

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  01/13/2015
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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 the Investigation of Complaint IN00162076.</p> <p>Complaint IN00162076 - Substantiated, Federal/State deficiencies related to the allegations are cited at F157 and F313.</p> <p>Survey dates: January 12 and 13, 2015</p> <p>Facility number: 000301 Provider number: 155341 AIM number: 100289090</p> <p>Survey team: Anne Marie Crays RN, TC</p> <p>Census bed type: SNF/NF: 54 Total: 54</p> <p>Census payor type: Medicare: 6 Medicaid: 38 Other: 10 Total: 54</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</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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F000157 SS=D	Quality review completed on January 15, 2015 by Jodi Meyer RN  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			
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	<p>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 the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure a resident's family member was notified of condition changes and of new physician orders, for 1 of 3 residents reviewed regarding family notification, in a sample of 4. Resident C</p> <p>Findings include:</p> <p>1. The clinical record of Resident C was reviewed on 1/12/15 at 11:00 A.M. The resident's admission record listed Family # 1 as "Emergency Contact, Responsible Party." Family # 2 was listed as a 2nd contact, and a document with the name and number of Family # 3 was also attached to the admission record.</p>	F000157	<p>"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." Licensed Nursing staff reeducated on timely notification of changes. DON/Designee will review applicable charts during clinical review daily (Mon-Fri) x 2 weeks to ensure timely family/responsible party notification of change took place when applicable, 3x per week for 2 weeks, weekly for 4 weeks and monthly thereafter. Identified non-compliance will result in 1:1 education with repeat non-compliance resulting in disciplinary action per policy up to and including termination. Identified trends will be reviewed</p>	01/30/2015			

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	<p>Nursing Progress Notes included the following notations:</p> <p>12/17/14 at 10:30 A.M.: "Res [resident] c/o [complains of] SOB [shortness of breath] [decreased] O2 sat [oxygen saturation] Bil [bilateral] chest congestion - Moist cough - O2 placed @ 2L/NC [nasal cannula] moisture. Hyperventilating. Resp [respiratory] HHN Tx [hand held nebulizer treatment] given, order for chest x-ray...."</p> <p>A Physician's order, dated 12/17/14, indicated, "Portable chest xray...D/T [due to] chest congestion [and] [decreased] O2 sats - Hypoxia [lack of oxygen]...O2 @ 2L/NC...O2 sat q [every] shift." A box on the order sheet which indicated, "Family Notified:" was left blank.</p> <p>12/17/14 at 9:30 P.M.: "...Started oral ATB [antibiotic] per new order from [physician name] tonight. CXR [chest x-ray] this evening showed LLL [left lower lobe] pneumonia. T-100...O2 per NC @ 2l/m...Occ moist cough noted...."</p> <p>A Physician's order, dated 12/17/17, indicated, "Levaquin...x 7 days...for LLL pneumonia." The box on the order sheet which indicated "Family notified" was left blank.</p>		in QA monthly for further recommendations as deemed appropriate.	

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	<p>Documentation of family notification was not found in the Nurses Notes or clinical record.</p> <p>Nursing Progress Notes continued:</p> <p>12/24/14 at 9:55 A.M.: "Rsd [resident] very sleepy today - [X-ray company] here to do F/U [follow-up] X-ray D/T [due to] LLL pneumonia...."</p> <p>12/24/14 at "3-11": "Rec'd chest x-ray. [Name of physician] notified of results. N.O. [new order] received. Pharmacy notified."</p> <p>A Physician's order form, dated 12/24/14, indicated, "Augmentin [antibiotic]...x 7 days, Zithromax [antibiotic]...x 5 days Dx [diagnosis] for ATB's Pneumonia. F/U CXR when ATBs completed...." The box on the order sheet which indicated "Family Notified:" was left blank.</p> <p>Documentation of family notification was not found in the Nurses Notes or clinical record.</p> <p>Nursing Progress Notes continued:</p> <p>12/26/14 at 9:55 A.M.: "[Physician] notified of [lab] values- VS [vital signs] [and] held Valium D/T [due to] [decreased] awareness - N.O. rec'd...hold</p>			

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	<p>Valium if systolic B/S [sic] [below] 100." The box on the Physician order form which indicated "Family Notified:" was left blank.</p> <p>12/28/14 at 2:45 P.M.: "New order received to encourage fluids - may straight cath every shift if no output...Has been alert but disoriented today...." The box on the Physician order form which indicated "Family Notified:" was left blank.</p> <p>On 1/12/15 at 11:40 A.M., during interview with Family # 3, he/she indicated the facility frequently did not notify the family of new physician orders.</p> <p>On 1/13/15 at 11:30 A.M., during interview with the Administrator, she indicated she thought the facility did notify the resident's family of new orders and condition changes, but staff should have documented that fact.</p> <p>2. On 1/13/15 at 12:45 P.M., the Administrator provided the current facility policy on "Notification of Resident Change in Condition," revised July 2014. The policy included: "...clinicians will immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an</p>			

