

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 02/13/2012
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NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & RESIDENTIAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501
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F0000	<p>This visit included the Investigation of Complaint IN00102663 and IN00103303..</p> <p>Complaint IN00102663-Substantiated, No deficiencies related to the allegations are cited.</p> <p>Complaint IN00103303- Substantiated, Federal/state deficiencies related to the allegations are cite at F 309.</p> <p>Survey dates: February 13, 2012</p> <p>Facility number: 000301 Provider number: 155341 AIM number: 100289090</p> <p>Survey team: Marla Potts RN TC Melinda Lewis RN Sharon Whiteman, RN Susan Worsham, RN</p> <p>Census bed type: SNF/NF: 66 Total: 66</p> <p>Census payor type Medicare: 7 Medicaid: 49 Other: 10</p>	F0000		

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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	<p>Total: 66</p> <p>Sample: 5</p> <p>This deficiency also reflects state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed 2/14/12 Cathy Emswiller RN</p>			

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F0309 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 continually assess 1 of 5 residents reviewed for a change of condition. (Resident A)</p> <p>Findings Include:</p> <p>Review of Resident A's closed clinical record on 02/13/12 at 11:15 a.m. indicated the following:</p> <p>Resident A had diagnoses which included but were not limited to, Hyperlipidemia (high fat in blood), hypertension (high blood pressure), Anxiety Disorder, and Bipolar Disorder. The clinical record indicated Resident A had a past history of renal failure.</p> <p>An admission MDS (minimum data set) assessment, dated 01/02/12, indicated Resident A had no cognitive impairment, no memory problem, and required minimal assistance of staff with care.</p>	F0309	<p>monitoring reassessment monitoring and follow up.including but not limited tothe 24 hourStatus Report,physicians orders and nurses notes of current in houseresidents was completedand services to maintainthe highest practicable, physical, andaPreparation and/or execution of this plan of coprrrectionj does not constitire admission or agreement by the provider of the truth of facts alleged or conclusions ste forthin the statement fo deficiencies.The plan of correction isprepared and or executed solley because it is required by the provosoins o fthe federal and state law.Eastgate Manor Nursing and Rehabilitation Center desires this plan of correction to be considered this facilities Allegation of Compliance. Compliance is effective March 6, 2012.F309It is the policy of Eastgate Manor to provide the necessary care and services to maintain the highest practicablephysical mental and psychosocial well being in accordance withthe comphehensive assessment and</p>	03/06/2012	

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	<p>A nursing progress note, dated 01/16/12 at 4:00 a.m., indicated Resident A had vital signs of - temperature 97.7, blood pressure 131/63, heart rate 139, respiratory rate 97%. The progress note indicated the resident requested Tylenol for sinus pressure, the resident denied any other problems, and the resident would be monitored.</p> <p>The clinical record lacked documentation indicating vital signs were taken again until 01/18/12.</p> <p>A nursing progress note, dated 01/18/12 at 9:45 a.m., indicated Resident A had vital signs of - heart rate 131, blood pressure 106/62, and temperature of 102 degrees.</p> <p>A nursing progress note, dated 01/19/12 at 10:20 p.m., indicated Resident A was asking staff to assist with tasks she normally did herself.</p> <p>The clinical record lacked documentation supporting vital signs were taken again until 01/20/12.</p> <p>A nursing progress note, dated 01/20/12 at 12:30 p.m., indicated, "res [Resident A] stated she felt dizzy and knelt down beside her bed (sic) res pale in color..." The nursing progress note indicated</p>		<p>plan of care. Resident A is not currently in the facility. A 100% medical record review including but not limited to the 24 hour report, physician's notes and nursing notes of current in house residents was completed to determine resident's having a change in condition to include but not limited to vital signs outside of the resident's normal parameters, and that subsequent resident assessments, monitoring and follow up were initiated. Licensed nurses will be responsible to initiate the Post Acute/Change in Condition Monitoring Record for residents experiencing a change in condition including but not limited to vital signs outside of the resident's normal parameters. The names of the residents having Post Acute Change in condition initiated will be placed on a Post Acute Change in Conditioning Log as well as the 24 Hour Status Report Sheet. Licensed Nurses will be re-educated for policy and procedure for Post Acute/Change in Condition Monitoring, resident assessment, monitoring and follow up. Through of the physicians orders, the 24 status report sheet. and Post Acute Change in Condition Monitoring Log the Director of Nursing/designee will identify residents having a change in condition; the medical record of identified residents will be</p>				

