

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 10/29/2014
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NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630
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F000000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey Dates: 10/22, 10/23, 10/27, 10/28, 10/29/14</p> <p>Facility Number: 000245 Provider Number: 155354 AIM Number: 100290800</p> <p>Survey Team: Barbara Fowler RN TC Diane Hancock RN Diana Perry TN Denise Schwandner RN Anna Villain RN</p> <p>Census Bed Type: SNF/NF: 104 Total: 104</p> <p>Census Payor Type: Medicare: 9 Medicaid: 70 Other: 25 Total: 104</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on November</p>	F000000	<p>Preparation and or execution of this Plan of Correction general or anyother corrective action set forth herein, in particular, does not constitute an admission by Newburgh Healthcare of the facts alleged or the conslucions set forth in the Statement of Deficiencies. The Plan of Correction and specific corrective actions are prepared and / or excuted soley because of provisions of State and Federal Law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiencystatement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000280 SS=D	<p>6, 2014 by Jodi Meyer, RN</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to ensure the care plan was revised to include antipsychotic medications, for 1 of 5 residents reviewed for psychoactive medications, in that the resident was started on a medication that included Haldol (an antipsychotic medication) and the care plan was not revised. (Resident #47)</p> <p>Finding includes:</p> <p>Resident #47's clinical record was</p>	F000280	<p>Corrective Action The care plan for resident # 47 will be updated to include behavioral disturbances. Others Having the Potential to Be Affected All other residents receiving antipsychotic medication will have care plans reviewed to reflect the appropriate diagnosis for the medication received and updated as necessary. Measures / Systemic Changes Diagnosis for antipsychotic medications will be reviewed with the Unit managers. The MDS Coordinator will continue to care plan antipsychotic medications by reviewing physician's orders daily</p>	11/28/2014	

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	<p>reviewed on 10/27/14 at 9:30 a.m. The resident's diagnoses included, but were not limited to, paralysis agitans, urinary tract infection, chronic cystitis, edema, gastroesophageal reflux disease, pain, depression, dysphagia, hyperlipidemia, dementia without behavioral disturbance, anxiety state, hypertension, emphysema, constipation, psoriasis, osteoporosis, and dysphagia.</p> <p>The resident's physician's orders, dated 9/29/14, included, but were not limited to, an order for ABH gel [Ativan (antianxiety medication), Benadryl (antihistamine), Haldol (antipsychotic medication)] "Apply to forearm topically three times a day for anxiety." The medication was originally ordered on 9/19/14.</p> <p>The record indicated the physician had discontinued several oral medications on 9/10/14 due to the resident resisting taking them. The discontinued medications included, but were not limited to, an antidepressant (Lexapro) and a medication used for dementia/memory loss (Aricept).</p> <p>An interdisciplinary care team Care Conference Report, dated 9/23/14, included a nursing summary: "...She receives Ativan [antianxiety] Gel for</p>		<p>during business hours. The Social Service Director will review the physician's orders daily during business hours. The attending physician will be notified after the behavior has been monitored for at least 72 hours and reviewed by the interdisciplinary team.</p> <p>Monitoring The MDS Coordinator and the Social Services Director will monitor daily during business hours. Findings will be included in the quarterly Quality Assurance Performance Improvement meetings. This monitor will be ongoing</p>		

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	<p>Anxiety... The report also included a Social Service summary, "[Resident's name] does have the dx's [diagnoses] of anxiety state and depressive disorder. She also has the dx of dementia.."</p> <p>The resident had a care plan for anti-anxiety medications related to anxiety disorder/depression, dated 5/28/13. Interventions included, but were not limited to, the following: "Administer Lexapro (antidepressant) as ordered for depression Apply ABH gel as ordered. Note effectiveness Assess for any negative side effects and call MD... Monitor/document/report PRN [as needed] any adverse reactions to anti-anxiety therapy: drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgement, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Unexpected side effects: mania, hostility, rage, aggressive or impulsive behavior, hallucinations..."</p> <p>The care plan was not revised to include administration of an antipsychotic medication and the potential side effects for an antipsychotic medication.</p>			

