

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501
--	--

(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
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: August 14, 15, 19, 20, 21, 2013</p> <p>Facility Number: 000301 Provider Number: 155341 AIM Number: 100289090</p> <p>Survey Team: Martha Saull, RN TC Terri Walters, RN Dorothy Watts, RN</p> <p>Census Bed Type: SNF/NF: 61 Total: 61</p> <p>Census Payor Type: Medicare: 11 Medicaid: 38 Other: 12 Total: 61</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 27, 2013, by Jodi Meyer, RN</p>	F000000		
---------	---	---------	--	--

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: 155341	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501
--	--

(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: 155341		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2013	
NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501			
(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			
F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F000225	-Staff reeducated regarding	09/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2013	
NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501			
(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>review, the facility failed to report immediately an allegation of abuse to the state agency for 2 of 2 reported allegations of abuse to the state agency reviewed. Resident #44, Resident #3</p> <p>Findings include:</p> <p>1. A report entitled "Indiana State Department of Health Care Quality and Regulatory Commission Incident Report Form" (incident date 8/14/13), had been received and reviewed on 8/19/13 at 8:10 A.M.</p> <p>The report indicated, "...During our annual survey, Resident # 44 reported to surveyors that CNA #9 had been verbally abusive towards him..."</p> <p>The Administrator had been notified of the allegation on 8/14/13 at 2:45 P.M.</p> <p>During interview with the Administrator on 8/19/13 at 9:00 A.M., she indicated she had reported the allegation by email to the ISDH (Indiana State Department of Health) on 8/25/13 at 7:39 A.M.</p> <p>2. Another Indiana State Department of Health Care Quality and Regulatory</p>		<p>Abuse Reporting, Policy and Procedures. -Allegations of abuse will be reported to ISDH and other officials in accordance with State law immediately, without the assumption of a 24-hour window. - Administrator/Designee will review all reports of allegations of abuse daily (Monday thru Friday) x 2 weeks, 3 times a week x 2 weeks, then weekly for 4months, and then monthly x 6 months. Identified non-compliance will result in 1:1 re-education up to and including termination. Identified trends will be reviewed in QA monthly times 6 months and quarterly times 2 qtrs to determine further recommendations as needed.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2013	
NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501			
(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>Commission Incident Report (incident date 7/23/13 evening) had been received and reviewed on 8/21/13 at 8:55 A.M.</p> <p>The report indicated, "...CNAs #10 and CNA #11 reported that while they were providing care to Resident #3 , that she (Resident #3) began grabbing at their arms and scratching them with her nails. Resident #3's mother was present at this time and the CNAs are alleging that they witnessed Resident #3's mother slap Resident #3 across the face and reprimand her."</p> <p>On 8/21/13 at 8:55 A.M., the Administrator indicated she had reported the 7/23/13 allegation to the ISDH by email on 7/24/13 at 4:13 P.M.</p> <p>3. On 8/21/13 at 9:00 A.M., the Administrator was interviewed regarding not reporting to the state agency promptly the above allegations of abuse. She indicated she had thought she had a 24 hour time period to report to the state agency any allegation of abuse.</p> <p>3.1-28(c)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2013
---	--	--	--

NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501
--	--

(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: 155341		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2013	
NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501			
(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			
F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure the facility's abuse policy indicated the state agency was notified promptly of an allegation of abuse.</p> <p>Findings include:</p> <p>On 8/19/13 at 8:10 A.M., the facility's abuse policy (revised April 2013), entitled, "Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property" was reviewed.</p> <p>The policy included but was not limited to the following: "All allegations that meet the definition of abuse and substantiated violations will be reported to state agencies and to all other agencies including the local law enforcement, elder abuse agencies, and Adult Protective Services, as required..."</p> <p>On 8/21/13 at 9:00 A.M., the Administrator was interviewed</p>	F000226	<p>The policy, Clinical Administrative manual 1.1.1 Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and misappropriation of resident property, has been reviewed by the IDT, and deemed appropriate. -Allegations of abuse will be reported to ISDH and other officials in accordance with State law immediately, without the assumption of a 24-hour window. - Administrator/Designee will review all reports of allegations of abuse daily (Monday thru Friday) x 2 weeks, 3 times a week x 2 weeks, then weekly for 4months, and then monthly x 6 months. Identified non-compliance will result in 1:1 re-education up to and including termination. Identified trends will be reviewed in QA monthly times 6 months and quarterly times 2 qtrs to determine further recommendations as needed.</p>	09/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501
--	--

