 7/9/12, indicating no limitations in range of motion. A MDS assessment, dated 7/23/12, indicated a limitation in range of motion on one side in the upper extremity.</p> <p>Range of motion assessments, dated 1/19/12, 3/7/12, and 7/5/12, indicated there were no impairments in the right or left upper or lower extremities. A Range of Motion Assessment, dated 7/20/12, indicated impairment in the right shoulder.</p> <p>There was no care plan for the change in range of motion.</p> <p>The lack of a care plan for range of motion was reviewed with the Director of Nurses on 8/17/12 at 12:30 p.m.</p>		<p>MONITORINGThe MDS Coordinator will monitor the Range of Motion Assessments with each MDS for accuracy. This monotor will be ongoing. A summary of the findings will be submitted at the next Q.A. meeting. Any negative fndings will be reviewed and revision of the system.V. COMPLETETION DATESeptember 19, 2012</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630
--	--

(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
	<p>On 8/20/12 at 9:30 a.m., the Director of Nurses indicated there was nothing available for review.</p> <p>3.1-35(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
F0323 SS=E	<p>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.</p> <p>A. Based on observation, interview, and record review, the facility failed to ensure the facility was without accident hazards in that, 4 of 4 housekeeping carts were observed to have unlocked chemicals and 1 of 4 janitors closet was observed to have unlocked chemicals. This had the potential to affect 6 residents who were independently mobile and cognitively impaired in the population of 108 residents. (Resident #11, Resident #37, Resident #89, Resident #113, Resident # 128, Resident #138)</p> <p>B. Based on record review, and interview, the facility failed to ensure the safety of a newly admitted resident with a history of falls by identifying the risk in 1 of 3 residents reviewed for falls in a sample of 6 who met the criteria for falls. (Resident #149)</p> <p>Findings include:</p> <p>A. 1. On 08/17/12 at 9:31 a.m., an</p>	F0323	<p>I. CORECTIVE ACTIONa. The housekeeping carts will have new locks installed. All janitor's closets will have locks and mechanical closures installed.b. Resident # 49 is no longer a resident of the facility.Other resident numbers listed were not a part of the sample and are not identifiable.II. OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTEDAll residents including new admissions have the potential to be affected.All residents will have their fall assessments reviewed for accuracy including prior history.III. MEASURES / SYSTEMIC CHANGESA. 1.A new housekeeping Policy and Procedure manual will be implemented. 2.The housekeeping / laundry staff will be inserviced to it's contents initially and annually thereafter. 3.All newly hired housekeeping and laundry staff will be oriented to the Policy and Procedure Manual to acknowledge their receipt of the information.B. Nursing staff will be inserviced regarding the Fall Assessment and it's content including follow</p>	09/19/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630			
(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			
	<p>unlocked housekeeping cart was observed on the West unit, no residents were observed in the area.</p> <p>In an interview with Housekeeper #1 on 08/17/12 at 9:35 a.m., she indicated the unlocked cabinet contained industrial strength glass cleaner, disinfectant, and creme cleanser. Housekeeper #1 indicated, at that time, the label on the bottle of glass cleaner included a warning of, 'Do not drink glass cleaner.' The label on the disinfectant indicated, 'Keep out of reach of children, danger do not drink,' and the creme cleanser label indicated 'hazardous to humans and domestic animals.'</p> <p>During an interview with RN #1 on 08/17/12 at 10:57 a.m., she indicated Resident # 89, Resident #113, and Resident #128 resided on the West unit and were cognitively impaired, and were able to propel themselves independently about the unit,</p> <p>During an interview with LPN #2 on 08/17/12 at 10:59 a.m., she indicated no residents on the West unit had the behavior of pilfering.</p> <p>A. 2. On 08/17/12 at 9:40 a.m., an unlocked housekeeping cart was observed on the East unit near the</p>		<p>up on potential concerns. The nurse involved received verbal coaching. Licensed Nursing staff will be inserviced to consider all data including transfer data.IV. MONITORINGA. All housekeeping carts and janitor doors will be checked no less than three (3) times a week by the housekeeping supervisor or designee. This monitor is ongoing and will be reviewed in each Q.A. meeting.B. The Fall Assessment will be reviewed for admissions prior to the receiving nurse to ensure that the prior fall history information is included. C. A summary of the findings will be submitted in the next Quality Assurance Committee Meeting to determine the need to revise the monitor. This monitor is ongoing and will be reviewed in each Q.A. meeting.V. COMPLETETION DATESeptember 19,2012</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630
