

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2012
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NAME OF PROVIDER OR SUPPLIER WATERS OF NEW CASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 N 16TH ST NEW CASTLE, IN 47362
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F0000	<p>This visit was for the a Recertification and State Licensure survey.</p> <p>Survey dates: October 3, 4, 5, 9, & 10, 2012</p> <p>Facility number: 000201 Provider number: 155304 AIM number: 100267910</p> <p>Survey team: Angel Tomlinson, RN-TC Sharon Lasher, RN Barbara Gray, RN Leslie Parrett, RN October 3, 4, 5, & 10, 2012</p> <p>Census bed type: SNF/NF: 49 SNF: 3 Total: 52</p> <p>Census payor type: Medicare: 21 Medicaid: 18 Other: 13 Total: 52</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on October</p>	F0000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or 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. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is November 9, 2012.</p>	

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.

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	16, 2012 by Bev Faulkner, RN			

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify a resident of a medication change for high blood pressure and failed to notify the physician of high blood</p>	F0157	It is the intent of this facility to ensure resident notifications are made related to medication change. It is the intent of this facility to ensure physician notifications are made related to	11/09/2012

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	<p>pressures for 1 of 1 residents reviewed for change of condition (Resident #52).</p> <p>Finding include:</p> <p>1.) Review of the record of Resident #52 on 10-5-12 at 9:30 a.m., indicated the resident's diagnoses included, but were not limited to, hypertension, depression, anxiety, seizure disorder status post Cerebral Vascular Accident (CVA) (stroke).</p> <p>The admission face sheet for Resident #52 indicated the resident was admitted to the facility on 4-26-12.</p> <p>The Minimum Data Set (MDS) assessment for Resident #52, dated 9-16-12, indicated the resident's BIMS (Brief Interview for Mental Status) was a 15, with a range of 13-15, indicating the resident was cognitively intact.</p> <p>The local hospital admission summary for Resident #52, dated 4-18-12, indicated the resident was found to be "markedly hypertensive." The resident's blood pressure was 260/130.</p>		<p>high blood pressure. I. Corrective action for affected resident: 1. In regards to resident #1, resident had in fact been notified of medication change on 10/4 /12 when the new order for HCTZ was given, this notification was documented in the Nurse Note written at 1620 on 10/4/12. In regards to Resident #1 MD notification was made on 10/24 /12 in reference to the noted missed blood pressure readings. II. Other residents with potential to be affected: 1. 100% audit completed of current resident orders starting with those written 10/4/2012 to ensure resident notification of medication change was documented in the Nurses Notes. No other residents were identified. 2. 100% audit completed of current residents with ordered blood pressure monitoring to ensure MD notification was documented in the Nurses Notes. No other residents were identified. III. Measures to prevent reoccurrence: 1. The Nursing staff was re-educated and re-inserviced to facility policy in regards to resident and MD notification being made and documented in Nurse Notes. IV. Monitoring of corrective action to ensure the practice will not recur: 1. DON/Designee will complete audit of new orders for proper Nurse Note regarding resident notification. 2. DON/Designee will</p>				

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	<p>The local hospital discharge summary for Resident #52, dated 4-26-12, indicated the resident was admitted with a hypertensive crisis. The resident was initially treated with intravenous (IV) antihypertensive medication to improve the resident's blood pressure. A Brain stem stroke was suspected.</p> <p>The physician recapitulation (recap) orders for Resident #52, dated August, September and October 2012, indicated the resident was to have a blood pressure check every shift.</p> <p>The August 30, 2012 Medication Administration Record (MAR) for Resident #52 indicated the resident's blood pressure was 219/128 on the 7:00 a.m. to 7:00 p.m. shift. There were no documentation of the physician being notified of the high blood pressure.</p> <p>The MAR for Resident #52, dated October 3, 2012 on the 7:00 a.m. to 7:00 p.m. shift indicated the resident's blood pressure was 228/98. There were no documentation of the physician being notified of the high blood pressure.</p> <p>The MAR for Resident #52, dated</p>		<p>complete audit of MAR for MD notification of blood pressure monitoring per order. 3. These audits will be done 3 times a week for 2 weeks, 2 times a week for 2 weeks, weekly times 2 weeks and then ongoing monthly.</p> <p>4. Administrator/designee will review the results in the scheduled quarterly QA meetings.</p> <p>V. Date Completed: 11/9/2012.</p>		

