PRINTED: 06/08/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155444		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE  A. BUILDING 00 COMPLETED  B. WING 04/28/2017			ETED		
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	0 20.	
	PROVIDER OR SUPPLIES  OD HEALTH AND	REHABILITATION CENTER		3720 N	NORWOOD RD NGTON, IN 46750		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG F 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
Bldg. 00	Complaint IN00 deficiencies relacited at F157 and Unrelated deficiencies: A Facility number Provider number AIM number: 1 Census bed type SNF/NF: 37 Total: 37 Census payor ty Medicare: 4 Medicaid: 24 Other: 9 Total: 37 These deficience cited in accorda	2228188 - Federal/State ated to the allegations are d F309.  Jency was cited.  April 26, 27 and 28, 2017  1: 000463  2r: 155444  200290910  2:	F 00	000	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and /or executed solely because required by the provision of the health and safety code section 1280 and 42 GFR 483.	1	
	16.2-3.1.  Quality review (2017.	completed on May 3,					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000463

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155444	ì	UILDING	00	(X3) DATE COMPL 04/28/	ETED
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	•	3720 N	.DDRESS, CITY, STATE, ZIP CODE NORWOOD RD IGTON, IN 46750		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
F 0157 SS=D Bldg. 00	resident; consult we physician; and not her authority, the rewhen there is-  (A) An accident intresults in injury and requiring physician (B) A significant of physical, mental, or is, a deterioration psychosocial status conditions or clinic (C) A need to alter (that is, a need to form of treatment of consequences, or of treatment); or  (D) A decision to the resident from the five season (B) (14) (16) (16) (17) (17) (18) (18) (19) (19) (19) (19) (19) (19) (19) (19	E/ROOM, ETC) In of Changes.  Immediately inform the with the resident's ify, consistent with his or resident representative(s)  Involving the resident which do has the potential for intervention;  In ange in the resident's per psychosocial status (that in health, mental, or is in either life-threatening real complications);  Interteatment significantly discontinue an existing due to adverse to commence a new form  In ansfer or discharge the accility as specified in  Interteatment significantly discontinue and existing due to adverse to commence and the form the state of the section, the eithat all pertinent ed in §483.15(c)(2) is ided upon request to the sesident representative, if					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) M		ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155444	B. W	NG		04/28/2017	
		1		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			NORWOOD RD		
	OD HEALTH AND I	REHABILITATION CENTER			NGTON, IN 46750		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(A) A change in ro assignment as sp	ecified in §483.10(e)(6); or					
	Federal or State la specified in parag	esident rights under aw or regulations as raph (e)(10) of this section.					
	update the addres phone number of representative(s).						
	Based on intervi	ew and record review,	F 0	157	F 157 SS=D Notify of Changes		05/20/2017
	the facility failed	d to notify the resident's			The Residents found to be affected		
	physician and/or	representative when a			by the deficient practice were		
	change of condit	tion was noted for 2 of 6			admitted to the hospital. Resident  D was sent to the hospital on		
	residents review	ed for notification.			1/9/2017 and Resident B was sent t	0	
	(Resident B and	D)			the hospital on 4/21/2017. Both of		
	,	•			these residents subsequently		
	Findings include	ed:			expired.		
					Residents have the potential to be		
	1 The closed cl	inical record for Resident			affected by the same deficient		
		on 4/26/17 at 1:08 p.m.			practice. LPN 3 has received		
		ded, but were not limited			individual one on one education		
	_	ey disease, heart failure,			regarding notifying the MD and Responsible party of the resident's		
		, hypertension and			change in condition, assessing a		
		ive pulmonary disease.			resident's change in condition,		
		•			documentation of the assessment o	f	
		admitted to the facility			resident change in condition and		
	on 11/2/16.				documenting administration of		
					medications in regards to change in		
		rent Health Care Plan,			resident's condition. RN 1's		
	•	esident D planned to			employment was terminated on 5/15/2017. Nurses will be educate	Ч	
	discharge to hon	ne.			on the following: The regulatory	u	
					verbiage for F157, the 'recognizing		
	Another Health	Care Plan, dated			and responding to the acute change	!	
	12/29/16, indica	ted Resident D had an			in condition' training module, the		
	· ·	ventions included, but			policy for 'covenant care operating		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155444 B. WING 04/28/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3720 N NORWOOD RD NORWOOD HEALTH AND REHABILITATION CENTER **HUNTINGTON. IN 46750** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG  $\mathsf{TAG}$ were not limited to, sensor pad to standards for managing change of condition within PCC' policy. wheelchair and bed. DON/Designee will review resident progress notes to monitor for Resident D had the following Physician change in resident condition five Order's: aspirin tablet 81 mg daily for days per week. DON/Designee will prophylactic use and warfarin review resident new Physician (anticoagulant) 2 mg daily on Monday, orders five days per week to monitor for new orders to signify change in Wednesday and Friday, as well as, 2.5 resident condition. DON/designee to mg every Sunday, Tuesday, Thursday and review the UDA (User defined Saturday. assessments portal) within Point Click Care five day per week to Review of a progress, dated 1/9/17 at monitor for any e-interact change in 5:02 a.m., RN 1 indicated "...send condition SBARS to review MD and family notification of any change in resident to Hospital via EMS. 911 called condition. for transport at 5:00 a.m. Resident Nurses will be disciplined if there is a transported via EMS at 0515." failure to notify MD/Responsible party of change in condition. The first neurological assessment, dated Deficiencies will be reported to 1/9/17 at 4:05 a.m., RN 1 indicated Quality Assurance monthly for six months. Clinical monitoring of nurse "Lethargic" as the Level of notes, MD orders and change in Consciousness (LOC) assessment. condition sbars will continue daily Resident D's pupils were not equal and five times per week in the clinical the response time of both pupils were meeting. noted as "Sluggish." Resident D was Training and systemic changes will unable to follow simple commands the it be complete by May 20, 2017. was noted the LOC was "Abnormal" for the resident. The second neurological assessment, dated 1/9/17 at 4:20 a.m., RN 1 indicated Resident D remained "Lethargic" with sluggish left and right pupils.