--	--

(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
	<p>nurse's station. At that time, the unlocked cabinet was observed to be unattended and to contain glass cleaner, disinfectant, and creme cleanser. Resident #22 was observed to be sitting on the opposite side of the nurse's station.</p> <p>In an interview with the Housekeeping Supervisor on 08/17/12 at 9:41 a.m., she indicated the cabinet on the housekeeping cart was used to store chemicals used for cleaning and the usual procedure was not to lock the cabinet door, but keep the cart positioned so the unlocked cabinet was facing towards the room the housekeeper was cleaning. The Housekeeping Supervisor further indicated, at that time, each cart contained glass cleaner, disinfectant, and creme cleanser.</p> <p>During an interview on 08/17/12 at 10:30 a.m., LPN #1 indicated Resident #138 and Resident #11 resided on East unit, were cognitively impaired, and were able to propel themselves independently about the unit.</p> <p>In an interview with LPN #1 on 08/17/12 at 10:33 a.m., he indicated Resident #22 was cognitively impaired and not able to proper a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630			
(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			
	<p>wheelchair independently.</p> <p>Housekeeper #2 indicated on 08/17/12 at 10:45 a.m., the cabinets on the housekeeping carts were to be locked at all times because they contained chemicals that were dangerous if swallowed.</p> <p>A. 3. On 08/17/12 at 9:45 a.m., an unattended housekeeping cart was observed in the hallway of the North unit. At that time, the cabinet was observed to be unlocked and to contain glass cleaner, disinfectant, and creme cleanser. Resident #19 and Resident #4 were observed at that time sitting in wheelchairs outside of the beauty shop, approximately 80 feet away.</p> <p>A. 4. On 08/17/12 at 9:50 a.m., an unattended housekeeping cart was observed outside of the dining room on the North unit. At that time, the cabinet was observed to be unlocked and to contain glass cleaner, disinfectant, and creme cleanser. At that time, Resident #107 was observed to be sitting in the dining room of the North unit.</p> <p>During an interview on LPN #4 on 08/17/12 at 10:32 a.m. LPN #4 indicated Resident # 37 resided on</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
	<p>the North unit, was cognitively impaired, and was able to propel independently about the unit.</p> <p>In an interview with LPN #3 on 08/17/12 at 10:40 a.m. she indicated Resident #19 and Resident #4 had no cognitive impairment. LPN #3 further indicated, at that time, Resident #107 was cognitively impaired, but was not able to propel his wheelchair independently.</p> <p>In an interview on 08/17/12 at 10:43 a.m., Housekeeper #3 indicated the cabinet on the housekeeping cart should be kept locked at all times. The MSDS (Material Safety Data Sheets) provided by the Housekeeping Supervisor on 08/17/12 at 11:35 a.m., indicated the following: Cleaner and disinfectant: "...DANGER! ...Harmful if inhaled or swallowed." Creme cleanser: "...Immediate health effects ...ingestion: Significant gastrointestinal duress is expected..." Glass cleaner...Warning! CAUSES RESPIRATORY TRACT, EYE AND SKIN IRRITATION..."</p> <p>A. 4. On 08/17/12 at 10:25 a.m., the janitor closet on east unit was observed with the door propped open</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630
--	--

(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
	<p>and containing the chemicals all purpose cleanser and buffing and burnishing compound.</p> <p>During an interview on 08/17/12 at 10:30 a.m., LPN #1 indicated the door to the janitor's closet had been left open by maintenance/housekeeping staff and normally that door is not left propped open.</p> <p>During an interview on 08/17/12 at 11:35 a.m. The Housekeeping Supervisor indicated janitor closets should be locked at all times. She further indicated there was no policy for storing hazardous chemicals.</p> <p>The MSDS for the burnishing compound "Renew Clean and Burnish" provided by the Housekeeping Supervisor on 08/20/12 at 11:13 a.m. indicated, "Hazard Data...Direct contact of product with eyes may cause irritation and reddening...Ingestion can cause gastrointestinal irritation, nausea, vomiting, and diarrhea..."</p> <p>B.1. In an interview with Licence Practical Nurse [LPN] #4 on 8/14/12 at 8:50 a.m., LPN #4 indicated Resident #149 fell on 8/11/12 due to unfamiliar surroundings.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630
--	--

(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
