

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155758	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ASBURY TOWERS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 102 W POPLAR ST GREENCASTLE, IN 46135
--	---

(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 the Investigation of Complaint IN00148728.</p> <p>Complaint IN00148728 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiency is cited.</p> <p>Survey dates: May 12, 13, 2014</p> <p>Facility number: 001120 Provider number: 155758 AIM number: 200525120</p> <p>Survey team: Connie Landman RN-TC</p> <p>Census bed type: SNF: 18 SNF/NF: 23 Residential: 51 Total: 92</p> <p>Census payor type: Medicare: 7 Medicaid: 35 Other: 50 Total: 92</p> <p>Sample: 3</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: 155758	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ASBURY TOWERS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 102 W POPLAR ST GREENCASTLE, IN 46135
--	---

(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
F000157 SS=D	<p>This deficiency also reflects state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed 05/16/14 by Brenda Marshall, RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155758	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ASBURY TOWERS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 102 W POPLAR ST GREENCASTLE, IN 46135
--	---

(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 resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified when a resident had a change in condition for 1 of 3 residents reviewed for physician notification in a sample of 3 (Resident B).</p> <p>Findings include:</p> <p>The record for Resident B was reviewed on 5/12/14 at 1:15 p.m. His diagnoses included, but were not limited to, chronic urinary tract infection, dementia, congestive heart failure, hypertension, peripheral vascular disease, coronary artery disease, and gastroesophageal reflux.</p> <p>A FAX order request, written by LPN #1 on 03/11/14, and provided by the Medical Records Director on 5/12/14 at 3:20 p.m., indicated, "We [sic] we have order to check urine for UTI? Res [Resident] has altered mental status." The record lacked documentation to indicate the physician was notified of Resident B's change in mental status and a request for urinalysis until 3/14/14.</p> <p>During an interview with Resident B's family member on 5/12/14 at 12:40 p.m., she indicated she informed a nurse on</p>	F000157	F 0157 SS=D The facility corrected the deficiency by notifying the resident's physician of the lab results and the physician ordered an antibiotic for the resident. LPN #1 was promptly in-serviced on the physician notification procedure by the Director of Nursing. No other resident was harmed by this deficient practice. On 05/23/14 an in-service was held covering HIPAA, Abuse and the Physician Notification policy and procedures. See Exhibit A & B The appropriate procedure is as follows: The nurse documents a resident's change in condition in the medical record and notifies the family/physician. The change in condition is documented on the 24 hour shift report. The Director of Nursing/designee reviews the 24 hour report and MD orders daily (Mon-Fri) for follow-up. The nurse on call is notified of resident change in condition 7 days per week (including weekends). The Director of Nursing/designee is responsible for monitoring facility practice of physician notification of resident change in condition. Monitoring is ongoing by the Director of Nursing/designee. She reviews the MD orders and the 24 hour report daily (Mon-Fri) for follow-up. Non-compliance with facility policy may result in staff re-education and/or disciplinary	05/28/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155758		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/13/2014	
NAME OF PROVIDER OR SUPPLIER ASBURY TOWERS HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 102 W POPLAR ST GREENCASTLE, IN 46135			
(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>3/11/14 she thought Resident B was getting a urinary tract infection (UTI) because he was leaning and had a mental change. The family member indicated she was concerned because a urine specimen was not sent to the lab (laboratory) until 4 days after she informed the nurse of Resident B's symptoms.</p> <p>During an interview with LPN #1 on 5/12/14 at 1:15 p.m., she indicated Resident B's physician did not have an office or a way to receive a FAX (facsimile copy). LPN #1 indicated the facility placed documents in a folder for the physician to review during his next visit to the facility. LPN #1 indicated she wrote a FAX request for Resident B's physician as soon as his daughter brought her concern to the nurse's attention and had placed it in his folder. LPN #1 indicated Resident B's physician came to the facility on 3/15/14, and after a conversation with Resident B's family member, ordered an antibiotic.</p> <p>During an interview on 5/13/14 at 9:35 a.m., the Medical Records Director indicated she saw the request for the urinalysis for Resident B in the physician's folder when she returned to work, after 4 days off, on 3/14/14. She indicated she saw the request from 3 days</p>		action up to and including termination. Completed 05/28/14				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155758	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/13/2014
NAME OF PROVIDER OR SUPPLIER ASBURY TOWERS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 102 W POPLAR ST GREENCASTLE, IN 46135		
(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>prior and a physician's order for urinalysis and culture and sensitivity due to an altered mental status was obtained. The Medical Records Director indicated when nurses needed to notify a doctor of a change in resident's condition or request an order, a FAX was sent to the physician's office. She indicated one physician did not have an office and indicated documents were placed in a folder for him to review when he visited the facility.</p> <p>During an interview with the DON (Director of Nursing) on 5/13/14 at 12:40 p.m., she indicated she expected the nurses to call the physician "right away" when there was a change in mental status and/or need for laboratory testing.</p> <p>A current facility policy, undated, titled "Guidelines For Physician Notification For Change in Condition Overview" was provided by the DON on 5/13/14 at 9:30 a.m. The policy indicated: "2. Medical care problems are communicated to the attending physician in a timely, concise, and thorough manner.... A. Symptoms Warranting Prompt Notification... 1. b. A marked change (i.e. much more severe) in relation to usual complaints or evidence of distress...</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155758	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/13/2014
NAME OF PROVIDER OR SUPPLIER ASBURY TOWERS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 102 W POPLAR ST GREENCASTLE, IN 46135		
(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	
	2. Specific examples of <u>new onset</u> symptoms (not meant to be all inclusive): ...Recurrent UTI..." 3.1-5(a)(2)				