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	<p>October 4, 2012 on the 7:00 a.m. to 7:00 p.m. shift indicated the resident's blood pressure was 226/88. The physician was notified and a new order was received for hydrochlorathiazide 25 milligrams one time a day (HCTZ) (a blood pressure medication). There was no documentation indicating the resident had been notified of the medication order to treat the high blood pressure.</p> <p>The MAR for Resident #52, dated October 5, 2012 on the 7:00 a.m. to 7:00 p.m., shift indicated the resident's blood pressure was 210/110. There was no documentation the physician was notified of the resident's high blood pressure.</p> <p>Interview with Resident #52 on 10-5-12 at 2:23 p.m., he indicated his blood pressure had been high for a couple months. Resident #52 indicated he had a stroke a few months ago. Resident #52 indicated he had a history of high blood pressure, but it had always been under control with medication and now it did not seem to be responding to the medication. Resident #52 indicated his blood pressure had been unusually high and he was worried about it. Resident #52</p>			

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	<p>indicated he had requested to talk to the physician about changing his medication but the physician had not responded to his request for a medication change.</p> <p>Resident #52 indicated no one had talked to him about a medication change. Resident #52 indicated he felt like the physician may not know about his high blood pressure. Resident #52 stated "it has me scared to death" and that his blood pressure had never been as high as it is now.</p> <p>Interview with RN #1 on 10-5-12 at 2:55 p.m., indicated Resident #52's blood pressure when she took it was 210/110. RN #1 indicated she was aware that Resident #52 was worried about his high blood pressure.</p> <p>Interview with the Assistant Director Of Nursing (ADON) on 10-5-12 at 3:15 p.m., indicated when a resident had a high blood pressure the protocol was to notify the physician and recheck the resident's blood pressure. The ADON indicated residents' blood pressures were checked when morning medication was given. The ADON asked RN #1 at this time if she had rechecked Resident #52 blood pressure and had notified the physician of the high</p>			

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	<p>blood pressure. RN #1 indicated no she had not rechecked the resident's blood pressure or notified the resident's physician of the high blood pressure. The ADON indicated for RN #1 to recheck the resident's blood pressure and indicated she would notify the resident's physician.</p> <p>The MAR for Resident #52, dated October 6, 2012, indicated the resident's blood pressure was 220/110. There were no documentation of the resident's physician being notified of the high blood pressure.</p> <p>Interview with the Director of Nursing on 10-10-12 at 12:45 P.M., indicated she was not able to find documentation that the physician was notified of Resident #52's high blood pressure on 8-30-12 or 10-3-12.</p> <p>The physician notification of resident change in condition policy provided by LPN #5 on 10-10-12 AT 1:30 P.M., indicated it was the intent of the facility for the attending physician to be notified of a change in a resident's condition by licensed personnel. The physician notification included, but were not limited to, significant change in/or unstable vital signs.</p>						

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	3.1-5(a)(2) 3.1-5(a)(3)			

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure effective pain management for 1 resident with complaints of continued and unrelieved pain and failed to monitor 1 resident's hypertension and to notify the physician of the resident's hypertension for 2 of 3 residents who met the criteria for quality of care. (Resident #15 and #52)</p> <p>Findings include:</p> <p>1.) Resident #15 record was reviewed on 10/5/12 at 11:00 a.m. Resident #15's diagnoses included but were not limited to pain, anxiety and depression.</p> <p>Resident #15's MDS (Minimum Data Set), assessment, dated 8/29/12, indicated the following: - BIMS (Brief Interview for Mental Status), 15, with a range of 13-15, indicating cognition intact - pain presence, have you had pain or</p>	F0309	<p>It is the intent of this facility to ensure effective pain management. It is the intent of this facility to monitor hypertension and to make MD notification of hypertension. I. Corrective action for affected residents 1. In regards to resident #15, all orders were reviewed with the physician to ensure the residents' needs were being met. New orders were written as needed to maintain the residents comfort. In regards to resident #52 hypertension was monitored and reviewed with the physician. II. Other residents with potential to be affected 1. 100% pain audit was completed for all residents to ensure their pain was being controlled. No other residents were identified. 2. 100% audit of current residents with ordered hypertension monitoring completed to ensure blood pressure reading and MD notification. No other residents were identified. III. Measures to prevent reoccurrence 1. The Nursing staff was re-educated and re-inserviced to facility policy</p>	11/09/2012			