(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>regarding the facility's abuse policy. The Administrator was made aware the facility's abuse policy did not include the time period required for the state agency notification. The Administrator was made aware the state agency needed to be notified immediately if an allegation of abuse had been reported to the Administrator. The Administrator indicated she understood but thought she had 24 hours to report allegation to the Indiana State Department of Health (ISDH).</p> <p>3.1-28(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2013
NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501		
(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	
F000247 SS=D	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review, the facility failed to ensure residents were notified in advance of a room change and/or roommate change for 3 of 3 residents reviewed for admission, transfer and/or discharge. Resident #12, Resident #44 and Resident #72</p> <p>Findings include:</p> <p>On 8/21/13 at 2:30 P.M., the SSD (Social Service Director) was interviewed. She indicated if a resident changed rooms or got a new roommate, she would first have notified the resident and/or the POA (power of attorney). She indicated she "almost always tries to give then at least 2 - 3 days notice" prior to the change. She indicated she tried to document the information in the clinical record, usually in the social service notes. She indicated she started her current job last November and found out the facility did not have a form to document this information so she developed a form herself last week.</p>	F000247	<p>-Residents with a room change in the last four months will be evaluated to ensure appropriate transition. -1:1 re-education for SSD on documentation requirements will be performed. -Social Services will utilize room change notification form to document the notification of room change. Written explanation of the room or roommate change will be given to the resident prior to the room or roommate change. -Administrator will review room changes daily (Monday thru Friday) x 2 weeks, 3 times a week x 2 weeks, then weekly for 2 months, and then monthly x 3 months. Identified non-compliance will result in 1:1 re-education up to and including termination. Identified trends will be reviewed in QA monthly times 6 months and quarterly times 2 qtrs to determine further recommendations as needed.</p>	09/20/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2013	
NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501			
(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 8/21/13 at 3:10 P.M., the SSD was interviewed. She indicated the Resident #44 was alert and oriented. She indicated this resident got a new roommate last week. She indicated she did inform the resident prior to the new roommate being admitted. The SSD indicated there was no documentation in Resident #44's clinical record indicating he and/or family had been informed of receiving a new roommate.</p> <p>At the time, the SSD indicated Resident #72 was moved to another room approximately 3 - 4 months ago. The SSD indicated she had talked to the resident about this prior to the move, but did not document this. The SSD indicated there was no documentation of this resident being moved to another room. The SSD indicated the room change did not work out and the resident was not happy, so the resident was moved back to the same room she originated from. The SSD stated there was no documentation of the resident was moved back to her original room. The SSD indicated the resident was alert and oriented.</p> <p>At the time, the SSD indicated Resident #12, had a roommate</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2013
NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501		
(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>admitted to her room. The SSD indicated she always informed the resident prior to receiving a roommate. At the time, the SSD was unable to provide documentation Resident #12 had been informed of received a new roommate. The SSD indicated she was aware residents should have been informed at least 2 days prior to having gotten a new roommate and/or room change. She indicated she was unable to provide documentation of any of the above resident's room changes notification of resident and/or family of the change, and/or new roommate placement.</p> <p>On 8/21/13 at 3:45 P.M., the SSD provided the policy and procedure titled "Change in room/roommate assignment." The form was dated January 2011. The form included, but was not limited to, the following: "...Once a decision to change a resident room has been made, the center will promptly notify the resident and the resident legal representative or interested family member of the room change. Reasonable notice of the room or roommate change, including oral or written explanation of the reason for the change, will be given to the resident prior to the room or roommate change."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2013
NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501		
(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	
	3.1-3(v)(2)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2013	
NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501			
(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			
F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review the facility failed to ensure a resident received the treatment ordered by the physician for a stage 2 pressure ulcer for 1 of 3 residents who were reviewed for pressure ulcers. Resident #59</p> <p>Findings include:</p> <p>On 8/20/13 at 2:00 P.M., Resident #59's dressing change was observed. A white treatment foam pad was removed from the Stage 2 pressure ulcer located on the resident's right posterior calf. After cleaning the pressure ulcer, RN #4 replaced the dressing on the pressure ulcer with a gray foam pad. The package in which the gray foam pad was removed by RN #4 was labeled as Mepilex AG (antibacterial foam dressing where</p>	F000314	<p>-Resident #59 was assessed with no ill effects noted. Appropriate dressing was applied. -A one time audit of current in-house residents with pressure areas has been completed to ensure appropriate dressings were in place. -Licensed Nursing Staff re-educated on providing treatments per physician's orders. -DON/Designee will monitor 50% of pressure dressings daily (Mon-Fri) x 2 weeks to ensure appropriate treatments are in place, 3 times per week for 2 weeks, weekly for 4 weeks and monthly times 10 months. Identified non-compliance will result in 1:1 re-education up to and including termination. Identified trends will be reviewed in QA monthly times 6 months and quarterly times two quarters to determine further recommendations as needed.</p>	09/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2013	
NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501			
(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>silver has been added).</p> <p>During an interview with RN #4 on 8/20/13 at 2:10 P.M., RN #4 indicated the treatment foam pad she had removed from Resident #59's leg looked different from the type of foam pad which was ordered by the physician and documented in the Medication Administration Record (MAR) and the treatment book. RN #4 indicated the order in the treatment book was for Mepilex AG foam pad to be applied to the posterior calf. RN #4 indicated Mepilex AG was a gray foam pad. RN #4 indicated she was confused by the white foam pad on Resident #59's leg and that she would need to talk with the Director of Nursing about the discrepancy.</p> <p>During an interview with the Director of Nursing (DON) on 8/20/13 at 3:20 P.M., the DON indicated she had called the Wound Care Clinic to learn and confirm which type of dressing was ordered for Resident #59's right posterior calf. The Wound Care Clinic faxed the current physician's order, and the DON indicated the MAR did not reflect the correct physician's order. The DON indicated Resident #59's orders were changed on 8/12/13 from Mepilex AG Foam</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2013	
NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501			
(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>(antibacterial foam dressing where silver has been added) to Mepilex (absorbent soft silicone foam dressing used to absorb drainage). The DON indicated that when Resident #59 returned from the Wound Care Clinic on 8/12/13, the nurse who was working at that time should have discontinued the old order for Mepilex AG and written the new order for Mepilex in the MAR and the treatment book.</p> <p>The clinical record for Resident #59 was reviewed on 8/20/13 at 3:30 P.M. The record indicated the diagnoses of Resident #59 included, but were not limited to, diabetes mellitus, renal insufficiency, depression, hypertension, atrial fib and peripheral artery disease.</p> <p>The physician's orders dated 8/12/13 read as follows: "...Dsg - Right Posterier calf Mepilex, change every 3 days..."</p> <p>The Medication Administration Record and treatment sheet for Resident #59 dated 8/13 read as follows: "right posterior calf ulcer Meplx AG -change every 3 days..."</p> <p>During an interview with RN #3 on 8/20/13 at 4:10 P.M., RN #3 indicated</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501
--	--