The third neurological assessment, dated

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155444	A. BUILDING <u>00</u> B. WING	COMPLETED 04/28/2017
100777	STREET ADDRESS, CITY,	
NAME OF PROVIDER OR SUPPLIER	3720 N NORWOOD	
NORWOOD HEALTH AND REHABILITATION CENTER	HUNTINGTON, IN 4	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ER'S PLAN OF CORRECTION  (X5)  ECOLUL ACTION SHOULD DE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)  DATE  COMPLETION  DATE
1/9/17 at 4:30 a.m., indicated Resident D	mo	DATE
was unable to follow simple commands		
and the response was abnormal for the		
resident. The pupils remained sluggish.		
All neurological assessments were		
completed by RN 1.		
Review of a "Fall Report of Incident,"		
RN 1 indicated Resident D had an		
unwitnessed fall at approximately 3:50		
a.m. on 1/9/17. Resident D was found in		
her room and noted to have fallen from		
her bed. The assessment indicated		
Resident D was currently on		
anticoagulant therapy. Resident D was		
unable to communicate what had		
occurred and her mental status was noted		
as "Lethargic." The report indicated the		
Nurse Practitioner (NP) was notified of		
the fall on 1/9/17 at 4:40 a.m. via phone.		
The NP indicated for the facility to send		
Resident D the the emergency room for		
evaluation. The report indicated either an		
alarm failure or device removal. The		
note did not indicated staff responded to		
an alarm.		
Review of the hospital records were		
completed on 4/28/17 at 11:28 a.m.		
completed on 4/20/1/ at 11.20 a.m.		
Review of an EMS transportation report,		
indicated the initial a call was received		
from the facility on 1/9/17 at 4:51 a.m.		
EMS was dispatched at 4:52 a.m. to the		