	<p>Resident #149's clinical record was reviewed on 8/15/12 at 2:20 p.m. A document, dated 8/10/12, and titled Continuity of Care Form For Transfers to Nursing Facilities from the hospital to the facility indicated Resident #149 had a diagnosis of but not limited to urinary tract infection [a condition of the urinary tract which sometimes causes altered mental status in the elderly]. The document indicated Resident #149 had a mental status of alert with mild confusion. It also indicated a behavior of cooperative with anxiousness at times. Resident #149's activity was documented as needing assistance of 1 person with walking and the use of a walker.</p> <p>A document titled History and Physical, dated 7/31/12, indicated Resident #149 was admitted to the hospital with altered mental status and had fallen backwards hitting his head at home prior to coming to the hospital.</p> <p>A document titled Admission Nursing Assessment and dated 8/10/12 indicated Resident #149 was admitted to the facility alert and oriented to person, place, and time. It indicated the resident needed the assistance of one person for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
	<p>transferring and ambulating and could bear full weight but was weak.</p> <p>A document titled Fall Risk Assessment and dated 8/10/12 indicated Resident #149 was alert and oriented to person place and time, even though the continuity of care form indicated the Resident was confused at times. The Fall Risk Assessment indicated Resident # 149 had not fallen in the last 3 months, even though the resident reported to the ER according to the History and Physical document dated 7/31/12 after a fall at home. The Fall Risk Assessment documented the Resident required the use of assistive devices, but left his cane at home, and had balance problems with gait and standing. Resident #149's total fall risk score was a 7, which did not indicate the resident was a high risk for fall. A score of higher than 10 would have indicated the resident was a high risk for fall. Had the fall risk been accurate regarding previous falls and orientation of intermittent confusion the fall risk score would have been 13 which would indicate Resident #149 was considered high risk for falls.</p> <p>A nurse's note, dated 8/11/12 at 8:05 p.m., indicated Resident #149 was</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630			
(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			
	<p>found on the floor in his room.</p> <p>A document titled Fall Report and dated Saturday, 8/11/12 at 8:05 p.m., indicated Resident #149 had fallen. The location of the fall was the resident's room and the resident was found on the floor on his back beside the bed. The resident's state of mind was confused. The fall report indicated Resident #149 was ambulating in the room, without staff present, and no use of an assistive device. There were no alarms present.</p> <p>In an interview on 8/16/12 at 9:05 a.m., LPN #6 indicated it is the floor nurse's job to admit the resident, and part of the admission process is to complete a fall risk assessment as well as an admission assessment. If someone was a fall risk at the hospital the nurse would utilize a fall risk assessment tool, which would indicate if a resident was a fall risk and initiate interventions such as alarms to bed and chair, and assist of 1 with ambulation.</p> <p>A document provided by the DoN [Director of Nursing] on 8/20/12 at 2:05 p.m., and titled Fall and Fall Risk Managing and dated August 2006 stated, "Based on previous</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630
--	--

(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
	<p>evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from the fall.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630			
(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			
F0329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure medications given had adequate indications for use, for 1 of 10 sampled residents reviewed for unnecessary medications, in that an antipsychotic was given for anxiety and was not reviewed for reduction. (Residents #128)</p> <p>Findings include:</p> <p>1. Resident #128's clinical record</p>	F0329	<p>I. CORRECTIVE ACTIONThe physician of resident # 118 was notified. An update was provided. An order was received to decrease the Haldol to 0.5m daily at noon.II. OTHERS HAVING THE POTENTIAL TO BE AFFECTEDAll residents receiving psychoactive medication will be reviewed to ensure current gradual dose reduction attempts. The attending physician will be notified according to the findings. III. MEASURES / SYSTEMIC CHANGESa. Gradual dose reductions will be made per unit</p>	09/19/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
	<p>was reviewed on 8/15/12 at 3:06 p.m. The resident was admitted on 12/7/11 with diagnoses of dementia with behavior disturbances, Parkinson's disease, hypertension, depressive disorder, and hypercholesterolemia.</p> <p>The resident had physician's orders, signed 8/15/12, including, but not limited to, the following medication: Haldol 0.5 milligrams [antipsychotic] by mouth twice a day. The medication was ordered 2/12/12. The diagnosis listed for the medication was "anxiety state..."