(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>she did not check the MAR to review the order. RN #3 indicated she just replaced the original dressing with the dressing sent back with the resident from the Wound Care Clinic.</p> <p>The facility's policy and procedure for Physician's Orders was reviewed on 8/20/13 at 5:30 P.M., and the order read as follows: "10. Discontinue the original physician's order when the physician changes an order that is currently in place."</p> <p>3.1-40(a)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2013	
NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501			
(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			
F000323 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. Based on observation, record review and interview, the facility failed to ensure comfortable and/or safe water temperatures were maintained for 4 of 4 confused and independently ambulatory residents on 1 of 3 units, in a total census of 61. Resident # 88 (room 135), Resident #89 (room 135), Resident #90 (room 132), Resident #91 (room 133).</p> <p>Findings include:</p> <p>On 8/14/13 at 11:55 A.M., the water temperatures were observed to be checked in the resident bathrooms by the Maintenance Man (MM), who used the facility provided thermometer. Water temperatures were checked in random resident bathrooms located on the "back" hall. Following are the temperatures obtained: Room #135: 123 degrees F (Fahrenheit); Room #138 and #137 shared a bathroom: 126.4 F Room #130 and #132 shared a</p>	F000323	<p>-Water heater was adjusted immediately and the temperature of the water was tested to ensure that the water temperature was at a safe and comfortable level. -Re-education of maintaining water temperatures at accepted levels daily and monitoring temps in early am to ensure water temps are at appropriate levels was performed. -Water was tested in the bathrooms of residents and found to be within safe temperature range. -Water temperature will be tested 3x per day for the next 30 days and 1x per day thereafter. -Administrator/Designee will review the water temperature log daily (Monday thru Friday) x 2 weeks, 3 times a week x 2 weeks, then weekly for 4 months, and then monthly x 6 months. Identified non-compliance will result in 1:1 re-education up to and including termination. Identified trends will be reviewed in QA monthly times 6 months and quarterly times two quarters to determine further recommendations as needed.</p>	09/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501
--	--

