

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  10/20/2014
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NAME OF PROVIDER OR SUPPLIER  EASTGATE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: October 14, 15, 16, 17, 20, 2014</p> <p>Facility Number: 000301 Provider Number: 155341 AIM Number: 100289090</p> <p>Survey Team: Dorothy Watts, RN-TC Terri Walters, RN Amy Wininger, RN Sylvia Scales, RN (10/15, 10/16, 10/17, 10/20, 2014)</p> <p>Census Bed Type: SNF/NF: 55 Total: 55</p> <p>Census Payor Type: Medicare: 7 Medicaid: 41 Other: 7 Total: 55</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2-3.1</p> <p>Quality review completed on October 24,</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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F000225 SS=D	<p>2014 by Jodi Meyer, RN</p> <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</p>			

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	<p>verified appropriate corrective action must be taken.</p> <p>Based on observation, interview, and record review, the facility failed to ensure an allegation of abuse was reported immediately to the Health Facilities Administrator, in that, the use of profanity in a resident care hallway, witnessed by two staff members, was not immediately reported to the Health Facilities Administrator for 1 of 1 observations that met the criteria for review of verbal abuse. (NA #8, CNA #7, and Housekeeping Supervisor #1)</p> <p>Findings include:</p> <p>During a random observation on 10/15/14 at 8:50 A.M., the HS (Housekeeping Supervisor) #1, NA (Nursing Assistant) #8, and CNA #7 were observed standing in the hallway near the nursing station. At that time, NA #8 loudly stated, "...She is not going to f----- talk to me like that!" No residents were observed in the hallway.</p> <p>During an interview on 10/15/14 at 9:05 A.M., the HFA (Health Facilities Administrator) indicated she was not aware of staff using profanity in the hallway. The HFA was notified, at that time, a staff member was heard using profanity in the hallway and indicated an</p>	F000225	<p><b><i>"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."</i></b></p> <p>-Staff reeducated regarding Abuse Reporting, Policy and Procedures. -Allegations of abuse will be reported to ISDH and other officials in accordance with State law immediately - Administrator/Designee will review 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>	11/10/2014

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	<p>investigation would be started immediately. The HFA further indicated, staff should report the use of profanity in the hallway to her immediately.</p> <p>An Indiana State Department of Health Incident Report Form dated 10/15/14 indicated, "...It was reported to the Administrator by a State Surveyor that she heard a male voice using profanity in the hallway...Investigation showed that a staff member expressed in a loud manner to another CNA, 'She can't f (inappropriate word) talk to me that way' in reference to the nurse on the unit...Two witnesses heard the statement..."</p> <p>During an interview on 10/17/14 at 9:00 A.M., CNA #7 indicated the HFA should be notified immediately of a staff member using profanity.</p> <p>During an interview on 10/20/14 at 8:45 A.M., the HS#1 indicated the HFA should be notified immediately of a staff member using profanity.</p> <p>The Abuse Prevention Policy provided by the HFA on 10/15/14 at 3:30 P.M., indicated, "...Verbal abuse is oral...includes disparaging and derogatory terms...Reporting 2. Report the incident immediately to the Administrator..."</p>						

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F000226 SS=D	<p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review, the facility failed to ensure the abuse policy was implemented, in that, the use of profanity in a resident care hallway, witnessed by two staff members, was not immediately reported to the Health Facilities Administrator for 1 of 1 observation that met the criteria for review of verbal abuse. (NA #8, CNA #7, and Housekeeping Supervisor #1)</p> <p>Findings include:</p> <p>During a random observation on 10/15/14 at 8:50 A.M., the HS (Housekeeping Supervisor) #1, NA (Nursing Assistant) #8, and CNA #7 were observed standing in the hallway near the nursing station. At that time, NA #8 loudly stated, "...She is not going to f----- talk to me like that!"</p> <p>During an interview on 10/15/14 at 9:05 A.M., the HFA (Health Facilities</p>	F000226	<p>-Staff reeducated regarding 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 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>	11/10/2014			