</p> <p>The resident's most recent Minimum Data Set [MDS] assessment, dated 5/26/12, indicated the resident was on an antipsychotic medication seven days a week. The MDS failed to indicate any behavior problems. It did indicate inattention and disorganized thinking. Social Service Progress Notes, dated 5/23/12, indicated no behavior issues, only inattention and disorganized thinking. The notes also indicated the resident had no psychiatric diagnosis. A Social Service Progress Note, dated 2/16/12, indicated trouble with sleep and trouble concentrating, combative during transfer on 2/12/12 and resistant to blood pressure being taken on 2/14/12. The resident was</p>		<p>per month vs. every unit every month. Reviewing a unit per month will provide a smaller segment of residents to review and increase the focus.b. Licensed nursing staff will be inserviced to assist in observing for order dates and documentation of behaviors.c. A tracking log will be revised and implemented to ensure the review of all residents and recommendations made. Residents who did not warrant recommendations during the monthly review will have documentation noted in the medical record.IV. MONITORINGa. The director of Nursing will monitor the tracking of the gradual dose reduction reviews monthly for two (2) months and as needed.b. The Social Service Director will monitor monthly thereafter in collaboration with the Unit Managers.c. A summary of this monitor will be entered in each quarterly Quality Assurance Committee meeting minutes. This monitor is ongoing. Any negative findings will be reviewed to determine the need to revise the system.V. COMPLETION DATESeptember 19,2012</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
	<p>being treated for urinary tract infection sepsis. Social Service Progress Notes, dated 2/22/12, indicated no behavior issues and the only mood issue noted was "sleeping too much."</p> <p>The resident had a care plan, dated 12/15/11, for the use of psychoactive medications for "treatment of dementia with behaviors, agitation and anxiety." The care plan interventions included, but were not limited to, the following: Administer Depakote [anti-convulsant medication used for behaviors] as ordered. Administer Haldol [anti-psychotic medication] as ordered and note effectiveness [the care plan indicated the Haldol was discontinued on 8/2/12]. Perform AIMS [Abnormal Involuntary Movement Scale] tests [to determine side effects of medication]. Work with MD [physician], pharmacy, nursing and social service to provide lowest therapeutic dosage. Do not rush him. Provide calm quiet atmosphere as much as possible.</p> <p>The facility was monitoring Target Behavioral Symptoms of agitation and aggression. The record indicated no episodes noted during July or August,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630			
(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			
	<p>2012.</p> <p>Interview with the Social Services Director on 8/16/12 at 3:30 p.m., she indicated she, the unit managers, and the pharmacist reviewed all psychoactive medications monthly. If they felt some may be able to be reduced, they sent a request to the physician. They track and log responses from the physician. There was no indication the routine Haldol had been considered for reduction.</p> <p>Only request sent for this resident was dated 7/26/12 to discontinue Haloperidol 5 mg/ml [milligram per milliliter]-1mg "IM" [intramuscular] q [every] 6 hrs [hours] prn [as needed] and D/C [discontinue] Haloperidol 1 mg q 6 hrs. prn. The physician agreed with the recommendation and the medications were discontinued on 8/2/12. The medication administration records [MARs] for July, 2012 were reviewed and these as needed medications had not been used.</p> <p>Pharmacy reviews, dated 1/3/12, 2/1/12, 3/1/12, 4/2/12, 5/1/12, 6/1/12, 7/3/12, 8/6/12, indicated no irregularities.</p> <p>The information was reviewed with</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630
--	--

(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
	<p>the Director of Nurses and Administrator on 8/17/12 at 12:30 p.m. They both indicated the resident was doing much better than when he was admitted. On 8/19/12 at 10:00 a.m., the Director of Nurses indicated there was no further information to provide.</p> <p>3.1-48(a)(2) 3.1-48(a)(4)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630			
(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			
F0412 SS=D	<p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, interview and record review, the facility failed to ensure routine dental services were provided to 2 of 3 residents sampled for dental services in a sample of 4 who met the criteria for dental status and services. (Residents #117, #7)</p> <p>Findings include:</p> <p>1. On 8/14/12 at 9:09 a.m., Resident #117 was observed laying in bed. She was observed to have missing teeth with large spaces between each remaining tooth.</p> <p>On 8/15/12 at 9:15 a.m., the resident was observed in bed on her right side. Some mouth odor was noted.</p> <p>Resident #117's clinical record was reviewed on 8/15/12 at 10:06 a.m. The resident's diagnoses included,</p>	F0412	<p>I. CORRECTIVE ACTIONA Dental Assessment will be completed for resident # 117 and resident # 7. The careplan will be updated according to the assessment findings.II. OTHERS HAVING THE POTENTIAL TO BE AFFECTEDA All residents will have an updated Dental Assessment completed and the plan of care updated according to the assessment findings.III. MEASURES / SYSTEM CHANGESa. The nursing Dental Assessment will be revised for clarification of specific areas of concern.b. The facility Dental Policy and Procedure will be revised to specify when a consent is needed e.g. " if treatment is necessary". c. The licensed nurse will forward a copy of the Dental Assessment to the Social Service department to make the referrals.d. Residents will be seen as soon as possible for their initial exam by the Dentist to ensure no delays.IV. MONITORINGa. The</p>	09/19/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