(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>bathroom: 126.2 F Room #131 and #133 shared a bathroom: 126.5 F Room #139: 126 F Shower room (available to all residents) on the back hall: 126.4 F.</p> <p>On 8/14/13 at 12:10 P.M., the MM was interviewed. He indicated he likes to keep the water temperatures approximately 110 F. He indicated he randomly checks water temperatures in resident rooms and shower room daily and he had not yet checked them today. The MM indicated at the time, all the above rooms utilized the same water heater.</p> <p>On 8/14/13 at 12:15 P.M., the water temperatures on the remaining two halls in the facility, the "front" hall and the "skilled" hall were also checked by the MM, with the facility thermometer used. The temperatures in the resident bathrooms and shower rooms on these units ranged from 101.2 F - 109.6 F.</p> <p>On 8/14/13 at 12:21 P.M., the MM was interviewed. He indicated he likes to keep the water temperatures "around 110 F." The MM indicated there were 3 separate water heaters, one for each hall. At the time, the water heater for the "back hall" was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2013
NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501		
(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>observed. At the time, the MM read the temperature set on the mixing valve for the water heater as 127 F. At the time, the MM then turned down the temperature setting to the water heater at 120 F.</p> <p>On 8/14/13 at 12:55 P.M., the MM provided copies of his water temperature logs for July and August 2013. These logs indicated to "check a different room/area daily and log actual temperature...and room...temperature not to exceed 110 degrees."</p> <p>On 8/14/13 at 1:50 P.M., the MM was interviewed. He indicated he rechecked the water temperatures in room #132 and #131 and both were 115 F or below.</p> <p>On 8/14/13 at 5:15 P.M., the MM provided a current copy of the policy and procedure for "Thirty-Day Maintenance Summary." This policy was dated 11/1/1997. The form included, but was not limited to, the following: "...daily checks: domestic water temperature check..."</p> <p>On 8/21/13 at 2 P.M., the MM was interviewed. He indicated he was now checking the water temperatures three times a day on each unit.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501
--	--