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	OF CORRECTION IDENTIFICATION NUMBER:  155444	A. BUILDING B. WING	00	COMPLETED 04/28/2017
	PROVIDER OR SUPPLIER OOD HEALTH AND REHABILITATION CENTER	3720 N	NDDRESS, CITY, STATE, ZIP CODE NORWOOD RD NGTON, IN 46750	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO! (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	facility.  The "Scene Information," indicated Resident D was found laying in bed, in the supine (face up) position.  The "History of Present Illness" information, indicated Resident D was found around 3:50 a.m. on the floor next to her bed. The resident was put back into bed and the physician was called. The neurological exam indicated Resident D was confused and non-responsive.  The "Initial Physical Findings," indicated Resident D had a "half dollar size contusion to her R [right] forehead."  The "Impression/Diagnosis" report, indicated when the night nurse was asked how long before the "patient" was checked on, the nurse stated approximately 2 hours prior. The nurse indicated the resident had been "going down hill" and it took several attempts to obtain what the resident's normal mental status was.  Resident D arrived to the local hospital on 1/9/17 at 5:39 a.m. She was noted as semi-responsive at times.  Review of a Computerized Tomography			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155444	l í	ILDING	nstruction <u>00</u>	(X3) DATE : COMPL <b>04/28</b> /	ETED
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		3720 N	DDRESS, CITY, STATE, ZIP CODE NORWOOD RD IGTON, IN 46750		
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TAG	(CT) scan done of indicated Resider convexity and particular hemorrhage with and 1.3 cm right. Impending uncarriage a.m., indicated a.m., indicated are scan showed a late of the second hospit mental status. So wentilator and second hospit mental status second hospit mental status. So wentilator and second hospit mental status second ho	on 1/9/17 6:30 a.m., nt D had a "Large left arafalcine subdural a significant mass effect ward midline shift. I herniation."  ess note, dated 1/9/17 at atted Resident D was on al fibrillation and the CT arge subdural hematoma. intubated and sent via arger hospital.  ess note, dated 1/9/17 at atted Resident D arrived at attal with an altered he arrived intubated on a		TAG	DEFICIENCY)		DATE
		removed from the epired on 1/12/17 at 4:15					

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	PROVIDER OR SUPPLIER OD HEALTH AND F	REHABILITATION CENTER	3720 N	DDRESS, CITY, STATE, ZIP CODE NORWOOD RD IGTON, IN 46750		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	p.m., LPN 2 indioff of duty as shed 4:00 a.m. to 4:30 indicated RN 1 are sident D's purseem "right." LID's pupils did not unsure at that time contacted the phrase RN 1 probably of Director of Nursead ADON then proliphysician. She in normally alert are before her fall, so changes. She incompared as Resident D, be sent out to the During a telephorat 1:20 p.m., RN call the physician but called the AIA ADON then call send Resident D indicated the startesident to the hemorgency with indicated herself Hoyer lift and pubed. Review of 1/8/17 through 1	ndicated Resident D was nd oriented, but days he did have some dicated the moment she she knew she needed to				