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	<p>Resident A's vital signs were - blood pressure 80/50 and heart rate 135. The nursing progress note indicated the resident's physician was informed of the resident's temperature was 99.4.</p> <p>A nursing progress note, dated 01/20/12 at 1:00 p.m., indicated the resident's physician was updated on the resident's vital signs and new orders for normal saline and D5 1/2 normal saline with 20 milliequivalents of potassium were obtained from the physician.</p> <p>A nursing progress note, dated 01/20/12 at 2:30 p.m., indicated the resident was re-assessed and her vital signs were - blood pressure 87/61, heart rate 121, and temperature 98. The progress note indicated, "res stated she is dizzy when she moves, pale in color (sic) called physician to update...."</p> <p>A nursing progress note, dated 01/20/12 at 4:00 p.m., indicated the D5 1/2 normal saline with potassium was started on Resident A.</p> <p>A nursing progress note, dated 01/21/12 at 1:00 a.m., indicated Resident A's vital signs were - temperature 98.7, heart rate 117, and blood pressure 99/49. The progress note indicated the resident complained of nausea at times.</p>		<p>reviewed by the Interdisciplinary Team to ensure that appropriate assessment monitoring and follow up documentation has been completed as required. Review will be completed daily for 14 days and then 5 times weekly thereafter. Identification of non compliance with policy and procedure will result in 1:1 re-education, with continued non compliance resulting in disciplinary action up to and including termination. Findings will be submitted to the Quality Assessment Committee monthly for 6 months for review and recommendations as deemed appropriate.</p>		

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	<p>A nursing progress note, dated 01/02/12 (sic) at 9:00 p.m. , indicated the resident appeared to be resting comfortably.</p> <p>The clinical record lacked documentation supporting Resident A's vital signs being taken again until 01/22/12.</p> <p>A nursing progress note, dated 01/22/12 at 3:45 p.m., indicated the resident's vital signs were - blood pressure 136/78, heart rate 123, respirations 18, temperature 98.7. The progress note indicated the resident complained of nausea at times but did not complain of pain. The progress note indicated, "...Family came to visit resident and requested her be sent to...(local hospital). They were considered (sic) about her K+ (potassium) level...[Resident A's physician] paged and resident sent to (local hospital)."</p> <p>A "Vital Signs - Individual Resident Flowsheet" indicated Resident A's blood pressure was 111/64 on the 11:00 p.m. to 7:00 a.m. shift on 12/23/11. The flowsheet indicated blood pressures of 110/62 on the 3:00 p.m. to 11:00 p.m. shift on 12/23/11, 150/88 on 12/29/11, 110/72 on 12/31/11, on 88/58 on 01/14/12, and 99/49 on 01/21/12.</p> <p>Interview of the DON on 02/13/12 at 1:30</p>						

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	<p>p.m. indicated the resident was sent out to the hospital due to the family coming in and requesting the resident being sent out because the were concerned about elevated potassium of 5.4.</p> <p>A physician's telephone, dated 01/22/12, indicated, "T.O. [Telephone Order] - Send to E.R. [Emergency Room]."</p> <p>Documentation provided by the DON on 02/13/12 at 1:20 p.m. indicated, "To whom it may concern (sic) I was aware of K (potassium) level at 5.4. This documentation indicated potassium could run 3.5 to 5.5 for "norms" (normal)." This documentation was signed by the resident's physician.</p> <p>A "History and Physical Examination" form, dated 01/22/12, indicated, "...the patient (Resident A)...was brought into the hospital, got evaluated and was found to have leukocytosis (abnormal blood), hypotension and acute renal failure. The patient was kept in the hospital....She has a poor prognosis and high mortality...."</p> <p>The Federal/State tag relates to Complaint IN00103303.</p> <p>3.1-37(a)</p>				

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