(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
	3.1-19(r)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2013	
NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501			
(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			
F000431 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 ensure medication refrigerator temperatures were maintained within</p>	F000431	-Medications in refrigerator on front hall nurses station and unlabeled medication in station 1 med cart were destroyed immediately. Medication cart on	09/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2013	
NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501			
(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>acceptable ranges for medications contained in the unit and/or expired medications were discarded and/or medications were appropriately labeled and/or medication carts were maintained in a clean manner and/or medications were not left unattended for 2 of 3 nursing units.</p> <p>Findings include:</p> <p>1. On 8/21/13 at 10:30 A.M., the medication room on the "front" unit was observed. LPN #1 read the temperature from thermometer in the medication refrigerator as 34 F (Fahrenheit). On the front of the refrigerator was a form titled "Refrigerator Temp (temperature) log." The form was dated August 2013. Daily temperatures were logged to date with the temperatures ranging from 30 F to 36 F. Eighteen of the twenty one days of logged temperatures were below 36 F.</p> <p>On 8/21/13 at 12:52 P.M., the medication room on the front unit was toured with the DON (Director of Nursing). At the time, the following contents of the medication refrigerator were observed:</p> <p>A. One unopened vial of Fluzone (flu vaccine) with expiration date of</p>		<p>station 1 was immediately cleaned. No ill effects noted. -A one time 100% observational review of refrigerated medications in facility was completed to ensure that they were being stored at the appropriate temperature per policy and procedure. A one time 100% medication cart audit was done to ensure all other med carts in the facility were clean and contained labeled, unexpired medication. -Licensed nurses will be reeducated regarding policy and procedure of expired medications, refrigerator temperatures, leaving meds unattended and cleanliness of medication carts. -DON/Designee will monitor temperature log and medication carts daily (Monday thru Friday) x 2 weeks, 3 times a week x 2 weeks, then weekly for 4 months, and then monthly x 6 months. Identified non-compliance will result in 1:1 re-education up to and including termination. Identified trends will be reviewed in QA monthly times 6 months and quarterly for two quarters to determine further recommendations as needed.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501
--	--

(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>5/2013. At this time, the DON indicated this should not be in the refrigerator and disposed of the expired medication.</p> <p>B. Megace suspension. Full 50 cc bottle, unopened. No date was observed on the pharmacy label and/or no date able to be viewed with the bottle label covered by the pharmacy label. The DON indicated at this time, the bottle of medication should have a date (expiration and/or received)and it did not.</p> <p>C. Four prefilled syringes of Hepatitis B vaccine</p> <p>D. An empty vial of TB solution, Aplisol, dated as opened 7/14/13. The DON indicated the empty vial should not be in the refrigerator.</p> <p>E. One unopened vial of pneumovac, with expiration date of 4/12/14.</p> <p>F. One dose pack of Risperdal injectables, 25 mg, (unopened), with an expiration date of 7/2015.</p> <p>G. Five unopened vials of insulin: Novolog, lantus and Humalog.</p> <p>2. On 8/21/13 at 1 P.M., the DON was interviewed. She indicated the night shift nurses are responsible for checking the medication refrigerator temperatures. She indicated if the nurses find the refrigerator temperatures are out of the desired range, they would readjust the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2013	
NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501			
(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>temperature dial in the refrigerator and then recheck the temperature. At that time, the temperature log was reviewed on the refrigerator. Documentation was lacking of temperatures being readjusted and/or rechecked.</p> <p>On 8/21/13 at 1:20 P.M., the DON was interviewed. She indicated she would throw all the medications out of the front unit medication refrigerator and would reorder them. She indicated at the time, that all meds should be labeled with the name and a date of receipt and/or medication opened. DON stated that they don't have a policy for cart cleaning and that night shift was supposed to clean the carts. She stated night shift was to monitor the refrigerator temperatures (temps), adjust as necessary and check for outdated medications. The DON indicated she thought the accepted temperature range was was 36 - 46 degrees F but she would check the policy.</p> <p>3. On 8/21/13 at 1:30 P.M., the medication cart on the front hall was observed with LPN #1. The top of the medication (med) cart on unit was observed to have a crushed powder type residue on the flat surface of the cart, along the edge which was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501
--	--