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	<p>Administrator) indicated she was not aware of staff using profanity in the hallway. The HFA was notified, at that time, a staff member was heard using profanity in the hallway and indicated an investigation would be started immediately. The HFA further indicated, staff should report the use of profanity in the hallway to her immediately.</p> <p>An Indiana State Department of Health Incident Report Form dated 10/15/14 indicated, "...It was reported to the Administrator by a State Surveyor that she heard a male voice using profanity in the hallway...Investigation showed that a staff member expressed in a loud manner to another CNA, 'She can't f(inappropriate word) talk to me that way' in reference to the nurse on the unit...Two witnesses heard the statement..."</p> <p>During an interview on 10/17/14 at 9:00 A.M., CNA #7 indicated the HFA should be notified immediately of a staff member using profanity.</p> <p>During an interview on 10/20/14 at 8:45 A.M. the HS#1 indicated the HFA should be notified immediately of a staff member using profanity.</p> <p>The Abuse Prevention Policy provided by the HFA on 10/15/14 at 3:30 P.M.,</p>			

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F000282 SS=D	<p>indicated, "...Verbal abuse is oral...includes disparaging and derogatory terms...Reporting 2. Report the incident immediately to the Administrator..."</p> <p>3.1-28(c)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure a transdermal drug patch was rotated from site to site when administered to prevent the same site administration for a 14 day administration period for 1 of 1 resident reviewed who had a physician's order for a daily transdermal patch. Resident #12</p> <p>Findings include:</p> <p>On 10/16/14 at 2:43 P.M., Resident #12's clinical record was reviewed. Her diagnoses included but were not limited to, depression, insomnia, and anxiety.</p> <p>Her current October 2014 physician's orders included but, were not limited to, "Exelon 9.5 MG/24 HR Patch..." ... APPLY 1 PATCH TOPICALLY ONCE</p>	F000282	<p>-Resident #12 was assessed and no ill effects noted. A one time review of current in-house residents with exelon patches were identified to ensure proper placement.</p> <p>-Licensed nursing staff reeducated regarding applying exelon patches per manufacturer's guidelines.</p> <p>-DON/Designee will monitor MAR 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>	11/10/2014	

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	<p>A DAY * DO NOT USE SAME AREA FOR 2 WKS (WEEKS) FOR DEMENTIA..."</p> <p>On 10/17/14 at 9:15 A.M., the October 2014 Medication Administration Record (MAR) for Resident #12 was reviewed with the Director of Nursing (DON). The MAR included but was not limited to, "... EXELON 9.5 MG/HR PATCH..." "...APPLY 1 PATCH TOPICALLY ONCE A DAY * DO NOT USE SAME AREA FOR 2 WKS FOR DEMENTIA..." Documentation included a blank box entitled "6 AM" for the nurses' initials (for nurse who administered the patch) and a blank box entitled "Site" for initials (initials of area the patch had been applied). Documentation of the site: 10/1/14 was RA (right arm), 10/2/14 was LA (left arm), 10/3/14 was RA (right arm), 10/4/14 was LA (left arm), the pattern of LA one day and RA the following day continued through the date of 10/17/14. The DON explained, at that time, that the initials LA indicated left arm and RA indicated right arm. The DON was made aware of the manufacturer's instruction on the patch placement to ensure site placement had not been repeated in a 2 week/14 day time period. The DON was also made</p>			

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F000441 SS=D	<p>aware that the facility MAR documentation did not ensure that patch placement had not been repeated in a 2 week/14 day period.</p> <p>The DON indicated she was unaware of the manufacturer's instruction to ensure transdermal patch placement was not repeated in a 2 week period.</p> <p>On 10/17/14 at 9:20 A.M., the facility drug book entitled, "Nursing 2015 Drug Handbook" page 1255 was reviewed with the DON. The handbook indicated Exelon patch transdermal: "... Change the site daily, and don't use the same site within 14 days..."</p> <p>3.1-35(g)(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 - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p>						

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	<p>(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. Based on observation, interview, and record review, the facility failed to follow its policy and procedure for hand washing, in that, a nurse did not wash her hands for 20 seconds between residents during 1 of 3 medication administrations observed. (Resident #59, Resident #4, Resident #25, Resident #3, Resident #74)</p> <p>Findings include:  During observations of the medication pass on the Front Hall on 10/16/14 at 11:26 A.M. and 2:21 P.M. the following hand washing by LPN #12 was observed:</p>	F000441	<p>-Staff reeducated on Infection Control and Handwashing Policy and Procedure. -Admin/DON/Designee will randomly monitor handwashing on each shift and do infection control rounds 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>	11/10/2014

