

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 06/07/2012
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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 was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 4, 5, 6 and 7, 2012</p> <p>Facility number: 000301 Provider number: 155341 AIM number: 100289090</p> <p>Survey team: Marla Potts RN TC Susan Worsham, RN</p> <p>Census bed type: SNF/NF: 58 Total: 58</p> <p>Census payor type: Medicare: 8 Medicaid: 44 Other: 6 Total: 58</p> <p>Sample: 15 Supplemental Sample: 4</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed 6/8/12 Cathy Emswiller RN</p>	F0000	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p>	

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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F0252 SS=E	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>Based on observation and interview, the facility failed to ensure door frames for bathrooms within residents rooms were maintained in a safe manner, in that the door frames were marred with gouges in the wood that were rough to touch and splintering, for 14 of 20 rooms observed during the environmental tour of the facility.</p> <p>Findings include:</p> <p>During the environmental tour on 6/7/12 at 10:00 A.M. with the Maintenance Supervisor, door frames on the inside and outside of bathroom door ways were observed to have deep gouges and the finish marred on the bottom of the wood door frames. Door frames observed to have deep gouges and marred surfaces were observed in the bathrooms between rooms 101 and 103, 104 and 102, 115 and 113, 125 and 126, 136 and 134 and in the bathrooms for rooms 106, 117, 128, and 124.</p> <p>During interview at this same time the Maintenance Director indicated there</p>	F0252	<p>Eastgate Manor Nursing and Rehabilitation Center desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective June 27, 2012.</p> <p>F 252</p> <p>Door frames will be repaired and /or wood trim replaced on bathroom doors between rooms 101 and 103, 104 and 102, 115 and 113, 125 and 126, 136 and 134 and in the bathrooms for rooms 106, 117, 128, and 124. An audit of 100% of the remaining door frames/wood trim will be conducted and any other door frames/wood trim found to have deep gouges and marred surfaces will be repaired/replaced.</p>	06/27/2012			

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	<p>were plans to remodel a shower room, but no definite plans at this time to replace the door frames. He indicated they would start immediately to try and repair or replace the door frames.</p> <p>3.1-9(a) 3.1-19(f)(5)</p>			

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F0332 SS=E	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based upon observation and record review the facility failed to ensure it was free of a medication error rate greater than 5 %, with the facility having 9 medication errors out of 43 opportunities, for an error rate of 21.43%. Resident # 23, 44, 45 and 28. This affected 1 of 1 sampled residents reviewed for medications, in the sample of 15, and 3 of 4 supplemental residents reviewed for medications in the supplemental sample of 4.</p> <p>Findings include:</p> <p>1. RN#1 was observed to be passing medications on 6/4/12 at 6:20 A.M. to Resident #23. She was observed to administer medications which included "Rivastigmine (Exelon) 3 mg," (Alzheimer's drug), the resident was given a whole pill with sips of water.</p> <p>During clinical record review on 6/4/12 at 10:00 A.M., for Resident #23, physician rewrite orders, dated 5/31/12, included an order for "Rivastigmine 3 mg capsule take 1 capsule orally 2 times day" and "Take with food/meal." This order was repeated on the June Medication administration</p>	F0332	<p>F 332 Medication orders for residents 23, 44, 45, and 28 have been reviewed. Physicians have been updated and medication times have been adjusted as needed.</p> <p>A 100% review of resident medication orders has been completed. Review included but was not limited to medications that are to be given before, with or after food/meals. Medication times have been adjusted as needed.</p> <p>Licensed nurses have been re-educated on the black box precautions for medications. Re-education also included the highlighting of medications requiring specific times on the medication administration record.</p> <p>All newly received medication orders will be reviewed by the IDT during DCR. The medications administration record for medications requiring meal specific times or instructions will be reviewed per nurse management during monthly rewrites to ensure medications required to be given during meals are highlighted.</p>	06/27/2012			