	<p>but were not limited to, atrial fibrillation, esophageal reflux, vitamin D deficiency, vascular dementia, hypertension, hypothyroidism, hyperlipidemia, malaise and fatigue. She was admitted 11/3/10.</p> <p>The record contained no record of routine dental visits.</p> <p>Nurses' notes, dated 7/17/12 at 2400 [midnight], indicated staff observed signs and symptoms of an abscessed tooth in the resident's jaw. The physician was notified, the resident was started on an antibiotic and an order for a dental consult was obtained.</p> <p>The resident was sent out to a dentist on 7/24/12. Nurses' notes, dated 7/24/12 at 9:15 a.m., indicated, "Received call from [name of dental office]. Resident un-cooperative with dental appt. [appointment]. They will have to re-schedule appt for when dgtr [daughter] can go with her..." Resident was on antibiotic for tooth abscess.</p> <p>A Care Conference Summary, dated 8/7/12, indicated the following: "She received assist with her ADLs [activities of daily living] et personal care...Appetite fair to good for</p>		<p>Assistant Social Services Director will monitor the dental referrals monthly.b. A tracking log will be implemented and maintained by the Assistant Social Services Director to ensure all dental referrals are made and dental exams are current. A summary of this monitor will be submitted in the Quality Assurance Committee meeting for a period of at least three (3) quarters, then it will be reviewed for revision.V. COMPLETION DATESeptember 19,2012</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630			
(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			
	<p>meals...Has own teeth. Feeds self with set up..."</p> <p>The annual Minimum Data Set [MDS] assessment, dated 10/31/11, indicated there were no dental problems, including missing or broken teeth.</p> <p>The Social Service Director and Social Service employee #2 were interviewed at 11:00 a.m. on 8/15/12. They indicated they did have a dentist who came to the facility. They indicated resident was not on the dentist list for the dentist who visited the facility. There was no indication why the resident had not been seen by a dentist on a routine basis for her remaining teeth.</p> <p>A care plan had been initiated on 7/31/12 for dental care related to upper dentures and 8-9 teeth at the bottom. Interventions included, but were not limited to, the following: Nursing to perform oral care BID [twice a day] and PRN [as needed] Assess/monitor for loose, missing, or carious teeth, poorly fitting or broken dentures Assess/monitor mouth, tongue, and gums for odor, redness, swelling, coating, sores, cracking, or fissures Arrange for dental consult yearly and</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
	<p>as needed Soft tooth brush</p> <p>Other than the consult for the abscessed tooth, there was no indication the resident had routine dental visits.</p> <p>2. An observation was made of Resident #7 on 8/13/12 at 2:56 p.m. The resident had no top teeth or dentures and some broken natural lower teeth. At the time of the observation an interview was conducted and Resident #7 indicated she couldn't eat hard things because they hurt her mouth.</p> <p>A review of Resident #7's medical record was done on 8/14/12 at 10:00 a.m. A document titled Admission Assessment and dated 10/30/08, indicated Resident #7 had some lower teeth which were in poor condition, and no upper teeth.</p> <p>A document titled Clinical Notes, dated 12/14/2009, and signed by a dentist, indicated Resident #7 had received dental services with a signed consent on 12/14/2009, but the record included no other dental record of routine visits.</p> <p>In an Interview with Social Service #2 at 1:55 p.m., on 8/15/12, she</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
	<p>indicated Resident #7 had not received routine dental services and the dentist who comes in house determines who will receive dental care based on signed consents. They previously had a dentist the residents went out to see and Resident #7 had seen that dentist in 2009.</p> <p>She further indicated it is decided which residents see the dentist if upon admission they sign a consent, she could not find a consent for this resident.</p> <p>In an Interview with the Director of Nursing [DoN] on 8/15/12 at 2:00 p.m., regarding the dental policy, she indicated she had realized the facility was in need of a dental policy, and had just recently started writing one. So at this time the facility only had a partial dental policy.</p> <p>On 8/15/12 at 2:15 p.m., the DoN provided a document titled Dental Services, not dated. The document stated "Routine and emergency dental services are provided to our residents through a contract agreement with a local dentist and the charge nurse is responsible for notifying social services of a resident's need for dental service."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630