(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>positioned towards the hall. LPN #1 opened each drawer of the cart. All of the drawers were observed to have a combination of the following: scattered papers remnants, dried spills and splatters of various colors. The bottom drawer of the cart, which housed the multiple use liquid containers, was observed to have large dried areas of spills on the bottom and sides of the interior of the drawer as well as the sides of the medication bottles. The sides of the pill crusher, which was sitting on the top of the cart, was observed with dried spills and crushed pill dust residue. The lip/handle of the closed plastic container, which housed spoons, was observed to have had a tanish residue buildup. In the second drawer from the top, a medication container, with a product label of "Symbicort" was observed. The medication was observed to have no label and/or bag and/or sticker which identified who the medication was for. The side of the cart, which housed the med cups, had paper clips and paper remnants as well as crumbs observed .</p> <p>On 8/21/13 at 1:50 P.M., the DON was interviewed. She indicated the desired temperature for insulins was 36 - 46 F. She indicated, "at least for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2013	
NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501			
(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 insulin the temperature was wrong in the medication refrigerator. She also indicated they found the box for the medication, Symbicort, but it wasn't with the actual medication. The DON also indicated the temperatures in the medication refrigerator were checked once a day and the pharmacy comes once a month to check for expiration dates of meds (medications). The DON indicated at that time, there was no policy to address who and how often the refrigerator was to be checked and also who checks for expired medications.</p> <p>4. On 8/21/13 at 2 P.M., the DON was interviewed. She indicated medications should never be left unattended. At the time, the DON was made aware of the following observation on 8/14/13 at 4:30 P.M.: LPN #2 was observed standing at the medication cart on the front hall/skilled hall intersection. A medication cup with two pills was observed sitting on the corner of the top of the cart. LPN #2 was observed to leave the cart and walk over to the back hall unit, while not being in view of the cart and/or pills. She returned under a minute later. At the time, LPN #2 was interviewed. She indicated she did leave the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2013
NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501		
(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 unattended on top of the cart but usually never does this. She indicated the two pills were Gabapentin (anticonvulsant) 300 mg each. LPN #2 indicated when she poured this pills out of the multi dose container, two extra pills had come out in the medication cup and she was going to dispose of them. At the time, she disposed of the pills in the sharps container at the med cart.</p> <p>The DON indicated at the time, medications should never be left unattended.</p> <p>5. On 8/21/13 at 4:05 P.M., the DON provided "Recommended Minimum Medication Storage Parameters." The form was last updated on 3/27/12. The form indicated the following temperatures: Aplisol injection (store at 36 - 46 F); influenza vaccine (store in refrigerator, no range identified); insulin vials (36 F - 46 F). The form also indicated for Symbicort inhaler was to be dated after the inhaler was opened from the foil pouch and discarded 3 months after opened.</p> <p>The CDC (Centers for Disease Control) website www.cdc.gov/flu was referenced on 8/22/13 at 9:25 A.M. The website indicated flu vaccines</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501
--	--

