

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2013
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NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630
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F000000	<p>This visit was for the Investigation of Complaint IN00133179.</p> <p>Complaint IN00133179 Substantiated - Federal/State deficiencies related to the allegations are cited at F309 and F322.</p> <p>Survey dates: July 29 and 30, 2013</p> <p>Facility number: 000245 Provider number: 155354 AIM number: 100290800</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: SNF/NF: 113 Total: 113</p> <p>Census payor type: Medicare: 4 Medicaid: 82 Other: 27 Total: 113</p> <p>Sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>Preparation and or execution of this Plan of Correction general, or any other corrective action set forth herein, in particular, does not constitute and admission or agreement by Newburgh Healthcare of the facts alleged or the conclusions set forth in the Statement of Deficiencies. The Plan of Correction and specific corrective actions are prepared and / or executed soley because of Federal and / or Stae law.</p>	
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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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	Quality review completed on August 2, 2013, by Janelyn Kulik, RN.				

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview, and record review, the facility failed to follow up on a PT (protime)/INR lab result, following a panic value and the administration of Vitamin K the evening prior, for 1 of 3 residents reviewed who received Coumadin, in a sample of 5. Resident A</p> <p>Findings include:</p> <p>On 7/29/13 at 10:10 A.M., the Assistant Director of Nursing [ADON] provided a list of residents who received Coumadin. Resident A was not on the list.</p> <p>The clinical record of Resident A was reviewed on 7/29/13 at 10:45 A.M. Diagnoses included, but were not limited to, coagulation defect.</p> <p>Physician orders, dated 7/17/13, indicated, "Cont. to monitor bruised area on AKA [above the knee amputation] stump on Rt. [right] leg for any changes...."</p>	F000309	<p>CORRECTIVE ACTION Upon review of the listing, teh ADON noted that resident A was not on the list and notified the surveyour immediately. Resident A has received repeat PT/INR on 7/22/13, 7/29/13, 7/31/13, 8/5/13, 8/12/13 and a repeat on 8/16/13. Her Coumadin dose continues to be adjusted according to the results of the PT / INR. OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED All residents who receive Coumadin will be reviewed for results of and timely follow up. MEASURES / SYSTEMIC CHANGES Instruction for nurses began on 7/31/13 regarding follow up on PT/INR results. The information included the use of the 24 hour report, checking the lab book, checking the printer, checking the lab website, notifying lab services, consulting with the physician, and documenting the events. This information will be included in the facility policy regarding Anticoagulation Therapy. MONITORING Each nurse is responsible for checking</p>	08/29/2013	

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	<p>Physician orders, dated 7/18/13, indicated, "Cont. to monitor bruised area on left shoulder for any changes...."</p> <p>Nurse's Notes included the following notations:</p> <p>7/18/13 at 9:30 P.M.: "[Physician] faxed to request an order for PT/INR d/t [due to] two unexplained bruises, will cont. to monitor [and] await return response."</p> <p>7/19/13 at 4:00 P.M.: "New order received for STAT [immediate] PT/INR. Lab called [and] resident aware."</p> <p>7/19/13 at 6:30 P.M.: "Lab called [with] panic level PT/INR [and] in turn call [sic] nursing home triage [and] will hold her Coumadin until further notice, give her 10 mg of Vit K this evening [and] recheck PT/INR in AM...."</p> <p>A Lab report, dated 7/19/13 at 4:28 P.M., indicated the resident's PT was at a panic level of 120.0 (normal 9.4-11.4), and the INR was >10.9 (normal 0.9-1.1).</p> <p>Nurses Notes continued:</p>		<p>the lab book on their shift. The unit mamangers will continue to monitor for the results of PT/INR Monday through Friday. The weekend supervisor will monitor for the weekend shifts. Monitoring of PT/INR's will be ongoing. A summary of results will be included in the quarterly quality assurrance meetings. Process changes will be made as needed based upon the findings.</p>		