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	<p>record. (MAR). RN #1 was not observed to have given the medication with food.</p> <p>The facility posted meal times for Breakfast was 7:00 A.M.</p> <p>The 2010 Nursing Spectrum Drug Handbook, reviewed on 6/6/12 at 1:00 P.M. indicated: Exelon (rivastigmine tartrate) "administration- give with food."</p> <p>2. RN# 2 was observed on 6/4/12 at 8:45 A.M., to administer medications to Resident #44, which included: -ASA 81 mg,(aspirin) one tablet, Klor- Con 20 meq one tablet,(potassium) and Metoprolol Succ XL 25 mg (to control blood pressure) one tablet. The medications were given whole with a glass of water.</p> <p>During clinical record review, for Resident #44 on 6/4/12 at 10:00 A.M., physician order rewrites, dated 5/18/12, included orders for: "Klor-Con 20 meq tablet SA, take one tablet orally once a day take with food," "ASA 81 mg (aspirin)(reduces inflammation) give one tablet orally once a day/take with food," "Metoprolol Succ ER 25 (used to lower blood pressure)-give one tablet orally once a day-take with food."</p> <p>RN #2 was not observed to have administered the medications with food.</p>		<p>Observational rounds will be completed by the DON/designee to observe for compliance with medications and times given. Observational rounds will be completed 5/week x 2 weeks then 2/week x 2 weeks then monthly thereafter. Results of these audits will be forwarded to the QA committee for review and/or recommendations as deemed appropriate. Identified non-compliance will result in 1:1 re-education with progressive discipline for failure to follow policy.</p>	

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	<p>The 2010 Nursing Spectrum Drug Handbook, reviewed on 6/6/12 at 1:00 P.M. indicated: " ASA give with food or large amounts of fluids to minimize GI (gastrointestinal) upset" "Klor-Con (potassium chloride) give oral form with meals and a full glass of water to juice to minimize GI upset" and "Metoprolol succinate-give with or immediately after meals..."</p> <p>3. RN #2 was observed on 6/4/12 at 9:00 A.M. to administer medication to Resident #45, which included: Coreg 3.125 mg tablet and Celebrex 200 mg with a glass of water.</p> <p>During clinical record review on 6/4/12 at 10:00 A.M., for Resident #45, physician order rewrites, dated 5/04/12, included an order for "Coreg 3.125 mg (used to lower blood pressure) give one tablet 2 times a day *Take with Food" and "Celebrex 200 mg(arthritis medication) give one capsule orally once a day *Take with Food/meal."</p> <p>The 2010 Nursing Spectrum Drug Handbook, reviewed on 6/6/12 at 1:00 P.M. indicated: "Coreg-give with food" and "Celebrex-instruct patient to take with food or milk."</p>			

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	<p>4. RN #3 was observed on 6/4/12 at 9:30 A.M. to administer medications to Resident #28, which included ASA 81 mg one tablet (aspirin) and Lopressor 25 mg one capsule (blood pressure medication). These were administered whole with water. RN #3 was observed to place a medication capsule in a hand held spiriva inhaler and had it to the resident. The resident was observed to administer two puffs. The resident was not observed to have been offered any water to rinse her mouth or have been instructed to do so by RN #3.</p> <p>During clinical record review, for Resident #28, on 6/4/12 at 10:00 A.M., the physician order rewrites, dated 5/04/12, included: "Aspirin (ASA)81 mg give one tablet orally Monday, Wed, Friday,*take with food/meal," "Lopressor 25 mg (used to lower blood pressure) give one tablet orally once a day *with or immediately after food/meal," "Spiriva 18 inhale (dilates bronchial tubes) one capsule orally via handheld device twice daily using 2 separate inhalations *rinse mouth after use.*"</p> <p>The 2010 Nursing Spectrum Drug Handbook, reviewed on 6/6/12 at 1:00</p>			

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	<p>P.M. indicated: Lopressor-give with or immediately after meals. An information sheet for "Spiriva," provided on 6/6/12 at 2:35 p.m. by the pharmacist at the local pharmacy utilized by the facility, indicated "rinse your mouth after using the inhaler to prevent dry mouth and throat irritation."</p> <p>5. During interview on 6/4/12 at 10:00 A.M. with the Director of Nursing, she indicated the pharmacy had only recently started adding the directions for medications such as with or without food to the physician rewrites and MAR (medication administration records). During interview with the Dietary Manager on 6/6/12 at 12:15 p.m. she indicated breakfast starts at 7 a.m. for the residents who eat in their rooms and at 7:30 A.M. for the dining room.</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>						