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F000329 SS=D	<p>The care plan was reviewed with the Director of Nurses on 10/29/14 at 11:40 a.m. There was no indication the antipsychotic was included on the care plan.</p> <p>3.1-35(d)(2)(B)</p> <p>483.25(l) 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 observation, interview, and</p>	F000329	Corrective Action a. A complete IDT antipsychotic	11/28/2014	

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	<p>record review, the facility failed to ensure 2 of 5 residents were free of unnecessary medications, in that antipsychotic medications were given without adequate indications and/or without consideration of dose reduction in the absence of behaviors. (Resident #47, Resident #75)</p> <p>Findings include:</p> <p>1. Resident #47's clinical record was reviewed on 10/27/14 at 9:30 a.m. The resident's diagnoses included, but were not limited to, paralysis agitans, urinary tract infection, chronic cystitis, edema, gastroesophageal reflux disease, pain, depression, dysphagia, hyperlipidemia, dementia without behavioral disturbance, anxiety state, hypertension, emphysema, constipation, psoriasis, osteoporosis, and dysphagia.</p> <p>The resident's physician's orders, dated 9/29/14, included, but were not limited to, an order for ABH gel [Ativan (antianxiety medication), Benadryl (antihistamine), Haldol (antipsychotic medication)] "Apply to forearm topically three times a day for anxiety." The medication was originally ordered on 9/19/14.</p> <p>The record indicated the physician had</p>		<p>medication pharmacy review was completed on 11/6/14 for resident #47 and on 11/10/14 for resident #75 with the consultant pharmacist unit managers, and social services director. b. Pharmacy recommendation was given to resident #47's physician on 11/12/14 in which physician clarified the use of ABH gel . The IDT also recommended that the physician consider Ativan gel rather than using ABH gel, but physician declined this recommendation. c. When resident #75 was visited by her in-house physician on 10/29/14, physician wrote new orders for therapeutic gradual dose reduction of resident's Risperdal due to resident not having any recent agitation. Resident's Risperdal was then discontinued on 11/12/14. Others Having The Potential To be Affected a. A complete IDT antipsychotic medication pharmacy review of all residents presently on an anti-psychotic medication was completed by 11/10/14 with the consultant pharmacist, managers, and social services director. Measures/System Changes a. The facility use of Antipsychotic Medication Use policy has been revised to include observation and assessment of behaviors for at least 72 hours and reviewed by the Interdisciplinary team before and antipsychotic is considered. b. Licensed nurses have been in serviced and will be re in serviced</p>				

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	<p>discontinued several oral medications on 9/10/14 due to the resident resisting taking them. The discontinued medications included, but were not limited to, an antidepressant (Lexapro) and a medication used for dementia/memory loss (Aricept).</p> <p>Nursing documentation included, but was not limited to, the following: -a Behavior Monitor Sheet dated 9/18/14 at 1:24 p.m. Behaviors identified included the following: making loud disruptive noises resistant to care screaming/shouting/yelling threatening others</p> <p>The behavior occurred in hallway. Precipitating Factors indicated it was during ADLs and a staff member was involved. The time was 1:00 p.m. and behaviors occurred 2-3 times during the shift. Interventions: Allowed decision making, approached in a calm manner, called resident by name, do not argue or confront, established eye contact, reapproached after a few minutes, staff explained what they were going to do</p> <p>The behavior form indicated for each intervention checked, the staff must list</p>		<p>regarding changes to the policy. c. The Behavior monitoring tool will be updated to allow for ease in recording behaviors, interventions and outcomes. d. Licensed nurses will be in serviced regarding the changes to the policy. Monitoring a. Use of antipsychotic medications will continue to be monitored by the Social Service Director and Consultant Pharmacist on a quarterly basis or more frequently as needed. b. Nursing staff will continue to fill out behavior sheets and unit managers will review all completed sheets on a daily basis. c. Social services director to review all residents in which a behavior sheet was completed on a daily basis. d. The Director of Nursing will monitor 3 random residents who receive antipsychotic medication daily to ensure completion of the Behavior monitor for 3 months. e. Recommendations that are incomplete will be re submitted to the attending physician by the unit manager. f. This monitor is ongoing. A summary will be included in the Quarterly Assurance / Performance Improvement Committee Meeting minutes. Changes to the system will be identified and revised as necessary.</p>		