--	--

(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
	3.1-24(a)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630			
(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			
F0428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure psychoactive medications were reviewed for lowest therapeutic dosages for 2 of 10 residents reviewed for unnecessary medications, in that antipsychotic medications, antianxiety medications and hypnotics were not evaluated and/or recommended for potential reduction. (Residents #128, #64)</p> <p>Findings include:</p> <p>1. Resident #128's clinical record was reviewed on 8/15/12 at 3:06 p.m. The resident was admitted on 12/7/11 with diagnoses of dementia with behavior disturbances, Parkinson's disease, hypertension, depressive disorder, and hypercholesterolemia.</p> <p>The resident's Minimum Data Set [MDS] assessment, dated 5/26/12, indicated the resident received an antipsychotic medication 7 days a</p>	F0428	<p>I. CORRECTIVE ACTIONThe physician of resident # 64 was notified on 8/17/12. The physician denied a dose reduction and stated that " She would not be able to sleep".II. OTHERS HAVING THE POTENTIAL TO BE AFECTEDAll residents receiving psychoactive medication will be reviewed to ensure current and timely gradual dose reduction attempts. The attending physician will be notified according to the findings. III. MEASURES / SYSTEMIC CHANGESa. Gradual dose reductions will be made per unit per month vs. every unit every month, reviewing a unit per month will provide a smaller segment of residents to review and increase the focus.b. Licensed nursing staff will be inserviced to assist in observing for order dates and documentation of behaviors.c. A tracking log will be revised and implemented to ensure the review of all residents and recommendations made. Residents who did not warrant recommendations will have</p>	09/19/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
	<p>week. The MDS failed to indicate any behavior problems.</p> <p>The resident had physician's orders, signed 8/15/12, including, but not limited to, the following medication: Haldol 0.5 milligrams [antipsychotic] by mouth twice a day, ordered on 2/12/12. The diagnosis listed for the medication was "anxiety state..."</p> <p>The facility was monitoring Target Behavioral Symptoms of agitation and aggression. The record indicated no episodes noted during July or August, 2012.</p> <p>Interview with the Social Services Director on 8/16/12 at 3:30 p.m., she indicated she, the unit managers, and the pharmacist reviewed all psychoactive medications monthly. If they felt some may be able to be reduced, they sent a request to the physician. They track and log responses from the physician. There was no indication the routine Haldol had been considered for reduction.</p> <p>Only request sent for this resident was dated 7/26/12 to discontinue Haloperidol 5 mg/ml [milligram per milliliter]-1 mg "IM" [intramuscular] q [every] 6 hrs [hours] prn [as needed] and D/C [discontinue] Haloperidol 1</p>		<p>documentation eneterd into the medical record.IV. MONITORINGa. The director of Nursing will monitor the tracking of the gradual dose reductions monthly for two (2) months and as needed.b. The Social Service Director will monitor monthly thereafter in collaboration with the Unit Managers.c. A summary of this monitor will be entered at each Quarterly Quality Assurance Committee meeting minutes. Any negative finding will be reviewed to determine the need for revision of the monitor. This monitor is ongoing.V. COMPLETION DATESeptember 19,2012</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630			
(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			
	<p>mg q 6 hrs. prn. The physician agreed with the recommendation and the medications were discontinued on 8/2/12. The medication administration records [MARs] for July, 2012 were reviewed and these as needed medications had not been used.</p> <p>Pharmacy reviews, dated 1/3/12, 2/1/12, 3/1/12, 4/2/12, 5/1/12, 6/1/12, 7/3/12, 8/6/12, indicated no irregularities.</p> <p>2. Resident #64's clinical record was reviewed on 8/15/12 at 9:34 a.m. The resident's diagnoses included, but were not limited to, diaphragmatic hernia, hyperlipidemia, esophageal reflux, macular degeneration, anxiety state, osteoporosis, insomnia, diabetes mellitus, malignant neoplasm of the breast, dementia, and depressive disorder.</p> <p>The resident's physician orders, signed 7/19/12, included, but were not limited to, orders for the following medications: 12/16/10 Ambien [sleeping medication] 5 mg [milligram] tab po [by mouth] qd [every day] @ HS [hour of sleep] for insomnia 12/18/10 Ativan [antianxiety medication] 0.25 mg tab po qd for</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