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	<p>1. At 11:26 A.M., LPN #12 administered medication to Resident #59. Prior to exiting the room, LPN #12 entered the bathroom and washed her hands for 10 seconds. LPN #12 then proceeded to the medication cart and prepared medications for Resident #4.</p> <p>2. At 11:32 A.M., LPN #12 administered medication to Resident #4, checked Resident #4's blood pressure and oxygen saturations. Prior to exiting the room, LPN #12 entered the bathroom and washed her hands for 8 seconds. Upon exiting the bathroom, LPN #12 had 2 brown paper towels in her hands. As LPN#12 returned to the medication cart, she was talking and drying her hands with the paper towels. At that time, she dropped the paper towels on the floor, then picked them up and continued to dry her hands with the soiled paper towels.</p> <p>3. At 11:40 A.M., LPN #12 prepared the medication administration for Resident #25 without washing her hands or using hand sanitizer.</p> <p>4. At 2:21 A.M., LPN #12 prepared and administered Resident #3's medication. Prior to exiting the room, LPN #12 entered the bathroom and washed her hands for 12 seconds. LPN #12 then proceeded to the medication cart and</p>			

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F000465 SS=E	<p>prepared medications for Resident #74</p> <p>5. At 2:25 P.M., LPN #12 administered Resident 74's medication. Prior to exiting the room, LPN #12 entered the bathroom and washed her hands for 11 seconds.</p> <p>During an interview on 10/17/14 at 12:05 P.M., RN #14 indicated staff should wash their hands for 20 seconds.</p> <p>The facility's policy for Hand Hygiene was made available by the DON and reviewed on 10/20/14 at 10:46 A.M. The policy read as follows: "...6. Rub hands together vigorously for 15-20 seconds generating friction on all surfaces of the hands and fingers."</p> <p>During an interview on 10/20/14 at 10:20 A.M., the DON indicated all staff must wash their hands for 20 seconds.</p> <p>3.1-18(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview, and record review, the facility failed to ensure</p>	F000465	-Soiled floors/commodos were cleaned immediately and rusted bolts on commode repaired. -Housekeeping staff reeducated	11/10/2014			

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	<p>the environment was sanitary and in good repair in that, walls, commodes, and/ or floors were soiled and/or in disrepair for 4 of 5 survey days on 2 of 3 units.</p> <p>Room 140, Room 133, Room 109, Room 132, Room 114, and Room 142, Nurses Stations 1 and 2.</p> <p>Findings include:</p> <p>1. On 10/14/14 at 11:30 A.M., the unit 1 nurses' station floor was observed to have soiling through with the vinyl flooring faded and worn in the middle area of the nurses' station. The edges of the flooring and the baseboard edges had black soiling. The heating/cooling unit on the wall of the nurses' station was scuffed and marred with paint missing. On 10/16/14 at 2:35 P.M., nurses' station 1 continued to have brown soiling along baseboard edges of the station with the middle flooring worn with gray discoloration.</p> <p>2. On 10/14/14 at 3:18 P.M., the bathroom of room 114, had bowel movement (bm) smeared on the front and back sections of the commode seat. A paper towel was observed in the bathroom trash smeared with a large amount of bm. On 10/15/14 at 9:57 A.M., in the bathroom of Room 114,</p>		<p>on Bathroom Cleaning Policy. -Maintenance to repair tile at nursing stations. -Admin/Designee will make bathroom rounds daily (Monday thru Friday) on various shifts 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>				

