

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155670	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2014
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF NEWBURGH	STREET ADDRESS, CITY, STATE, ZIP CODE 5233 ROSEBUD LN NEWBURGH, IN 47630
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 18, 19, 20, 24, and 25, 2014</p> <p>Facility number: 011049 Provider number: 155670 AIM number: 200258520</p> <p>Survey Team: Denise Schwandner, RN TL Diana Perry, RN Anna Villian, RN Sylvia Scales, RN Barbara Fowler, RN (11/18,19, 24, 25/14) Diane Hancock, RN (11/18,19, 24, 25/14)</p> <p>Census bed type: SNF/NF: 96 Total: 96</p> <p>Census Payor Type: Medicaid: 62 Medicare: 14 Other: 20 Total: 96</p> <p>These deficiencies reflect State findings</p>	F000000	<p>This Plan of Correction is submitted under the State and Federal Regulations and Statues applicable to long-term care providers. This Plan of Correction does not constitute an admission on part of the facility. We request this Plan of Correction serve as our credible allegation of compliance. In addition, we are asking for desk review, paper compliance consideration for this survey. To support this request, we have included copies/exhibits of all inservice materials and sign in sheets to date. Should you have any questions, please feel free to contact me at (812) 473-4761. Sincerely, Fairley (Lee) R. Taylor Jr. HFA Administrator</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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F000241 SS=D	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on December 1, 2014 by Jodi Meyer, RN</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review, the facility failed to provide a dignified meal service to 3 of 7 residents served, in that residents at tables were not served together and one resident who required assistance with meals did not receive assistance. (Resident #22, Resident #30, unidentified resident)</p> <p>1. On 11/18/14 at 12:41 p.m., Resident #30 was observed sitting at a table alone. Resident # 30 was observed using her fingers to eat food. A large amount of food was observed in Resident #30's lap. During the meal observation no staff were observed to attempt to assist</p>	F000241	<p>It is the practice of this facility to provide dignity to our residents.</p> <p>1. No immediate corrective action could be taken for residents #22 or #30. OT referral for self feeding was made for resident #30 but family refused the evaluation. 2. All residents have the potential to be affected. 3. Dining room services observed and residents interviewed. Based on finding a new seating chart was made and communicated to dietary and nursing staff(exhibit A). Tables are numbered for order of serving meal. Seating chart will be reviewed monthly in QA for any changes or updates needed. Staff education will be completed by SDC or designee on quality of life/dignity</p>	12/19/2014

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	<p>Resident #30 with her meal.</p> <p>2. During an observation in the 200 hall dining room on 11/18/14 at 12:20 p.m., Resident #22 was observed sitting at a table with two other residents who had received their meal trays and were eating. Resident #22 did not receive her tray until 12:35 p.m.</p> <p>3. On 11/18/14 at 12:33 p.m., a random observation of four unidentified residents were observed to be eating the noon meal. One of the four residents at the table was not assisted with the noon meal until 12:53 p.m.</p> <p>On 11/25/14 at 2:14 p.m., CNA #5 indicated during meal times all the residents at a table are served at once.</p> <p>3.1-3(t)</p>		<p>on meal service and with assisting and/or promoting independence with meals (exhibit B). 4. Meal service will be observed by DON/designee daily for 5 days a week x 2 months, then daily 3 days a week x 2 months, then once weekly x 2 months(exhibit C). Findings will be reviewed in the QA meeting monthly x 6 months or until 100% compliance has been achieved.</p>	