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	<p>interested family member when there is a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health...)...If the change in the resident's condition is not crucial or significant...the resident's Physician and family or legal representative will be notified at the earliest convenient time during regular business hours...Document in the Nurses Notes the times notification was made and the names of the person(s) to whom you spoke...."</p> <p>This Federal tag relates to Complaint IN00162076.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>			

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F000313 SS=D	<p>483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.</p> <p>Based on interview and record review, the facility failed to ensure a resident who utilized glasses had her glasses either replaced or available for her use, for 1 of 3 residents reviewed with assistive devices, in a sample of 4. Resident C</p> <p>Findings include:</p> <p>1. The closed clinical record of Resident C was reviewed on 1/12/15 at 11:00 A.M.</p> <p>A Nursing Admission Assessment, dated 10/7/13, indicated, "Vision: Impaired. Glasses: Wears: Yes. Present upon admission: [left blank]...."</p>	F000313	<p>F313: Resident #3 no longer resides at facility. Social Services to perform an audit of current residents infacility to ensure that residents that require eye glasses are in possession of appropriate eye wear. Residents needing glasses will be referred to optometrist. Care plans will be updated as needed. Admin/SSD/Designee will randomly review residents for possession of appropriate eye wear daily (Mon-Fri) x 2 weeks, 3x per week for 2 weeks, weekly for 4 weeks and monthly thereafter. Identified non-compliance will result in 1:1 education with repeat non-compliance resulting in disciplinary action per policy up</p>	01/30/2015

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	<p>A Social Service Progress Note, dated 5/28/14, indicated, "...Optometrist here to examine [Resident C], please see progress note."</p> <p>An "Eye Care Consult Report, " dated 5/28/14, indicated, "Visual Acuity: Right Eye: 20/20, Left Eye: Hand Motion...patient appears to be currently wearing a ballanced [sic] lens OS [left eye]...Plan: 1. Decreased vision OS [left eye], longstanding per pt. [patient]. Suspect history of optic neuritis...Monitor. Follow up in 12-15 months...Stay with current glasses...."</p> <p>A Quarterly Nursing Assessment, dated 12/10/14, included: "Vision: Impaired, Glasses: Wears: Yes, Present upon admission: Yes...."</p> <p>On 1/12/15 at 11:40 A.M., during interview with Family # 3, he/she indicated the resident needed glasses, and he/she had been "promised for 6 months that they were in the process of getting her some." Family # 3 indicated he/she had loaned the resident some glasses, but they had been misplaced. He/she indicated when the family came in to retrieve Resident # 3's belongings, he/she asked about her glasses, and was told that she never received glasses.</p>		to and including termination. Identified trends will be reviewed in QA monthly for further recommendations as deemed appropriate.	

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	<p>On 1/13/15 at 9:00 A.M., during interview with the Social Services Director (SSD), she indicated Resident C saw the eye doctor in May, because the family requested an eye exam. The SSD indicated she never saw the resident wear glasses. She indicated she had never received any report of the resident losing her glasses. When reviewing the eye consult report, dated 5/28/14, at that time, she indicated she guessed the physician did not think she needed new glasses, but appeared surprised to see the notation, "Stay with current glasses."</p> <p>On 1/13/15 at 9:45 A.M., during interview with RN # 1, she indicated she routinely took care of Resident C, and never saw her wear glasses.</p> <p>On 1/13/15 at 11:35 A.M., during an interview with Staff # 1 at the eye consultant office, she indicated the report indicated the resident did not require new glasses that visit. She indicated she could not provide further information regarding what type of glasses the resident had.</p> <p>On 1/13/15 at 1:10 P.M., during interview with the Assistant Director of Nursing (ADON), he indicated the resident had reading glasses that she</p>			

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	<p>would wear. He indicated he never knew of her wearing prescription glasses. He indicated the family picked up her reading glasses.</p> <p>On 1/13/15 at 2:00 P.M., the ADON provided an "Inventory of Personal Effects, dated 11/7/13 on admission and 1/8/14 on discharge. The Inventory sheet indicated the resident was admitted with "1 pair" of glasses. The "Discharge" section indicated the family member "Refused to sign," and was signed by the Director of Nursing.</p> <p>On 1/13/15 at 2:30 P.M., the SSD indicated she found documentation that the eye doctor had seen the resident in March. She indicated she did not know what the eye doctor recommended. She was unable to find documentation of the results of that visit by survey exit.</p> <p>2. On 1/13/15 at 2:20 P.M., the Administrator provided the current facility policy on "Vision/Hearing Services - Referral to," dated April 2000. The policy included: "...The Social Services department will work to assist and/or coordinate services such as, but not limited to, the following: Routine services...Prompt referrals (e.g., broken hearing aid, glasses)...Identify those residents who need services, including,</p>			

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	<p>but not limited to: Eye exam...Identify those residents who require a prompt referral. Examples include, but are not limited to: Damaged or broken hearing aids, glasses, or other assistive devices...Document all interventions in the resident's medical record.</p> <p>This Federal tag relates to Complaint IN00162076.</p> <p>3.1-39(a)</p>			