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	<p>7/20/13 at 9:30 A.M.: "Res [resident] denies pain and discomfort at this time. no new bruising noted...."</p> <p>The results of the PT/INR, drawn on 7/20/13, were not documented until 7/21/13 at 7:07 P.M.</p> <p>A Nurse's Note, dated 7/21/13 at 7:07 P.M., indicated, "Nursing Home Triage notified of recent PT/INR results...continue to hold Coumadin...."</p> <p>A Lab report, dated 7/20/13 at 6:00 A.M., indicated the resident's PT was "H" (high) 51.6, and the INR was H 4.8. A hand written notation indicated, "Faxed [and] called to N.H. [nursing home] Triage 7/21/13, 19:07 [7:07 P.M.]."</p> <p>Nurse's Notes continued:</p> <p>7/22/13 at 7:40 P.M.: "[Physician]...has gave [sic] order to Re [check] PT/INR and for the facility to address results of PT/INR [with] Nursing Home Triage on the same day lab is drawn."</p> <p>On 7/29/13 at 10:55 A.M., the ADON indicated she had forgotten to add Resident A to the list of residents who</p>						

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	<p>received Coumadin.</p> <p>On 7/29/13 at 1:20 P.M., during interview with RN # 3, she indicated she was working the day of 7/20/13. She indicated she did not get nor see the PT/INR lab result on 7/20/13 or 7/21/13. RN # 3 indicated the lab results would usually be faxed to the facility, and she never received the fax. RN # 3 did not indicate why she did not call the lab to check on the result.</p> <p>On 7/30/13 at 9:00 A.M., during an interview with the Administrator and Director of Nursing [DON], the DON indicated she thought the PT/INR lab result "somehow got tripped up in the fax machine." The DON indicated the lab usually calls with a panic value lab result. The DON did not indicate why the nursing staff did not call the lab to obtain the results, or document an assessment of the resident.</p> <p>On 7/30/13 at 11:15 A.M., during an interview with the Unit Manager, she indicated she was unsure why the nurse on 7/20/13 did not receive the PT/INR lab results. The Unit Manager indicated that lab results were usually faxed, or the lab would call with results. The Unit Manager indicated the "Sunday evening [7/21/13] nurse</p>			
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	<p>followed up." The Unit Manager indicated she thought that nurse found the results on the fax machine. The Unit Manager indicated she would have called the lab to obtain the results, if they had not been faxed.</p> <p>This Federal tag relates to Complaint IN00133179.</p> <p>3.1-37(a)</p>				

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F000322 SS=G	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a gastrostomy tube (feeding tube) stoma was appropriately cared for, in that purulent drainage and insects were found around the site, resulting in treatment with an antibiotic cream; and failed to ensure a gastrostomy tube dressing was applied as ordered by the physician, for 2 of 3 residents reviewed with g-tubes, in a sample of 5. Residents B and C</p> <p>Findings include:</p> <p>1. On 7/29/13 at 10:20 A.M., the Assistant Director of Nursing (ADON) indicated Resident B had a feeding</p>	F000322	CORRECTIVE ACTIONWound culture reports for resident B were obtained on 7/24/13 and reported to the attending physician. An order was received to repeat the culture on 8/9/13. The treatment to the GT site was discontinued on 8/3/13 and restarted on 8/9/13. A physician's order was obtained on 8/7 and 8/9 for ova and parasite testing of stool.The dressing was reapplied to the GT site of resident C. The nurse was informed to document when the resident refuses or removes her dressing. The careplan will be updated to state the residents removal of the dressing.OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTEDAll residents who have G Tubes have been reviewed for treatment orders and	08/29/2013