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>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 record review and interview, the facility failed to ensure services were provided in accordance with the written physician orders for 1 of 37 residents in the stage 2 sample of 37 residents, whose records were reviewed for physician's orders, in that, a resident whose wounds were to be reassessed continued to receive wound care with no physician's order and the resident had a physician's order for weights to be obtained for a week and faxed to the physician with no weight being obtained. (Resident #24)</p> <p>Findings include:</p> <p>The clinical record of Resident #24 was reviewed on 11/24/14 at 8:33 a.m. Resident #24 had diagnoses including, but not limited to, hypertension, stage 3 (three) chronic kidney disease, fracture left hip with open reduction and internal fixation of the left femur. The clinical record indicated Resident #24 developed a blister to the left heel on 10/29/14.</p> <p>A care plan, dated 10/28/14, indicated changes in skin status are to be reported</p>	F000282	<p>It is the practice of this facility to follow physicians orders. 1. Immediate corrective action take: MD notified on 11/24/14 and received new treatment order for resident #24 as stated in 2567.</p> <p>2. All residents with daily weight orders and skin treatment orders have the potential to be affected.</p> <p>3. All new orders will be reviewed in morning meeting 5 days a week(exhibit D). All treatment orders will be reviewed weekly for 6 months by DON/Designee. All daily weights will be reviewed by RD, DON/designee during weekly NAR (Nutritional At Risk) meeting to ensure MD orders are being followed. 100% audit of all daily weight orders completed 11/28/14. Staff will be educated on following MD orders and MD notification(exhibit E) and Weight Monitoring System (exhibit F) by SDC or designee.</p> <p>4. Daily weights will monitored by DON/Designee 7 days a week x 2 months, 5 times a week x 2 months, 3 times a week x 2 months and then weekly. Findings will be discussed in QA monthly for 6 months or until 100% compliance has been achieved.</p>	12/19/2014			

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	<p>to the physician.</p> <p>Resident #24 had a physician's order, dated 10/27/14, for skin prep to be applied to a blister on the left heel tid (three times a day) for 10 days, then reassess.</p> <p>Resident #24 had a physician's order, dated 10/31/14, to d/c (discontinue) the skin prep to the left heel and start Marathon skin prep (a type of skin prep) to the left heel every 3 (three) days for 10 days, then reassess.</p> <p>During an observation on 11/24/14 at 9:49 a.m. LPN #2 was observed to cleanse the left heel of Resident #24 with normal saline and apply Marathon skin prep.</p> <p>The clinical record lacked documentation of any reassessment or any further physician's orders for wound care to the left heel.</p> <p>During an interview on 11/24/14 at 3:05 p.m., LPN #2 indicated no follow up assessments or physician's orders had been obtained for Resident #24's left heel. LPN #2 indicated she had notified the physician today and received new orders for Resident #24's wound care to the left heel.</p>			

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F000325 SS=D	<p>Resident #24 had an additional physician's order, dated 11/4/13, for a daily weight and to fax the weights to the physician in 1 (one) week.</p> <p>The clinical record lacked any documentation of the daily weights for the week of 11/4/14 or the physician being notified. The clinical record indicated Resident #24 did not have daily weights started until 11/11/14.</p> <p>During an interview on 11/24/14 at 3:15 p.m., LPN #2 indicated the weights had not been obtained until 11/11/14 and the physician had not been notified.</p> <p>3.1- 35(g)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of</p>			