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	<p>hurting at any time in the last 5 days, yes</p> <ul style="list-style-type: none"> - pain frequency, frequently - over the past 5 days, have you limited your day-to-day activities because of pain, yes - pain intensity, "7" numeric rating scale 0-10 - should the staff assessment for pain be conducted, no <p>Resident #15's care plan, dated 8/23/12, indicated "problem, chronic pain. Goal, patient will have relief from interventions with in 1 hour of administration. Interventions, keep call light in reach and answer light in timely manner, educate patient on staying ahead of pain, medication as ordered, monitor effectiveness and adverse reactions to medications, assist patient as needed with transfers/adl's (activities of daily living), notify physician and family as needed, offer repositioning for comfort and pain assessments PRN."</p> <p>Resident #15's physician's orders , dated 8/22/12, indicated "MS, ER (extended release, 90 mg, by mouth, every 12 hours, at 8:00 a.m. and 8:00 p.m. Hydrocodone/tylenol (narcotic pain medication) 5/325 mg, by mouth, once daily at 2:00 p.m. and Hydrocodone 5/325 mg, by mouth, 2</p>		<p>in regards to pain management.</p> <p>2. The Nursing staff was re-educated and re-inserviced to facility policy in regards to MD notification. IV. Monitoring of corrective action to enlure the practice will not recur</p> <p>1. The QA team will monitor during daily rounds for any resident who appears uncomfortable or complains of pain/discomfort. The DON will be notified immediately.</p> <p>2. The DON/Designee will review these tools in the daily QA morning meeting, and weekly in the QA Patient at Risk meeting.</p> <p>3. The MDS Coordinator/Designee and the Care Plan Team will ensure quarterly the pain assessment is reviewed and updated as necessary to ensure the residents' pain is controlled.</p> <p>4. DON/Designee will complete audit of MAR for MD notification of hypertension monitoring per order, these audits will be done 3 times a week for 2 weeks, 2 times a week for 2 weeks, weekly for 2 weeks and ongoig monthly.</p> <p>3. Administrator/Designee will review results in the scheduled quarterly QA meetings.</p> <p>V. Date completed: 11/9/2012</p>		

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	<p>tablets by mouth every 4 hours, PRN"</p> <p>Resident #15's MAR (Medication Administration Record) for September and October, 2012 indicated Resident #15 received Hydrocodone 5/325 mg, 2 tablets, PRN on the following days and times:</p> <ul style="list-style-type: none"> - 9/15/12 at 10:30 a.m. - 9/15/12 at 9:30 p.m. - 9/15/12 at 3:00 a.m. - 9/16/12 at 6:00 p.m. - 9/16/12 at 11:00 p.m. - 9/17/12 at 5:15 a.m. - 9/17/12 at 9:30 p.m. - 9/18/12 at 12:45 p.m. - 9/19/12 at 6:00 a.m. - 9/19/12 at 11:00 p.m. - 9/20/12 at 7:30 p.m. - 9/21/12 at 6:00 a.m. - 9/21/12 at 10:00 p.m. - 9/22/12 at 6:45 p.m. - 9/23/12 at 6:20 a.m. - 9/24/12 at 6:00 a.m. - 9/24/12 at 9:00 p.m. - 9/25/12 at 6:00 a.m. - 9/25/12 at 6:30 p.m. - 9/26/12 at 6:00 a.m. - 9/26/12 at 9:30 p.m. - 9/27/12 at 6:00 a.m. - 9/27/12 at 10:30 p.m. - 9/28/12 at 6:30 a.m. - 9/28/12 at 6:00 p.m. - 9/29/12 at 5:30 a.m. - 9/30/12 at 6:00 a.m. 						