	<p>anxiety state 1/27/12 Celexa [antidepressant medication] 40 mg tab po qd @ HS, reduced to 20 mg on 7/24/12.</p> <p>Pharmacy reviews dated 1/12 through 8/12 indicated no irregularities.</p> <p>During interview with the Social Service Director on 8/16/12 at 3:30 p.m., she indicated the unit managers and the pharmacist met once a month to review medications and see if any of them could be reduced. She indicated recommendations had been made by the Psychiatrist to reduce the Celexa [antidepressant] and they had been acted upon. She indicated the resident's Ambien and Ativan had not had any recommendations for review since 2010.</p> <p>3.1-25(i)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630
--	--

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630			
(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
F0431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Based on observation, interview, and record review, the facility failed to store and label drugs in accordance with current principles and to include</p>			F0431	I CORRECTIVE ACTIONa. The resident numbers are said to be identifiers only and not a part of the resident sample.b. These medications will be disposed of		09/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
	<p>the appropriate expiration date and resident's name in 2 of 3 medication storage rooms, 2 of 3 medication refrigerators, and 1 of 3 medication carts in a sample of 4 medication carts.</p> <p>Findings include:</p> <p>On observation of the North Unit medication room on 8/16/12 at 1:45 p.m., 2 Phenergan suppositories 25 mg [milligram] and 1 Tylenol suppository 650 mg were found lying loosely in the locked medication refrigerator with no resident's name on them. An intravenous bag of D51/2 NS with Potassium Chloride 20 meq [milliequivalents] for Resident #37 with an expiration date of 7/2012 on it was found in the refrigerator..</p> <p>On observation of the medication cart on the North Unit on 8/16/12 at 2:25 p.m., it was noted to have the following medications in it with no open date noted: Novolog Insulin 100 U [units] /ml [milliliter] for Resident's #34 and #50, Levimir Insulin 100 U/ml for Resident #100, Ear Wax Removal gtts [drops] for Resident's #50, #71, and #125, Azopt 1% ophthalmic drops for Resident #36 Lantanoprost 0.005% ophthalmic drops for Resident #36, and Lique Tears</p>		<p>appropriately.II. OTHERS HAVING THE POTENTIAL TO BE AFFECTED.a. All residents receiving medication have the potential to be affected.b. All medication rooms and medication carts will be inspected for medication disposal, outdated medication, and opened medication without dates. III. MEASURES / SYSTEMIC CHANGESI. licensed nurses will be inserviced regarding dating opened medication and disposal of expired medication.IV. MONITORINGa. Nursing administration or a designee will monitor the medication rooms and carts weekly for four (4) weeks then monthly for three (3) months.b. Pharmacy services will continue to monitor the carts and medication rooms monthly. The Unit Managers will follow up on the findings.c. The night shift nurse will check the carts and medication rooms at least two (2) times a week.d. The Unit Managers will follow up on the night shift monitoring.e. A summary of the monitor will be submitted in the next Quality Assurance Committee to determine the frequency of monitoring by the night nurses. The monitoring will continue monthly thereafter by Nursing Admin and or the unit Managers. Pharmacy will continue the monthly audits.V. COMPLETION DATESeptember 19,2012</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
	<p>ophthalmic drops for Resident #17.</p> <p>On observation of the refrigerator in the medication room on the West Unit on 8/16/12 at 2:50 p.m., the following medications were expired: Bicolax suppository 10 mg for Residents #25 and #39, expired 3/2012; Hemorrhoidal HC suppository 25 mg for Resident #40, expired on 3/2012; Bicolax suppository 10 mg for Resident #117, expired on 5/2012; Phenadoz suppository 12.5 mg for Resident #84, expired on 4/12; Phenadoz suppository 12.5 mg for Resident #72, expired on 5/2012; Phenadoz suppository 25 mg for Resident # 38, expired on 4/2012 and 5/2012, and Promethazine suppository 25 mg for Resident #117, expired on 5/2012.</p> <p>On observation of the medication carts on the North Unit on 8/16/12 at 3:10 p.m., the no open dates were indicated on the following medications: Resident #55 - Fluticasone Prop 50 mcg Resident #43 - Atropine ophthalmic drops Resident #80 - Latanoprost 0.005% ophthalmic drops Resident #4 - Lumigan 0.01% ophthalmic drops</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