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	<p>nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, interview and record review, the facility failed to ensure 1 of 3 residents sampled for nutrition, in the sample of 4 who met the criteria, was provided treatment and services to maintain nutritional status, in that the residents experienced weight loss interventions were not implemented for three weeks. (Resident #46)</p> <p>Finding includes:</p> <p>Resident #46's clinical record was reviewed on 11/24/2014 at 8:35 a.m. The resident was admitted on 9/18/12 with diagnoses including, but not limited to, anemia, dysphagia, edema, chronic obstructive pulmonary disease, congestive heart failure, chronic pain syndrome, osteoarthritis, anxiety state, depressive disorder, epilepsy, visual disturbance, transient cerebral ischemia, asthma, bone and cartilage disease, history of breast malignancy, hypertension, hyperlipidemia, late effect hemiplegia, and senile dementia.</p> <p>The resident's weights included the</p>	F000325	<p>It is the practice of this facility to maintain nutritional status of our residents unless unavoidable.</p> <p>1. MD, RD and family was notified of weight loss for resident #46 on 11/24/14. RD saw resident #46 on 11/24/14 and started a thickened house shake BID with med pass, a nutritional treat cup x 1 daily with meal and an MVI daily. Resident #46 was not agreeable to enriched foods. 11/28/14, placed on weekly weight and on 12/1/14-Megace was also ordered as appetite stimulant. 2. All residents have the potential to be affected. 3. Weights will be documented in weight book (exhibit G) as ordered by nurse and verified by DON/Designee based on order frequency. MD/Family/RD will be notified by nurse of any significant weight changes as per policy. Weights will be discussed with RD weekly during NAR (Nutritionally At Risk) meeting (exhibit D) and RD will make an IDT entry in progress notes for all team members present to review and sign. Staff education on weight monitoring system (exhibit F) and MD notification (exhibit E) will be completed by SDC or designee. 4. Weekly/Monthly weights will be monitored by</p>	12/19/2014

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	<p>following: 11/6/14 180.6 pounds 10/4/14 209 pounds 8/4/14 213 pounds</p> <p>Physician's orders included an order dated 11/5/14 for liquids to be upgraded to nectar thick, "Pt. [patient] to remain on mechanical soft solids. Continue thin liquids between meals with precautions."</p> <p>The resident had a comprehensive care plan for swallowing difficulty, dated 10/30/14. Interventions included, but were not limited to, the following: Provide meals per physician's diet order Allow sufficient time to eat Close supervision during meals Feeding/dining assistance as needed Ensure resident is alert and sitting in upright position during meals and remains upright for 30-45 minutes afterwards Observe for coughing, tearing, runny nose, wet vocal tone, difficulty breathing, pocketing food Obtain weights as ordered Obtain laboratory data as ordered Monitor/evaluate food/beverage intake via meal intake records and observations Notify Registered Dietitian, family and physician of significant weight changes.</p> <p>On 11/24/2014 at 9:01 a.m., LPN #1 was</p>		<p>DON/Designee for 5 x week for 2 months, then 3 x week for 2 months, then once weekly for 2 months to ensure MD notified of weight changes.(exhibit G). Findings will be discussed in QA monthly for 6 months or until 100% compliance has been achieved.</p>				

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	<p>interviewed about Resident #46's weights. She looked up the resident on a computer at the desk. She was only able to access the 11/6/14 weight of 180 pounds. The computer would not allow her access to the previous weights at that time. LPN #1 indicated nursing staff put the weights in the computer and were supposed to note changes, and notify the doctor and family. A re-weight of Resident #46 was requested. At 10:00 a.m., LPN #1 reported the resident's re-weight was 174.5 pounds. She indicated the physician and family had been notified of the weight loss at that time.</p> <p>On 11/24/14 at 11:04 a.m., LPN #1 indicated physician's orders had been received for nutritional supplements and a multivitamin. She indicated the nurse who put the weights in the system should note differences.</p> <p>Resident #46 was observed on 11/24/2014 at 8:32 a.m., in her room seated in a wheelchair; she indicated she ached all over. There was food debris in her mouth. The resident was observed on 11/24/14 at 12:10 p.m., in her room with her meal tray. A mechanical soft diet with nectar liquids was served. A Speech Language Pathologist was working with the resident. She indicated she didn't</p>			

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F000441 SS=E	<p>have much appetite today.</p> <p>3.1-46(a)(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 (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</p>			