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	<ul style="list-style-type: none"> - 9/30/12 at 8:45 p.m. - 10/1/12 at 10:15 a.m. - 10/2/12 at 10:50 p.m. - 10/3/12 at 10:50 p.m. - 10/4/12 at 6:15 a.m. - 10/4/12 at 9:00 p.m. - 10/5/12 at 6:00 a.m. - 10/6/12 at 11:15 a.m. - 10/6/12 at 9:00 p.m. - 10/7/12 at 12:15 a.m. - 10/7/12 at 9:00 p.m. - 10/8/12 at 9:00 p.m. - 10/9/12 at 7:00 a.m. - 10/9/12 at 9:00 p.m. <p>On 10/5/12 at 11:25 a.m., Resident #15 was observed lying in bed and indicated her hip hurt too bad to sit up and talk.</p> <p>Interview with Resident #15 on 10/5/12 at 11:31 a.m., indicated she had constant pain in her left leg and left hip that she rated the pain 8 while lying down and 10 when sitting up and she thinks it is a nerve pain. Resident #15 stated "I can't sit up it just hurts too bad, there are a lot of things I would like to do but it just hurts too bad. I have reported this to the nurses and all they can do is give me the pain medication but it doesn't help much. I don't think the doctor knows about my pain but I am going</p>						

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	<p>to tell him the next time he comes to see me."</p> <p>Interview with Activities Staff #4 on 10/9/12 at 11:28 a.m., indicated Resident #15 does not come to activities often as she is in too much pain. "She wanted to come to the dog show the other day and she tried but sitting up just caused her too much pain. She has tried a couple of other activities recently and was just in too much pain and had to go back to bed."</p> <p>Interview with Physical Therapist #6 on 10/10/12 at 10:46 a.m., indicated Resident #15 is going to be discharged from therapy next Friday because she is in too much pain and she is not making any progress.</p> <p>Interview with DON on 10/10/12 at 11:45 a.m., indicated Resident #15's physician did see her this morning and is going to refer her to another physician for an injection because he feels like her pain is sciatica (nerve in back of thigh) nerve pain.</p> <p>2.) Review of the record of Resident #52 on 10-5-12 at 9:30 a.m., indicated the resident's diagnoses included, but were not limited to,</p>				

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	<p>hypertension, depression, anxiety, seizure disorder status post Cerebral Vascular Accident (CVA) (stroke).</p> <p>The admission face sheet for Resident #52 indicated the resident was admitted to the facility on 4-26-12.</p> <p>The Minimum Data Set (MDS) assessment for Resident #52, dated 9-16-12, indicated the resident's BIMS (Brief Interview for Mental Status) was a 15, with a range of 13-15, indicating the resident is cognitively intact.</p> <p>The care plan for Resident #52, dated 4-26-12, indicated the resident problem was hypertension and the resident's goal was not to have any complications related to hypertension. The interventions included, but were not limited to, monitor blood pressure as ordered and notify the medical doctor as needed.</p> <p>The local hospital admission summary for Resident #52, dated 4-18-12, indicated the resident was found to be "markedly hypertensive." The resident's blood pressure was 260/130.</p> <p>The local hospital discharge summary</p>						

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	<p>for Resident #52, dated 4-26-12, indicated the resident was admitted with a hypertensive crisis. The resident was initially treated with intravenous (IV) antihypertensive medication to improve the resident's blood pressure. A Brain stem stroke was suspected.</p> <p>The physician recapitulation (recap) orders for Resident #52, dated August, September and October 2012, indicated the resident was to have a blood pressure check every shift.</p> <p>The August 2012 Medication Administration Record (MAR) for Resident #52 indicated the resident's blood pressure was not obtained on 8-6-12 on the 7:00 p.m. to 7:00 a.m. shift; on 8-15-12, the blood pressure was not obtained on the 7:00 a.m. to 7:00 p.m. shift and the blood pressure for the 7:00 p.m. to 7:00 a.m. blood pressure was 200/78 with no recheck of the blood pressure or notification to the physician. On 8-18-12 on the 7:00 a.m. to 7:00 p.m. shift there were no blood pressure obtained. On 8-19-12 on the 7:00 a.m. to 7:00 p.m. shift, there were no blood pressure obtained. On 8-25-12 on the 7:00 p.m. to 7:00 a.m. shift, there were no blood pressure obtained. On 8-29-12</p>			