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	<p>the intervention and the outcome, whether the behavior decreased, increased, if the resident calmed or the behavior changed. None of the interventions and outcomes were listed.</p> <p>A brief summary of event indicated the following: "CNA began talking with resident to ask her to walk for some exercise. Res. began screaming at CNA "No! Don't do that!" as resident making the statement, raised her right hand, CNA backed away from resident. Stated it was ok, she did not have to."</p> <p>No behavior monitoring records were present from 6/11/14 until the one dated 9/18/14.</p> <p>A nursing progress note, dated 9/20/14 at 10:22 p.m., indicated, "Refused all PO (oral) meds at HS (bedtime). Did allow nurse to apply ABH (topical antianxiety, antipsychotic, and antihistamine) gel to wrist, but then grabbed nurse's arm and shook it repeatedly. Attempted to slap nurse X 4 when PO meds were offered, then took meds and slung them onto the floor. After staff cleaned meds off floor, resident became calm and quiet."</p> <p>A monthly nursing summary, dated 8/19/14, identified behaviors: anxious, apprehensive, uncooperative, and</p>			

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	<p>sociable.</p> <p>A monthly nursing summary, dated 9/26/14 at 1:47 p.m., indicated "Behavior" items checked were refuses to follow instructions, uncooperative, and sociable.</p> <p>Social Service documentation included, but was not limited to, the following: A Social Service quarterly assessment, dated 8/25/14 at 6:44 p.m., indicated the resident was having no behaviors. A Social Service assessment, dated 9/18/14 at 7:56 a.m., indicated the resident was having no behaviors.</p> <p>An interdisciplinary care team Care Conference Report, dated 9/23/14, included a nursing summary: "...She receives Ativan (antianxiety) Gel for Anxiety..." The report also included a Social Service summary, "[Resident's name] does have the dx's (diagnoses) of anxiety state and depressive disorder. She also has the dx of dementia.."</p> <p>Resident #47 had a care plan, dated 8/5/13, regarding having episodes of agitation in which she had become combative with staff or resistive to care due to confusion related to her diagnoses of dementia due to brain injury with anxiety. Interventions included, but were</p>			

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	<p>not limited to, the following: "All staff/caregivers are to call resident by her name, introduce self, explain procedures using one-step directions, allow ample time for resident to respond... Attempt care at a later time Attempt to coax but do not force (resident) to accept care Attempt to find alternatives that (resident) will except Attempt to modify (resident's) environment by: adjusting room temperature, reducing noise during ADL's by closing door, changing times of ADL's during less busy hours... Avoid commands using "don't" or "no"... Gently but firmly remind resident that this is not acceptable behavior whenever it occurs... If a particular staff member has a good relationship with (resident) ask them to attempt care. Medicate as ordered by MD. Monitor and record response..." Monitor any behaviors in (computer program) and notify resident's primary MD of behaviors worsen as appropriate. Observe (resident) for any non-verbal signs of agitation as appropriate Offer diversional activity (i.e. talking about birds outside her window) to redirect behavior as appropriate..."</p>			