	<p>Resident #80 - Tobramycin - Dexamethasone ophthalmic drops</p> <p>Interview with RN #2 on 8/19/12 at 1:30 p.m., indicated medications are to have the "open" date placed on them when they are opened.</p> <p>Interview with RN #3 on 8/19/12 at 3:30 p.m., indicated medications, such as eye drops, ear drops, and insulins, in the medication cart are to have the "open" date wrote on them whenever the staff opens the medications.</p> <p>The facility policy obtained from the DoN [Director of Nursing] on 8/20/12 at 2:15 p.m., indicated medications are to be labeled with the resident's name and are to be stored safely, securely, and properly following the manufacturer's recommendations or those of the supplier.</p> <p>3.1-25((k)(1) 3.1-25(o)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630
--	--

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630			
(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			
F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to</p>	F0441	I. CORRECTIVE ACTION Resident # 34 is not	09/19/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
	<p>ensure staff used the appropriate cleaning agent for sanitizing glucometers [a machine used to obtain a blood sugar] prior to and after use for 1 of 2 residents observed with blood glucose checks. (Resident # 34)</p> <p>Findings include:</p> <p>An Accucheck (fingerstick blood sugar test) was observed to be completed on Resident #34 on 8/15/12 at 3:33 p.m., by LPN #5. LPN # 5 obtained the glucometer from the medication cart and wiped the machine with an alcohol prep pad. After obtaining the resident's oral medication and glucometer supplies, LPN #5 went to assist on another resident who was attempting to get out of her chair unassisted. She placed the oral medications back into the cart and locked it and left the glucometer machine lying on top of the cart. LPN #5 returned to the cart at 3:43 p.m., sanitized her hands and obtained another alcohol pad. LPN #5 proceeded into Resident #34's room where she proceeded to obtain the resident's blood sample for the Accucheck. LPN #5 obtained the results and gave the resident his oral medications. LPN #5 placed the glucometer on the top of the</p>		<p>listed in the sample. The nurse was inserviced during the survey.II. OTHERS HAVING THE POTENTIAL TO BE AFFECTEDAll residents who receive glucose testing have the potential to be affected.III. MEASURES / SYSTEMIC CHANGESNurses and QMA's will be inserviced to review the policy and procedure for disinfecting the glucose monitor.The policy for disinfecting the glucose monitor has been revised to include no substitutions to the PDI sani-cloth wipes as others are not effective disinfectants / germicidal agents.IV. MONITORINGThe Central Supply clerk will monitor daily for stock of the PDI sani-cloth wipe availability on each unit. This monitor will be ongoing.Nursing Administration or a designee will observe nurses throughout the units and throughout the shifts for proper technique on disinfecting the glucometers. This will occur three (3) times a week for three (3) months, then monthly on each unit and a random nurse or QMA. This information will be submitted in the next Quality Assurance meeting. This monitor will continue monthly thereafter unless negative findings are identified, then the monitor will be revised for more frequent monitoring.V. COMPELTION DATE September 19,2012</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630			
(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			
	<p>medication cart and documented the medications and Accucheck results. LPN #5 stated she needed to do one more Accucheck on another resident. LPN #5 proceeded to clean the glucometer with another alcohol pad. When questioned, LPN #5 indicated other wipes were available to clean the glucometer, but she does not know the name of them. She indicated when she does not have the correct germicidal wipes to clean the glucometer she will use an alcohol wipe. LPN #5 indicated she frequently does not have the germicidal wipe available for cleaning the glucometer. Upon query, LPN #5 indicated the germicidal wipes are available but were not on the medication cart. LPN #5 indicated she has to go to the desk area to obtain them. A request was made of LPN #5 to not use the alcohol pad and to locate the proper cleaning wipe for the glucometer. LPN #5 obtained a Super Sani-Cloth Germicidal Wipe and cleaned the glucometer.</p> <p>On query of LPN #4 on 8/16/12 at 10:05 a.m., LPN #4 indicated she would use an alcohol wipe to disinfect the glucometer machine if a germicidal wipe was not available.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
	<p>On interview with the ADoN [Assistant Director of Nursing] on 8/ 15/12 at 4:20 p.m., she indicated germicidal wipes were always available for disinfecting the glucometer machines. The ADoN indicated the policy for disinfecting the glucometer machines indicated the machines are to be disinfected with a germicidal wipe after each resident's use of them.</p> <p>The procedure obtained on 8/20/12 at 2:15 p.m. from the DoN, indicated the glucometer machine is to be cleaned with a germicidal disposable wipe x 2 and air dried for 2 minutes.</p> <p>3.1-18(b)(1)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630
--	--

(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