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	<p>on the 7:00 a.m. to 7:00 p.m. shift, there were no blood pressure obtained and on 8-30-12 the resident's blood pressure was 219/128 with no documented recheck of the blood pressure or notification to the physician.</p> <p>The MAR for Resident #52, dated October 3, 2012 on the 7:00 a.m. to 7:00 p.m. shift indicated the resident's blood pressure was 228/98. There were no documentation of the physician being notified of the high blood pressure.</p> <p>The MAR for Resident #52, dated October 4, 2012 on the 7:00 a.m. to 7:00 p.m. shift, indicated the resident's blood pressure was 226/88. The physician was notified and a new order was received for hydrochlorathiazide 25 milligrams one time a day (HCTZ) (a blood pressure medication). There was no documentation indicating the resident had been notified of the medication order to treat the high blood pressure.</p> <p>The MAR for Resident #52, dated October 5, 2012 on the 7:00 a.m. to 7:00 p.m. shift, indicated the resident's blood pressure was 210/110. There was no documentation the physician was</p>			

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	<p>notified of the resident's high blood pressure.</p> <p>Interview with Resident #52 on 10-5-12 at 2:23 p.m., indicated his blood pressure had been high for a couple months. Resident #52 indicated he had a stroke a few months ago. Resident #52 indicated he had a history of high blood pressure, but it had always been under control with medication and now it did not seem to be responding to the medication. Resident #52 indicated his blood pressure had been unusually high and he was worried about it. Resident #52 indicated he had requested to talk to the physician about changing his medication, but the physician had not responded to his request for a medication change.</p> <p>Resident #52 indicated no one had talked to him about a medication change. Resident #52 indicated he felt like the physician may not know about his high blood pressure. Resident #52 stated "it has me scared to death" and that his blood pressure had never been as high as it is now.</p> <p>Interview with RN #1 on 10-5-12 at 2:55 p.m., indicated Resident #52 blood pressure when she took it was</p>				

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	<p>210/110. RN #1 indicated she was aware that Resident #52 was worried about his high blood pressure.</p> <p>Interview with the Assistant Director Of Nursing (ADON) on 10-5-12 at 3:15 p.m., indicated when a resident had a high blood pressure the protocol was to notify the physician and re check the residents blood pressure. The ADON indicated residents' blood pressures were checked when morning medication was given. The ADON asked RN #1 at this time if she had rechecked Resident #52 blood pressure and had notified the physician of the high blood pressure. RN #1 indicated, no, she had not rechecked the resident's blood pressure or notified the resident's physician of the high blood pressure. The ADON indicated for RN #1 to recheck the resident's blood pressure and indicated she would notify the resident's physician.</p> <p>The MAR for Resident #52, dated October 6, 2012, indicated the resident's blood pressure was 220/110. There were no documentation of the resident's physician being notified of the high blood pressure.</p> <p>Interview with the Director of Nursing</p>						

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	<p>on 10-10-12 at 12:45 P.M., indicated she was not able to find documentation that Resident #52's blood pressures that were missing in August 2012 were obtained or documentation of the physician being notified of the resident's high blood pressures or documentation the resident's blood pressure was rechecked after the high readings.</p> <p>The "Senior Select Geriatric Formulary and Nursing Drug Handbook 2005" page 1026, indicated the normal adult classification for blood pressure was below 120 for systolic (top) reading and below 80 for diastolic (bottom) reading.</p> <p>According to the American Heart Association web cite http://www.heart.org, High blood pressure often does its damage without creating symptoms, but when blood pressure numbers rise above 180 for the systolic pressure (top reading) or 110 for the diastolic pressure (bottom reading), you need emergency treatment.</p> <p>3.1-37(a)</p>				