(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>should be stored between 35 F and 46 F and should not be frozen.</p> <p>3.1-25(m)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2013	
NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501			
(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			
F000441 SS=E	<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>	F000441	-Resident #59's room was disinfected with 1:10 bleach/water	09/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2013	
NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501			
(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 a resident's isolation room/and or foodservice carts were cleaned with anti- bacteriacidal solution that was effective in killing Clostridium difficile (C. diff.) Resident #27</p> <p>Findings include:</p> <p>1. During an observation of Resident #59 on 9/19/13 at 1:10 P.M., Resident #59 was observed sitting on her bed with the bedside table positioned across her lap. Resident #59's meal tray was sitting on the bedside table. After CNA #4 finished assisting Resident #59 with her meal, CNA #4 took Resident #59's tray and placed it inside the food cart.</p> <p>During an interview with CNA #4 on 8/19/13 at 1:10 P.M., CNA #4 indicated that Resident #59 was determined to be positive for Clostridium Difficile (C-Diff). CNA #4 indicated Resident #59 gets a tray in her room for all meals</p> <p>2. During an interview with House Keeper 1 (HK1) on 8/21/13 at 10:15A.M., HK1 indicated she used QUAT H5 to clean the floors of isolation rooms. HK1 indicated this was the same product she used on all the residents' floors.</p>		<p>solution and then followed by recommended germicide solution. -Housekeeping staff re-educated on policy for cleaning an isolation room. -In rooms in which a patient is found to be positive for C-Diff, horizontal surfaces in the patient room will be disinfected with bleach solution containing 1 part Clorox Ultra bleach to 10 parts water. The cleaning will then be followed with recommended germicide solution (U-1 Plus mixed with 1 Gallon of water). -Housekeeping Manager /Designee will review the cleaning of an isolation room daily (Monday thru Friday) x 2 weeks, 3 times a week x 2 weeks, then weekly for 4 months, and then monthly x 6 months. Identified non-compliance will result in 1:1 re-education up to and including termination. Identified trends will be reviewed in QA monthly times 6 months and quarterly times two quarters to determine further recommendations as needed.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2013	
NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501			
(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>During an interview with the Housekeeping Manager (HKM) on 8/21/13 at 10:30A.M., the HKM indicated that the cleaning staff cleaned all residents' rooms with Quat H5 daily including isolation rooms. She also indicated the floor were cleaned with bleach once a month.</p> <p>Review of the facility's "Cleaning Procedure for Clostridium Difficile (C-Diff)" on 8/21/13 at 1:56 P.M., read as follows: "...All surfaces, particularly horizontal surfaces, in the patient room will be disinfected twice (2 x's). The first cleaning will be with CDC/STATE recommended bleach solution (1 part Clorox Ultra, 10 parts water)..."</p> <p>During an interview with a representative from 3M corporation (Manufacturer of 3M Quat Disinfectant Cleaner Concentrate H5) on 8/21/13 at 11:03 A.M., the representative indicated this product did not kill Clostridium difficile (c-diff).</p> <p>During an interview with the Housekeeping Manager (HKM) on 8/21/13 at 12:29 P.M., the HKM indicated that the housekeeping staff should be using bleach in the mop</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501
--	--

(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>water when cleaning the floors in isolation rooms.</p> <p>3. On 8/20/13 at 10:05 A.M., the Food Service Manager (FSM) was interviewed regarding the cleaning of all dietary food carts (enclosed dietary carts, open shelve dietary carts, and snack carts). She indicated all dietary carts were cleaned (wiped out) after each meal with the sanitizing solution (Quat). She also indicated once a week the carts were taken to the dishwasher area and cleaned with "soap and water".</p> <p>On 8/21/13 at 11:58 A.M., the FSM provided a copy of the label of the Oasis146 Multi-Quat sanitizer that the dietary department used for cleaning all kitchen carts. The label included but was not limited to: "... Oasis 146 Multi -Quat Sanitizer is an effective sanitizer against Eschericha coli, Staphyloccus aureus on food contact surfaces, Camplobacter jejuni, Klebsiella pneumoniae, Listeria monocytogenes, Salmonella enterica, Shigella sonnei, Yersinia enterocolitca and Enterobacter sakazakii..." The FSM was made aware that documentation was lacking to indicate Oasis 146 Multi-Quat sanitizer would be effective against Clostridium Difficile (C.Diff).</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501
--	--

(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 8/21/13 at 2:15 P.M., the Administrator was made aware of Quat used in dietary department would not be effective against C. Diff. The Administrator indicated at that time the facility would start using bleach for cleaning carts.</p> <p>3.1-18(b)(1) 3.1-18(j)</p>			