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NAME OF PROVIDER OR SUPPLIER  EASTGATE MANOR NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501			
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	<p>toilet tissue with bm was observed on the floor by the trash can, bm specks were also noted inside the commode bowl.</p> <p>3. On 10/15/14 at 9:44 A.M., the bathroom floor of room 133 had soiling and staining around the base of the commode. The lower section of the wall by the closet and the lower section of one of the closet doors had the paint marred. On 10/17/14 at 11:00 A.M., the bathroom of room 133 had bm observed inside the bowl of the commode, the bathroom floor and the edges of the floor had brown soiling. The lower section of one closet door and the adjacent wall had the paint marred.</p> <p>4. On 10/15/14 at 10:44 A.M., the bathroom of room 140 had a strong urine odor with urine noted on the floor around the commode base. On 10/17/14 at 10:58 A.M., the bathroom floor of room 140 had a pungent urine odor.</p> <p>5. On 10/15/14 at 11:48 A.M., bathroom floor of room 132 had staining at the base of the commode. Toilet mounting bolts on each side of the commode base were rusty and corroded. On 10/17/14 at 11:01 A.M., the bathroom floor was soiled through out with 2 rusty bolts noted at the base of commode.</p>						

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	<p>6. On 10/15/14 at 2:42 P.M., the bathroom floor of room 109 had staining around the base of the commode. On 10/17/14 at 11:30 A.M., the bathroom flooring around the commode base had rust colored staining.</p> <p>7. On 10/16/14 at 2:37 P.M., the unit 2 nurses' station desk area had small sections of vinyl flooring tiles missing with brown soiling and dust noted in the gaps of the missing flooring. The baseboard edges of the flooring had brown soiling and the heater cooling unit was scuffed and marred with paint missing.</p> <p>8. On 10/17/14 at 11:35 A.M., during environmental tour with the Administrator the bathroom of 140 had a urine odor. The Administrator indicated she was aware of the urine odor of the room. The baseboard along the wall beside the commode was separating from the side of the wall. The Administrator indicated that was related to frequent urinary incontinence of one of the residents who utilized the bathroom. She indicated that housekeeping staff were aware of the frequent incontinence and were to check the bathroom several times a day. On 10/17/14 at 11:37 A.M., the Administrator was made aware of the soiling of the bathroom floor of room 133</p>			

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	<p>especially around the commode base. The Administrator was also made aware of the marring of the paint of the closet door and wall. She indicated that was related to the use of a wheel chair in Room 133.</p> <p>9. On 10/17/14 at 11:45 A.M., the Administrator was made aware of the soiling of the bathroom floor of room 132 and of rusty bolts at the base of the commode. Next, during the tour of the bathroom of room 114, bm was observed smeared on the side of the commode seat. The Administrator indicated at that time that both residents of room 114 were able to toilet independently. A hand swipe was completely across the bathroom floor with soiling and dust noted. The Administrator agreed to the soiling and went to get a housekeeper to address the soiling. On 10/17/14 at 11:52 A.M., the Administrator was made aware of the rust colored stains of the bathroom flooring of room 109 around the front, the side, and behind the commode. The Administrator agreed to the bathroom floor staining.</p> <p>10. On 10/17/14 at 12:35 P.M., the Administrator was made aware of the soiling of the baseboard edges of both nurses' stations. She was made aware of gray discoloration and soiling of the vinyl flooring in the middle of the nurses '</p>			

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	<p>station floor. A hand swipe was done under the desk area of nurses ' station 2 where vinyl floor was missing. Dust and dirt was observed from the swipe. The Administrator indicated at that time, "We ' ll address it."</p> <p>11. On 10/17/14 at 2:05 P.M., the Housekeeping supervisor was interviewed regarding the cleaning of resident bathrooms. She indicated there were "problem bathrooms" that were cleaned more than once a day. She indicated there was no written list or schedule indicating which resident bathrooms needed cleaning more than once a day. The Housekeeping Supervisor also indicated the two nurses station floors were to be stripped and waxed 2 or 3 times a year and had needed to be stripped and waxed during the survey.</p> <p>12. On 10/17/14 at 2:12 P.M., the Housekeeping Supervisor provided a cleaning policy (dated 1/1/2000) entitled, "HEALTHCARE SERVICES GROUP, INC. JOB TO BE DONE: BATHROOM CLEANING." The policy included but was not limited to: "...7. Damp mop. Start in far corner. Get behind commode, move trash can, mop out the door. Use 'Wet Floor' sign when finished..."</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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