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	<p>disease.</p> <p>(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.</p> <p>Based on observation, interview, and record review, the facility failed to provide a sanitary environment to prevent the transmission of infections in 5 of 10 residents observed receiving care, in that, hand hygiene was not performed and personal care equipment was not changed between residents. (Resident #50, #24, #14, #102, #95)</p> <p>Findings include:</p> <p>1. During an observation on 11/19/14 at 8:45 a.m., the DON (Director of Nursing) was observed to perform tracheostomy care to Resident #50. The DON washed her hands and applied sterile gloves. The DON wiped thick yellow sputum from around the tracheostomy using a gauze sponge and proceeded to walk to the trash can and open the plastic bag of trash to discard the soiled gauze. The DON obtained the inner cannula from LPN #2 and inserted it into the outer cannula of the tracheostomy. No hand hygiene or</p>	F000441	<p>It is the practice of this facility to establish and maintain an infection control program to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection .</p> <p>1. No immediate corrective action taken for residents #50, #24, #14, #102 and #95. Immediate in-service started on hand washing, PPE and contact isolation (exhibit H) on 11/20/14. 2. All residents have to potential to be affected. 3. Staff will be educated with return demonstration on hand washing technique (exhibit I). Inservicing will also be completed on c-difficile, PPE(exhibit H) and on proper ice pass (exhibit J) by SDC or designee. 4. DON/Designee will observe hand washing technique, and removal of PPE (exhibit K) and ice pass techniques (exhibit J) through random rounds 5x week for 2 months, then 3x week for 2 months, then weekly for 2 months. Findings will be reviewed in the QA meeting monthly x 6 months or until 100%</p>	12/19/2014

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	<p>glove change was performed.</p> <p>2. During an observation on 11/24/14 at 9:49 a.m., LPN #2 was observed to do a dressing change to Resident #24. LPN #2 applied gloves upon entering the resident's room. LPN #2 removed the right house shoe and sock from the right foot and feel the resident's heel. LPN #2 removed the left house shoe and moved up the thromboembolitic sock on Resident #24. LPN #2 felt the left heel of Resident #24. LPN #2 washed the left heel wound with normal saline and applied Marathon skin prep to the left heel. LPN #2 changed her gloves and washed her hands after applying the skin prep. LPN #2 elevated the bed and repositioned Resident #24's lower extremities. LPN #2 lifted Resident #24's shirt and removed a dressing from Resident #24's mid-back area. LPN #2 cleansed the area with normal saline and applied an Mepilex foam dressing to the area. LPN #2 applied Resident #24's socks and shoes, removed her gloves and washed her hands.</p> <p>3. During an observation on 11/24/14 at 11:05 a.m., RN #1 and CNA #1 was observed to be giving a bed bath to Resident #14. No hand hygiene was performed prior to the start of the the bath by RN #1 and CNA #1. After</p>		compliance achieved.	

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	washing Resident #14's face and upper torso, RN #1 and CNA #1 changed their gloves but no hand hygiene was performed. RN #1 and CNA #1 washed and dried Resident #14's lower legs and feet. RN #1 and CNA #1 applied deodorant to Resident #14's axilla areas and lotion to the upper torso, bilateral upper extremities, bilateral lower extremities, and bilateral feet. RN #1 and CNA #1 changed their gloves. Resident #14 was assisted to turn to the left side. CNA #1 tucked a wet brief and pad under Resident #14's left buttock and obtained a clean washcloth from RN #1 . CNA #1 washed and dried the right buttock, rectal area, and right hip area of Resident #14. CNA #1 obtained a clean brief and pad and tucked them under Resident #14's buttocks. CNA #1 applied lotion to Resident #14's back and right hip and buttock areas prior to turning the resident to the right side. RN #1 removed the wet brief and pad from under the resident and pulled the clean brief and pad put from under the resident's buttocks. RN #1 proceeded to wash and dry the left buttock and left hip of Resident #14. RN #1 applied lotion to Resident #14's back and left hip area. CNA #1 obtained clean water and changed her gloves. RN #1 performed pericare to Resident #14. Upon completion of pericare, RN #1 tore the brief and CNA #1 and RN #1			