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	<p>The resident had a care plan for anti-anxiety medications related to anxiety disorder/depression, dated 5/28/13. Interventions included, but were not limited to, the following: "Administer Lexapro (antidepressant) as ordered for depression Apply ABH gel as ordered. Note effectiveness Assess for any negative side effects and call MD... Monitor/document/report PRN (as needed) any adverse reactions to anti-anxiety therapy: drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgement, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Unexpected side effects: mania, hostility, rage, aggressive or impulsive behavior, hallucinations..."</p> <p>Resident #47 was observed at the following dates and times: 10/28/14 at 8:34 a.m., in bed asleep. 10/28/14 at 10:26 a.m., seated in wheelchair across from nurse's station, head down, eyes closed. 10/28/14 at 12:40 p.m., seated in w/c in dining room. Head down and eyes closed. 10/28/14 at 12:49 p.m., woke up and sat</p>			

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	<p>up when meal came. Would not eat anything though</p> <p>On 10/28/2014 at 10:49 a.m., the SW (Social Worker) reviewed the clinical records for Resident #47 regarding starting of ABH gel. She indicated she was unable to locate any information.</p> <p>RN #1 was interviewed on 10/28/2014 at 10:52 a.m. She indicated they were having trouble getting the resident to take medications. When she didn't take the medications, she became very aggressive. She indicated the resistance became hard to manage. The resident didn't want to go to the dining room to eat, didn't want to take medications. She indicated when they reported the behaviors to the physician, he ordered the ABH gel. She indicated any behaviors should have been documented in behavior notes or nurses' notes. Notes should also have documented interventions attempted and effectiveness.</p> <p>The policy and procedure for Antipsychotic Medication Use, dated 2001, revised 2007, included, but was not limited to, the following: "Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective."</p>			

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	<p>"Nursing staff will document in detail an individual's target symptoms." "The Attending Physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications." "The staff will observe, document, and report to the Attending Physician information regarding the effectiveness of any interventions, including antipsychotic medications." "Based on assessing the resident's symptoms and overall situation, the Physician will determine whether to continue, adjust, or stop existing antipsychotic medication." "Antipsychotic medications shall only be used for the following conditions/diagnoses as documented in the record...</p> <ul style="list-style-type: none"> a. Schizo-affective disorder; mood disorders... b. Depression with psychotic features, and treatment refractory major depression. c. Psychosis d. Brief psychotic disorder e. Schizophrenia f. Delusional disorder g. Schizophreniform disorder h. Atypical psychosis i. Dementing illnesses with associated behavioral symptoms 						

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	<p>j. Medical illnesses or delirium with manic or psychotic symptoms and/or treatment-related psychosis or mania..."</p> <p>"For enduring psychiatric conditions, antipsychotic medications will not be used unless behavioral symptoms are:</p> <p>a. Not due to a medical condition or problem...</p> <p>b. Persistent or likely to reoccur without continued treatment; and</p> <p>c. Not sufficiently relieved by non-pharmacological interventions; and</p> <p>d. Not due to environmental stressors...</p> <p>e. Not due to psychological stressors..."</p> <p>A pharmacy policy and procedure, dated 2006, included, but was not limited to, the following:</p> <p>"Antipsychotics. If a resident is admitted on an antipsychotic medication or the facility initiates antipsychotic therapy, the facility must attempt a GDR (Gradual Dose Reduction) in two separate quarters (with at least one month between attempts) within the first year, unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated."</p> <p>"A GDR is considered clinically contraindicated if:</p> <p>a. Target symptoms returned or worsened after the most recent attempt at a GDR and the physician documents the</p>			

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	<p>clinical rationale for why any additional attempted dose reductions would likely impair the resident's function, increase distressed behavior, or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. OR</p> <p>b. The continued use is in accordance with relevant current standard of practice and the physician documents the clinical rationale for why any additional attempted dose reductions would likely impair the resident's function, increase distressed behavior, or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder."</p> <p>2. The clinical record of Resident #75 was reviewed on 10/27/14 at 9:13 a.m. The record indicated the diagnoses of Resident #75 included, but were not limited to, history of fall, dysphagia, urinary obstruction, constipation, retention of urine, atherosclerosis, cardiomegaly, scoliosis, hyperlipidemia, anxiety, anemia, senile dementia, pain, persistent mental disorder, and essential hypertension.</p> <p>The most recent Quarterly MDS (Minimum Data Set Assessment), dated 9/10/14, indicated Resident #75 experienced severe cognitive impairment.</p> <p>A physician's order, dated 12/30/13,</p>			