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F0385 SS=D	<p>483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.</p> <p>The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable.</p> <p>Based on interview and record review, the facility failed to ensure a resident received timely medical care when a physician failed to respond to numerous calls related to a critical lab value and complaints of nausea and vomiting for 1 of 1 resident who met the criteria for quality of care. (Resident #22)</p> <p>Findings include:</p> <p>Resident #22's record was reviewed on 10/5/12 at 8:44 a.m.</p> <p>Resident #22's MDS (Minimum Data Set), assessment, dated 5/17/12, indicated BIMS (Brief Interview for Mental Status), 13, with a range of 13-15, indicating cognition intact and discharge plans is for Resident #22 to return to the community.</p> <p>Resident #22's care plan, dated</p>			F0385	<p>It is the intent of this facility to ensure timely medical care when a physician fails to respond. I. Corrective action for affected resident: 1. In regards to resident #22, discharge date from facility was 5/20/2012. II. Other residents with potential to be affected: 1. 100% audit of current residents for lack of MD response to critical lab values and/or complaints of nausea and vomiting. No other residents were identified. III. Measures to prevent reoccurrence: 1. The Nursing staff was re-educated and re-inserviced to facility policy in regards to MD notification. 2. DON/Designee to review the 24 hour report and the clinical record daily for residents having a critical lab value or complaints of nausea and vomiting for MD response forwarding concerns to the Medical Director. IV. Monitoring of corrective action to ensure the practice will not recur: 1. The DON/Designee will complete audit of MD</p>		11/09/2012

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	<p>5/10/12, indicated "problem, short term placement. Goal, discharge plans will be in place prior to discharge. Interventions, help resident to adjust to placement, offer community resources, home evaluation as needed and prepare resident for discharge."</p> <p>Resident #22's care plan, dated 5/10/12, indicated "problem, resident states she is here for therapy. She plans to return home once therapy goals are met. Goal, for resident to interact with peers for socialization during therapy. Interventions, provide calendar, personally invite and assist to and from activities as needed and encourage and praise resident.</p> <p>Resident #22's admission physician's summary, dated 5/5/12, indicated "(Resident #22) who normally lives alone with close attention paid by her son who comes in daily. Yesterday morning, he fixed her breakfast and then left. When he returned at 3-4 in the afternoon, she still had not eaten it. At that point, the patient was quite confused, unable to speak in coherent sentences. She was unable to walk. On 5/4/12, she was her normal self, up and about with no evidence of disability. In the emergency room, she was</p>		<p>response following notification for critical labs and complaints of nausea and vomiting, audit to be done 3 times a weeks for 2 weeks, 2 times a weeks for 2 weeks, weekly times 2 weeks, and then ongoing monthly. 2. Administrator/designee will review the results in the scheduled quarterly QA meetings. V. Date Completed: 11/9/2012</p>				

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	<p>found to have a urinary tract infection and was admitted with dehydration. Laboratory data: ...18,000, WBC (White Blood Cells) with reference range WBC, 4.6-10.2."</p> <p>Resident #22's laboratory test, dated 5/17/12, indicated WBC, 59.66 (critical level)</p> <p>Resident #22's nursing notes indicated the following:</p> <ul style="list-style-type: none"> - 5/17/12 at 5:30 p.m., Resident had critical lab this a.m. MD's nurse was notified by phone immediately after receiving critical lab. Resident has had episodes times 2 of nausea and vomiting with emesis times 1. MD notified of situation and that family's requesting PRN nausea medication - 5/18/12 at 6:45 a.m., resident continues to be nauseous. Resident has had 2 episodes of emesis noted so far this shift - 5/18/12 at 9:30 a.m., MD office called about patient's critical lab from 5/17/12, MD's nurse stated that MD is fully aware of lab and he has consulted with other physician's but she does not know what he is going to do about it - 5/18/12 at 2:30 p.m., left voice mail for MD. MD has not called back - 5/18/12 at 3:45 p.m., MD paged due to no return call 			

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	<p>- 5/18/12 at 4:45 p.m., MD has not responded to this writer's attempts at reaching him related to resident's labs and nausea</p> <p>- 5/19/12 at 11:30 a.m., (physician) called in new order after patient's family found him in hospital Resident #22's physician's orders, dated 5/19/12, indicated "MS (morphine sulfate) Contin (narcotic pain medication) 30 mg (milligrams), by mouth, every 4 hours, PRN (as needed), pain. Phenergan (nausea) 25 mg, by mouth, every 4 hours, PRN, nausea and Morphine for injection 2-4 mg IV (intravenous) or IM (intramuscularly) every 2 hours, PRN, pain</p> <p>- 5/19/12 at 4:20 p.m., complaint of pain times 1, PRN pain medication given, effective. Complaint of nausea times 1, nausea PRN medication given, effective</p> <p>- 5/20/12 at 12:20 a.m., lung sounds diminished bases with notable rhonchi (a whistling or snoring sound)</p> <p>- 5/20/12 at 05:25 a.m., this writer went down to resident's room unable to visibly observe chest rise. Oxygen saturation checked with no results, unable to obtain apical heart rate...respiration have ceased.</p> <p>Interview with DON (Director of Nursing), on 10/10/12 at 1:16 p.m.,</p>			