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	<p>tube.</p> <p>The clinical record of Resident B was reviewed on 7/29/13 at 11:30 A.M. Diagnoses included, but were not limited to, senile dementia and anorexia.</p> <p>A Minimum Data Set (MDS) assessment, dated 6/17/13 indicated the resident scored a 3 out of 15 for cognition, with 15 indicating no memory problems. The resident required extensive assistance of one staff for transfer, dressing, and personal hygiene.</p> <p>A Physician's order, initially dated 2/29/12 and on the current July 2013 orders, indicated, "Cleanse g-tube site w [with] Normal Saline, Apply gauze drsg [dressing] daily."</p> <p>An additional Physician's order, dated 3/21/12 and on the July 2013 orders, indicated, "Jevity 1.2 [a feeding formula] @ 80 cc/hr per g-tube from 2000 [8:00 P.M.] to 0600 [6:00 A.M.]."</p> <p>Nurse's Notes included the following notations:</p> <p>7/20/13 at 4:30 P.M.: "Purulent drainage noted at the G-tube insertion site, N.O. [new order] from MD to</p>		<p>dressing changes by the wound nurse and completed on 8/8/23.MEASURES / SYSTEMIC CHANGESThe nursing staff will inserviced regarding the following: Documentation of the GT site when the condition changes; Consulting with the physician when unable to proceed with orders; CNA reporting of findings to nurse and not disturbing the area; Collecting and sealing abnormal specimens in a zip lock bag abd biohazard bag if able and appropriate due to staff unable to accurately determine their perception except for drainage at the site; A review of the facility policy regarding cleansing of the GT site to include gently raising of the silicone disc, since such disc have a tendency to cause redness and mild serousanganous drainage due the the close contact with the skin and the stoma.The wound nurse will managed the care and treatment fo the GT dressings to include assessment of changes, documentation of abnormal findings, and treatment changes as needed. The wound nurse will monitor Monday through Friday.The weekend manage will complete the dressing changes and document, document abnormal findings, and notify the physician as needed and document.MONITORINGThe facility wound nurse and weekend supervisor will monitor via their</p>		

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	<p>treat [with] Gentamycin TID [three times daily], and get culture of drainage." This was signed by RN # 3.</p> <p>The g-tube site appearance or drainage was not documented on 7/21/13.</p> <p>Nurses notes continued:</p> <p>7/22/13 at 2:00 A.M.: "Res. dressing change to peg tube [g-tube] completed. [No] drainage present. Culture no [sic] able to obtain...."</p> <p>7/22/13 at 6:30 A.M.: "Culture obtained @ this time of G-tube drainage. Minimal amt [amount] of yellowish drainage obtained. Surrounding skin slightly pink...Drain sponge re-applied."</p> <p>The resident's Treatment Administration Record [TAR], dated July 2013, included: "Cleanse G-tube site w/Normal Saline, Apply gauze drsg daily. Day." The entry was initialed as completed from July 1-July 21.</p> <p>On 7/29/13 at 11:50 A.M., a skin assessment of Resident B's g-tube stoma site was requested. RN # 1 removed the resident's old dressing,</p>		<p>dressing changes and staff feedback.A summary of the frdings will be submitted to the Quality Assurance Committee for at least one (1) year. The results will be reviewed and the necessary changes made as needed.</p>				

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	<p>which had a moderate amount of brownish-red drainage. RN # 1 indicated, "It looks pretty good," referring the resident's g-tube site. RN # 1 was asked to raise the plastic g-tube disc, which kept the g-tube in place, so a closer observation could be made. The stoma site was reddened, with fresh blood oozing from the stoma site. The resident indicated the area was "sore."</p> <p>On 7/29/13 at 12:30 P.M., during an interview with LPN # 1, she indicated she was working on 7/20/13. She indicated she was called into Resident B's room by CNA # 1. She indicated CNA # 1 "had a weird look on her face, and said she needed me now." LPN # 1 indicated she took another nurse in with her to the resident's room. LPN # 1 indicated CNA # 1 showed her the resident's g-tube dressing, which "had a lot of drainage on it." LPN # 1 indicated the old dressing had "what may have been an insect" on it. LPN # 1 indicated she could not say what type of insect it was, but that it was approximately .5 centimeters long and clear-looking. LPN # 1 indicated she did not see any type of insect on the skin, but saw the "insect-looking thing" on the dressing. She indicated the "desk nurse" notified the</p>			

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	<p>physician, and obtained an order to culture the area. She indicated there was no further drainage to culture at that time.</p> <p>On 7/29/13 at 12:45 P.M., during an interview with CNA # 1, she indicated she was working on 7/20/13, and was giving Resident B her bath. She indicated the resident's g-tube dressing looked "dirty and nasty," so she removed the dressing. She indicated she saw "3 little worm things" on the resident's skin. She indicated she thought they must have fallen from the resident's dressing. CNA # 1 indicated she "immediately summoned my nurse [LPN # 1]." She indicated LPN # 1 came into the room, as well as other nurses. She indicated she questioned the supervisor if she should put the insects in a specimen cup, and was informed to "just throw the washrag and everything away." CNA # 1 indicated, "It looked like maggots to me. They were alive and wriggling." CNA # 1 indicated the dressing appeared as if "it hadn't been touched all week." CNA # 1 indicated LPN # 1 "was really distraught." CNA # 1 indicated she herself called the Director of Nursing [DON], because she wasn't sure that any of the nurses were going to call her. CNA # 1</p>						