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	<p>indicated a new order was obtained for, "Risperdal (an antipsychotic medication) 0.25 mg (milligram) po (by mouth) BID (twice a day) for mental disorder"</p> <p>Resident #75 continued to receive Risperdal as ordered without any behaviors exhibited per behavior tracking records and nurses notes from 12/30/13 to 10/29/14.</p> <p>The Consultant Pharmacist Recommendation, dated 8/28/14, indicated an attempt to decrease Risperdal to every day at 4:00 p.m. The doctor disagreed with the recommendation on 9/10/14 without explanation.</p> <p>An interview with LPN #5 on 10/28/14 at 10:11 a.m., indicated the resident was started on Risperdal for increased behaviors.</p> <p>An interview with the DON (Director of Nursing) on 10/29/14 at 11:55 a.m., indicated there was no further information regarding the antipsychotic medication use.</p> <p>Resident #75 was observed on 10/22/14 at 11:15 a.m. She was awake and slightly confused.</p>			

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F000332 SS=D	<p>Resident #75 was observed on 10/28/14 at 9:00 a.m. sitting in her wheel chair at the nurse's station and was awake and alert.</p> <p>3.1-48(a)(4) 3.1-48(b)(1) 3.1-48(b)(2)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the facility was free of medication error rates of five percent or greater, for 2 of 6 residents observed during medication administration, in that 2 errors were made out of 30 opportunities for error, resulting in an error rate of 6.66 percent. 2 of 6 licensed nurses observed made errors. (Resident #82, Resident #36)</p> <p>Findings include:</p> <p>1. On 10/27/14 at 9:32 a.m., LPN #1 was observed to administer medications to Resident #82. LPN #1 was observed to administer Miralax (a medication used to prevent constipation) powder diluted in a small cup of water.</p>	F000332	<p>Corrective Action</p> <p>Licensed nurses will be re – in serviced regarding insulin administration including the times of onset for the medication.</p> <p>Others Having the Potential to be Affected</p> <p>Residents that receive insulin and bulk laxatives have the potential to be affected.</p>	11/28/2014	

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	<p>On 10/27/14 at 9:38 a.m., LPN #1 was queried regarding the amount of water the cup she had diluted the Miralax in held. LPN #1 indicated the cup held 120 ml (milliliters) of water.</p> <p>On 10/28/14 at 7:54 a.m., Resident #82's electronic medication orders were reviewed. The orders indicated the Miralax should have been diluted in 8 ounces of water (240 ml).</p> <p>2. On 10/28/14 at 3:36 p.m., LPN #2 was observed to administer medications to Resident #36. LPN #2 was observed to inject 2 units of Novolog insulin (a medication used to treat diabetes). No food or snack was served with the insulin.</p> <p>On 10/29/14 at 8:21 a.m., LPN #3 indicated insulin's are given approximately 30 minutes prior to a meal.</p> <p>On 10/29/2014 at 8:32 a.m., Resident #36's electronic medication orders were reviewed. The orders indicated Novolog should be administered before meals.</p> <p>On 10/29/14 at 1:00 p.m., the scheduled meal times were reviewed. The schedule indicated the meals were to be served at</p>		<p>Measures / Systemic changes</p> <p>Licensed nurses will be re inserviced</p> <p>Larger medication cups will be purchased to ensure consistency.</p> <p>Monitoring</p> <p>This area will be monitored by a member of nursing administration 3 times a week daily for 3 months then monthly. A summary of the results will be included in the quarterly Quality Assurance Performance Improvement meeting.</p>				