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	<p>indicated the physician was paged and called starting on 5/17/12 and the first time he answered was the answer from the family on 5/18/12. She also indicated the Medical Director is available almost all the time but was not notified when the attending physician did not respond to the phone calls or pages when the nurses tried to reach him.</p> <p>3.1-22(a)(2)</p>			

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F0465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to provide an environment that was free of urine odor for 2 of 2 residents who met the criteria for the presence of incontinence (Resident #28 and Resident #17).</p> <p>Findings include:</p> <p>1.) During observation on 10-3-12 at 3:00 p.m., outside Resident #28 and #17's bedroom door there was a strong smell of urine. Resident #28 and Resident #17 resided in the same bedroom.</p> <p>During observation on 10-4-12 at 11:23 a.m., Resident #28 was laying in bed and there was a strong urine smell in the resident's room.</p> <p>During observation on 10-5-12 at 12:00 p.m., Resident #28 and Resident #17 were both in their beds with their eyes closed. The resident's room had a strong urine odor. The urine smell was also detected in the hallway outside of the resident's</p>			F0465	<p>It is the intent of this facility to ensure an environment that is free of urine odor I. Corrective action for affected residents: 1. In regards to resident #28 and #17 who reside in the same room, resident #28's bed mattress was replaced. II. Other residents with potential to be affected: 1. 100% audit completed of all resident mattresses, no other residents identified. III. Measure to prevent reoccurrence: 1. All Nursing Staff and Housekeeping staff re-inserviced on mattress care/cleaning. 2. Housekeeping Supervisor/Designee to inspect mattresses monthly as part of preventative maintenance program. IV. Monitoring of corrective action to ensure the practice will not recur: 1. QA members will monitor for urine odors daily during rounds, findings from these rounds will be discussed in daily QA morning meeting. 2. Administrator/designee to review findings in the scheduled quarterly QA meeting. V. Date completed: 11/9/2012</p>		11/09/2012

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	<p>bedroom.</p> <p>During observation on 10-5-12 at 12:20 p.m., CNA #2 and CNA #3 transferred Resident #28 out of bed into a chair. CNA #2 and CNA #3 both agreed the resident's room smelled like urine. CNA #2 indicated the resident was a "heavy wetter" and CNA #3 indicated the urine smell was because the resident had excoriation under her abdominal fold. CNA #2 indicated housekeeping cleaned residents' mattresses one time a month and CNA's cleaned the mattresses when they were soiled. CNA #2 took the sheets off Resident #28's bed and agreed the mattress smelled like urine.</p> <p>Interview with Resident #17's family member on 10-5-12 at 2:00 p.m., indicated the facility came in and changed the mattress on Resident #28's bed. When queried if the family member had noticed a urine smell in Resident #17's bedroom when visiting, the family member indicated the resident's roommate was bedfast most of the time and did not feel the facility could help the urine smell.</p> <p>Interview with the Maintenance Assistant on 10-5-12 at 2:15 p.m.,</p>			

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NAME OF PROVIDER OR SUPPLIER WATERS OF NEW CASTLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 N 16TH ST NEW CASTLE, IN 47362			
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	<p>indicated he changed the mattress of Resident #28 because the Administrator had requested for it to be changed.</p> <p>2.) Review of the record of Resident #28 on 10-5-12 at 12:05 p.m., indicated the resident's diagnoses included, but were not limited to, depression, degenerative joint disease, diabetes mellitus and spinal stenosis.</p> <p>The Minimum Data Set (MDS) assessment for Resident #28, dated 9-6-12, indicated the resident was totally dependent on two people for toileting and was always incontinent of the bladder.</p> <p>3.) Review of the record of Resident #17 on 10-9-12 at 10:00 a.m., indicated the resident's diagnoses included, but were not limited to, osteoarthritis, renal insufficiency and osteoporosis.</p> <p>The MDS for Resident #17, dated 7-22-12, indicated the resident required extensive assistance of one person for toilet use and was frequently incontinent.</p> <p>3.1-19(f)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2012
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