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	<p>indicated the DON was informed of the presence of insects, and "seemed nonchalant about it."</p> <p>On 7/29/13 at 1:20 P.M., during an interview with RN # 3, she indicated she was working on 7/20/13. RN # 3 indicated she went into Resident B's room after everything was cleaned, and did not see anything. She indicated she heard "maggots were growing under" the g-tube dressing. RN # 1 indicated LPN # 1 was "extremely upset about it. She saw it." RN # 1 indicated she called the physician and informed him of the purulent drainage, but did not mention the insects. RN # 1 indicated the physician gave an order to obtain a culture and start gentamycin.</p> <p>On 7/29/13, during a confidential interview with Staff # 5, she indicated, "Someone was not doing the treatments" to Resident B's g-tube site.</p> <p>On 7/30/13 at 9:00 A.M., during an interview with the Administrator and DON, the DON indicated the culture was not obtained from the resident's g-tube site earlier than 7/22/13, due to no drainage from the site. The DON indicated she realized there was no documentation regarding the site</p>						

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	<p>on 7/21/13. The DON indicated she called the attending physician on 7/22/13, and informed him what she had heard regarding the presence of insects. The DON indicated she had told LPN # 1 to fill out an incident report regarding the incident, which she did, but now could not find it. The DON indicated she knows staff had changed the dressing on Friday 7/19.</p> <p>On 7/30/13 at 10:40 A.M., during an interview with CNA # 5, she indicated she was working on the same unit as Resident B on 7/20/13, but was not taking care of her that day. She indicated she "knew the nurse was really upset about something," but that she didn't know what it was. She indicated that she heard gossip, but did not really listen to that.</p> <p>On 7/30/13 at 11:15 A.M., during an interview with the Unit Manager, she indicated she knew Resident B's dressing had been changed on 7/19, because she was in the room and observed it was off. She acknowledged that she did not look under the plastic disc to observe the site. The Unit Manager indicated she hoped that staff had lifted up the plastic disc and cleansed under it when they did the dressing changes.</p>			

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NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630
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	<p>2. On 7/29/13 at 10:20 A.M., the ADON indicated Resident C had a feeding tube.</p> <p>On 7/29/13 at 12:10 P.M., Resident C's gastrostomy tube [g-tube] site was observed. A dressing was not observed on the site. A slight red irritation was observed around the site. RN # 1 indicated at that time that Resident C did not have dressings applied to the site, because she "didn't like dressings on."</p> <p>The clinical record of Resident C was reviewed on 7/29/13 at 12:25 P.M. Diagnoses included, but were not limited to, cerebral palsy, nutrition deficiency, and mild intellect disability.</p> <p>A Physician's order, initially dated 5/20/08 and on the current July 2013 orders, indicated, "G-tube care QD [every day]. Cleanse G-tube stoma with normal saline [and] apply gauze dressing."</p> <p>A care plan, dated 7/19/13, indicated, "Focus, Alteration in Nutrition...She has a g-tube..." The Interventions included, "Cleanse g-tube stoma with NS [normal saline] and apply gauze dressing."</p> <p>A care plan which indicated the</p>			

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	<p>resident refused dressing changes was not documented.</p> <p>On 7/30/13 at 9:10 A.M., the DON provided a Treatment Administration Record (TAR), dated July 2013. The TAR indicated, "Cleanse g-tube stoma with Normal Saline [and] apply gauze dressing. Day [shift]." The TAR was initialed as completed daily, including on 7/29/13.</p> <p>3. On 7/30/13 at 11:45 A.M., the ADON provided the current facility policy on "Gastrostomy Tube Care," undated. The policy included: "...The purpose of G-tube care is to: Prevent infection, Prevent tube complications...Provide proper skin care of the stoma site. Stoma care for G-tubes should be done on a daily basis...Documentation may appear on any form used in the facility...."</p> <p>This Federal tag relates to Complaint IN00133179.</p> <p>3.1-44(a)(2)</p>				

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