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F000441 SS=D	<p>approximately 4:45 p.m., on Resident #36's unit.</p> <p>On 10/29/14 at 1:22 p.m., the DON (Director of Nursing) provided the "[Name of Pharmacy] Insulin Storage Recommendations", no date provided. The policy indicated, the Novolog Vial's onset was approximately 10-20 minutes.</p> <p>On 10/29/14 at 1:30 p.m., the DON provided the "Medication Administration-General Guidelines policy", dated 2006. The policy included, but was not limited to, "Medications are administered as prescribed...Medications are administered within (60 minutes) of scheduled time, except before or after meal orders, which are re-administered (based on mealtimes)."</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p> <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 -</p>			

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	<p>(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 maintain an infection control program, in that glucometer machines were not disinfected according to "Sani-Cloth" directions for 1 of 2 staff members observed disinfecting the glucometer machine. (LPN #4)</p> <p>Findings include:</p>	F000441	<p>Corrective Action</p> <p>The facility is unable to correct.</p> <p>Others Having the Potential to be Affected</p>	11/28/2014

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	<p>On 10/27/14 at 11:45 a.m., LPN #4 was observed to exit a resident room with a glucometer. LPN #4 indicated she was about to clean the machine. LPN #4 was observed to apply gloves and cleanse the machine for approximately 30 seconds with a "Sani-Cloth". LPN #4 was observed to wipe the glucometer machine off with a paper towel. LPN #4 was queried regarding the action and indicated because the wipes were very wet she used the paper towel to get the excess moisture off of the machine.</p> <p>On 10/27/14 at 11:51 a.m., LPN #1 was asked to explain the glucometer cleaning process. LPN #1 indicated she performed hand hygiene, applied gloves, laid out two pieces of paper towel, used a "Sani-Cloth" to cleanse the machine for approximately 5-10 seconds, and placed the machine on a dry paper towel for two minutes before it is used again.</p> <p>On 10/27/14 at 1:10 p.m., the Administrator provided the "Disinfection of Blood Glucose Monitoring Machine", dated 06/2010. The policy indicated, "...place clean meter on clean paper towel and allow to dry for 2 minutes or until completely dry..."</p> <p>3.1-18(b)(1)</p>		<p>Residents that required the use of the glucometer have the potential to be affected.</p> <p>Measures / Systemic Changes</p> <p>Licensed nurses will be re in serviced regarding the policy for disinfecting glucometers.</p> <p>Monitoring</p> <p>Disinfecting glucometers will be monitored 3 times a week for 3 months by the ADON and weekend supervisor. Then 2 times weekly indefinitely.</p> <p>A summary of this monitor will be included in the Quarterly Quality Assurance Performance Committee meeting minutes.</p>				

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F000465 SS=E	<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.</p> <p>Based on observation and interview, the facility failed to ensure a safe and sanitary environment, in that, rooms had cracked caulking around commodes, bathroom floors were dirty with debris buildup in the corners, personal items, bedpans, and urine collection containers were unlabeled, and large pieces of wood missing from doors. This occurred in 23 of 23 rooms, (Rooms 1, 3, 4, 8, 9, 14, 15, 19, 22, 27, 32, 33, 37, 40, 44, 46, 49, 51, 52, 55, 56, 59, and 60.)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During an observation on 10/22/14 at 3:45 p.m., Room 1's bathroom was observed to have dirty and cracked grout and caulking around the toilet. There were scuff marks on the wall. 2. During an observation on 10/23/14 at 8:44 a.m., Room 3 was observed to have dirt and debris buildup in the corners and edges of bathroom. 	F000465	<p>Corrective Action</p> <p>Personal care items have been bagged , labeled, removed or replaced and placed out of reach for rooms listed.</p> <p>All cracked caulking, wax build up, sink handles, drywall repair, and fan replacement</p> <p>will be corrected for the rooms listed.</p> <p>New doors have been ordered for the rooms listed on 11/18/14 with an estimated date of delivery of 4-6 weeks</p>	11/28/2014			