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF NEWBURGH	STREET ADDRESS, CITY, STATE, ZIP CODE 5233 ROSEBUD LN NEWBURGH, IN 47630
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	<p>replaced the brief under the resident's buttocks. RN #1 and CNA #1 changed gloves and placed a clean bra, clean shirt, clean pants, and clean socks onto Resident #14. CNA #1 removed her gloves and turned the resident side to side to pull up the pants and pull down the shirt. Oral care was provided. RN #1 and CNA #1 removed their gloves and performed hand hygiene prior to exiting the room</p> <p>During an interview on 11/24/14 at 3:10 p.m., CNA #6 indicated hands should be washed and gloves changed prior to and after providing care to a resident and when going for dirty to clean areas.</p> <p>4. During an observation 11/19/14 at 9:00 p.m., CNA #4 was observed wearing a gown and gloves while assisting Resident #102 who was in contact isolation to the restroom. Following assisting the resident to her chair, she was observed wearing the same gown and gloves and going to the bedside of Resident #95 who was not on isolation and rearranging objects on the table. CNA#4 was observed to remove PPE (Personal Protective Equipment), placed in isolation containers and exit room without performing hand hygiene.</p>			

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	<p>5. On 11/24/14 at 10:45 a.m., during observation of a dressing change being performed on Resident #95 with the RN #2 and CNA #3. RN #2 was observed donning gloves and to remove the soiled dressing from Resident #95. She than removed soiled gloves and washed hands for 10 seconds donned a new pair of gloves and cleaned wound. RN# 2 was observed to remove soiled gloves and wash hands for 7 seconds after which she donned a new pair of gloves and replaced the dressing. After repositioning resident CNA #3 was observed to remove gloves and perform hand hygiene for 8 seconds prior to exiting room and RN# 2 was observed to perform hand hygiene 10 seconds prior to exiting room.</p> <p>6. On 11/18/14 at 12:20 p.m., CNA #2 was observed placing clothing protectors on residents in the 200 unit dining room. She was than observed grasping a drinking cup using it to scoop ice out of the ice chest. CNA #2 was then observed placing clothing protectors on two more residents prior to assisting with passing trays. CNA #2 was not observed to</p>			

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	<p>perform hand hygiene during this observation.</p> <p>7. During an interview on 11/24/14 at 3:08 p.m. with LPN# 3, she indicated that while doing a dressing change, she would wash hands for at least 20 - 30 seconds and don new gloves when going from a dirty to clean action. LPN #3 further indicated it is policy to remove the PPE (Personal Protective Equipment) between resident contacts.</p> <p>CNA # 4 was interviewed on 11/25/14 at 9:44 a.m., she indicated she would perform hand hygiene in between applying clothing protectors on residents and passing trays. She further indicated while passing ice in the dining room, cups should not be used as an ice scoop.</p> <p>During an interview with the Director of Nursing on 11/24/14 at 3:37 p.m., she indicated they had completed in servicing on the proper use of PPE and hand washing techniques. She indicated the facility policy stated hand washing should be performed for a minimum of 30 seconds and that PPE should be changed in between resident contact.</p>			

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	<p>8. The Facility Policy titled " Hand washing/Hand Hygiene " dated August 2012, was provided on 11/24/14 at 3:37 p.m., included, but was not limited to, " ...2. All personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors, 5. Employees must wash their hands for at least 15 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions ... " ... " Before and after direct resident contact ", " Before and after entering isolation precaution setting ", " Before and after changing a dressing ", " After contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shingella and C. Difficile (hand washing with soap and water) ", "after handling soiled or used linens, dressings ..."</p> <p>The facility Policy titled "Clostridium Difficile" dated August 2013 was provided on 11/24/14 at 3:37 p.m., by the DON. It included, but was not limited to ...Healthcare workers and visitors will wear gloves and gowns when entering the room of a resident with C. difficile</p>			

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	infection ... Glove use when caring for residents with C. difficile infections, washing hands with soap and water upon exiting the room of a resident with C. difficile infection AND strict adherence to hand hygiene in general is considered best practice. 3.1-18(b)(1) 3.1-18(l)			