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	<p>3. During an observation on 10/23/14 at 8:40 a.m., Room 4 was observed to have dirt and debris buildup in corners of bathroom. There was also a black area on the tiles beside the commode.</p> <p>4. During an observation on 10/22/14 at 4:04 p.m., Room 8 was observed to have a container of Magic Butt Cream (a protective skin barrier) on the shelf in bathroom. There was also a jar of Vick's Vapo Rub on the bedside table.</p> <p>5. During an observation on 10/22/14 at 2:16 p.m., Room 9 was observed to have dirt and debris buildup in corner in the bathroom and a dirty brief in the bath tub.</p> <p>6. During an observation on 10/23/14 at 8:35 a.m., Room 14 was observed to have stained and cracked grout around the toilet.</p> <p>7. During an observation on 10/23/14 at 10:14 a.m., Room 15 was observed to have 2 (two) unlabeled bagged bedpans under the sink.</p> <p>8.. During an observation on 10/22/14 at 2:33 p.m., Room 19 was observed to have a denture cup with no lid or label, 2 fingernail clippers on the bathroom shelf with no labels, and a urine collection</p>		<p>Others Having the Potential to be Affected</p> <p>All residents who have personal care items have the potential to be affected.</p> <p>All resident rooms have the potential to be affected.</p> <p>Measures / Systemic Changes</p> <p>Nursing staff will be inserviced regarding storage and labeling of personal care items. The policy has been updated to include disposal of graduates after each use.</p> <p>Monitoring</p> <p>Monitoring will occur daily each shift by the nurse and each individual CNA for personal items in resident rooms. Nursing administration will monitor daily.</p> <p>Housekeeping and maintenance will monitor weekly for repairs.</p> <p>A summary of the findings will be included in the quarterly Quality Assurance Performance Improvement meeting minutes.</p>	

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	<p>container in the corner under the sink with no label.</p> <p>9. During an observation on 10/23/14 at 10:01 a.m., Room 22 was observed to have a travel mug on the back of the toilet, a hair pick, a container of mouthwash, fingernail clippers, 2 denture brushes, and a denture cup with no names on them. The drywall near the bed was chipped, and the entry door and bathroom door had large pieces of wood missing from them.</p> <p>10. During an observation on 10/23/14 at 8:20 a.m., Room 27 was observed to have gray buildup in bathroom floors and corners. The area around the toilet was stained dark brown.</p> <p>11. During an observation on 10/22/14 at 11:50 a.m., Room 32 was observed to have brown stool on the inside of toilet.</p> <p>12. During an observation on 10/22/14 at 11:56 a.m., Room 33 was observed to have a unlabeled wash basin in the tub.</p> <p>13. During an observation on 10/22/14 at 12:08 p.m., Room 37 was observed to have dirty floors in the bathroom corners around the edges. Pieces of wood were missing from the doors and there was scuff marks on the walls.</p>			

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	<p>14. During an observation on 10/22/14 at 11:09 a.m., Room 40 was observed to have dirty floors in bathroom corners and edges. There is also an electrical charging device for an electric shaver sitting on the sink plugged into the wall, there were no breaker switches on the plug in.</p> <p>15. During an observation on 10/22/14 at 3:26 p.m., Room 44 was observed to have a hairbrush and deodorant on the back of the commode with no name on them. The ceiling fan in the bathroom was extremely noisy. The caulking at the base of the toilet was dirty and cracked with dirt buildup in the corners of the bathroom. There was also loose wallpaper in corner of the bathroom.</p> <p>16. During an observation on 10/22/14 at 2:39 p.m., Room 46 was observed to have a pair of TED hose, a wash basin, a bedpan, and a collection container in the tub with no name on them. A coffee cup, a hairbrush, a bottle of lotion, and a tube of toothpaste were on a plastic cabinet in the bathroom unlabeled. The bathroom had cracked caulking around the base of the tub and commode. The bathroom sink had cracked caulking around the base.</p> <p>17. During an observation on 10/23/14 at 8:41 a.m., Room 49 was observed to</p>			

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	<p>have dirty caulking around the floor edges, the caulk around the commode was stained and cracked, and the bathroom sink handles had green lime buildup and were corroded.</p> <p>18. During an observation on 10/22/14 at 3:10 p.m., Room 51 was observed to have a wet brief in a rocking chair, caulking around the commode was cracked and stained, and the walls in the bathroom were stained.</p> <p>19. During an observation on 10/22/14 at 11:42 a.m., Room 52 was observed to have a bottle of shampoo, a container of bodywash, a cup, 3 (three) tubes of toothpaste, 2 toothbrush holders, an emesis basin, and a plastic cup containing a toothbrush in the bathroom unlabeled. The caulking around the sink was cracked and there was dirt in the corner of the bathroom sink.</p> <p>20. During an observation on 10/22/14 at 2:55 p.m., Room 55 was observed to have the anti-slip strips missing near the bed, the caulking around commode was cracked and stained, and the bathroom floors had grout and dirt debris in the corner.</p> <p>21. During an observation on 10/22/14 at 11:57 a.m., Room 56 was observed to</p>			

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	<p>have Listerine (mouthwash) on a bathroom shelf unlabeled, the commode had rust stains in the bottom, the bedroom door was scratched, and the bathroom floors had cracked caulking and dirty tiles.</p> <p>22. During an observation on 10/22/14 at 2:50 p.m., Room 59 was observed to have a bedside commode collection container in the bathroom with a dried substance on the interior. It was stored upside down in the corner of the bathroom.</p> <p>23. During an observation on 10/22/14 at 11:06 a.m., Room 60 was observed to have a live brown bug in the corner. The fan in the bathroom was very noisy.</p> <p>On 10/27/14 at 4:00 p.m., the Administrator was informed of an electrical charging device in Room 40 being plugged into the wall. The device was observed to be sitting on an indentation on the sink which had standing water in it. There was no breaker on the plug. The Administrator indicated the device would be removed from the water and the sink.</p> <p>On 10/28/14 between 11:00 a.m. and 1:00 p.m., the rooms were rechecked and all the above items were found to be</p>			

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NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630
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(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>unchanged except:</p> <p>24. In Room 40, the electrical charging device was removed.</p> <p>25. In Room 51, the wet brief was no longer in the rocking chair.</p> <p>26. In Room 60, the brown bug in the corner of the room was no longer there.</p> <p>On 10/29/2014 at 9:05 a.m., the Policy and Procedure Manual was received from the Housekeeping Supervisor. It indicated floors and bathrooms were cleaned in an efficient manner to support each resident's choice. The policy further indicated deep cleaning was done monthly for bathrooms from the top to the bottom, including the walls. The daily cleaning policy indicated floors in the resident rooms were dust mopped daily.</p> <p>During an interview on 10/29/2014 at 9:39 a.m., the Maintenance Supervisor indicated doors are scheduled to be replaced in January, 2015.</p> <p>During an interview on 10/29/2014 at 10:24 a.m., the ADON (Assistant Director of Nursing) indicated personal care items were not being labeled or bagged. The ADON further indicated personal care items should be placed in a</p>			

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	<p>resident's personal bag and labeled with their names. The ADON also indicated bedpans, urine collection pans, and washbasins should be bagged and labeled and not be stored in bath tubs.</p> <p>A policy was received on 10/29/2014 at 10:31 a.m., from the ADON for cleaning and disinfecting resident care items. The ADON indicated there was no policy specifically for labeling and bagging personal care items.</p> <p>3.1-19(f)</p>				