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	PROVIDER OR SUPPLIER	REHABILITATION CENTER		3720 N	DDRESS, CITY, STATE, ZIP CODE NORWOOD RD IGTON, IN 46750		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
		right related to the fall.					
	p.m., the ADON call her and then physician of an eRN 1 did not doo the ADON related No date or time.	iew on 4/27/17 at 1:32 indicated the staff could she would notify the event. She was informed cument any phone call to ed to Resident D's fall. was listed as the ADON ling the physician or o the facility.					
	B was reviewed Diagnoses include to, Chronic Obst Disease (COPD) anxiety and atria was admitted to A 3/21/17, Quar	inical record for Resident on 4/26/17 at 11:32 a.m. ded, but were not limited ructive Pulmonary diabetes mellitus, al fibrillation. Resident B the facility on 1/30/15. terly, Minimum Data Set ent, indicated Resident B intact.					
	dated 8/27/15, in problem related Reflux Disease ( included, but we	rent Health Care Plan, adicated Resident B had a to Gastroesophageal GERD). Interventions re not limited to, give ardered, document side tiveness.					
		had a Health Care Plan, adicating Resident B had					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155444	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	COMP	E SURVEY LETED 3/2017
	PROVIDER OR SUPPLIER OD HEALTH AND F	REHABILITATION CENTER	3720 N	ADDRESS, CITY, STATE, ZIP COE I NORWOOD RD NGTON, IN 46750	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	-	d to COPD. cluded but were not ted the head of bed.				
	at 10:00 p.m., Ll "Resident had [intramuscular]]	vomited x one. IM phenergan [a medication nd vomitting] given at				
	4/21/17 at 5:00 a "Resident noted [blood pressure] moist respiration staff, but follows commands." Th documentation f	ext progress note, dated a.m., RN 1 indicated to have decrease BP, and decreased 02 sats, as. Will not speak to a [sic] aimple [sic] ere was no from 10:00 p.m. on e1/17 at 5:00 a.m.				
	a.m., RN 1 indic	dated 4/21/17 at 5:15 ated the ADON was lent B's condition and hysician.				
		dated 4/21/17 at 5:57 ated EMS was in the ort Resident B.				
	the last documer	NA charting on 4/21/17, ntation was done at 1:40 owel and bladder for				

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	PROVIDER OR SUPPLIER  OOD HEALTH AND REHABILITATION CENTER	3720 N	ADDRESS, CITY, STATE, ZIP CODE NORWOOD RD NGTON, IN 46750	
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	Review of the Medication Administration Record (MAR) for April 2017, there was no documentation Resident B was given phenergan or if the medication was effective.			
	Review of the MAR for March 2017, Resident B was given phenergan on 3/23/17 at 10:43 a.m., 3/27/17 at 9:15 a.m., and 3/30/17 at 11:15 p.m. The medication was noted as effective after each administration.			
	Review of the progress notes from 3/23/17 through 3/30/17, neither the physician or responsible party were notified of the injections or vomiting episodes.			
	Review of the hospital records were completed on 4/28/17 at 11:28 a.m.			
	Review of an EMS transportation report, indicated the initial call was received from the facility on 4/21/17/17 at 5:39 a.m. EMS arrived at the facility at 5:47 a.m.			
	The "Scene Information," indicated Resident B was laying in bed on their arrival. They heard audible lung sounds from the door. Resident B had a green liquid on the middle of his bottom lip that			

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NAME OF PROVIDER OR SUPPLIER  NORWOOD HEALTH AND REHABILITATION CENT	3720 N NO	RESS, CITY, STATE, ZIP CODE DRWOOD RD FON, IN 46750	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY F TAG REGULATORY OR LSC IDENTIFYING INFORMAT		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
ran down to his chin that was not flowing, as well as, a strong smell of urine.			
The "History of Present Illness" information, indicated Resident B had complained to staff "last night" of epigastric pain. Staff indicated Resident B refused Maalox. Staff indicated Resident B had been vomitting and had received phenergan. Staff indicated Resident B continued to vomit until approximately 11:30 p.m.  The "Impression/Diagnosis" report, indicated Resident B's hands were cold the touch and his oxygen saturation was 73%. Oxygen was placed at 2 L/min.  Review of a chest X-ray completed on 4/21/17 at 6:51 a.m., Resident B was noted to have bilateral infiltrates in both lung bases.  A physical exam dated, 4/21/17 at 7:08 a.m., indicated the primary diagnosis fo Resident B was sepsis, due to unspecificorganism and atrial fibrillation with rap	to s		
ventricular response. Resident B was made comfort measures only by his family and expired on 4/21/17.  During a telephone interview on 4/27/1 at 10:42 a.m., LPN 3 indicated she left			

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	after she gave Resident B the phenergan, but put it on the 24 hour report. She indicated she did not document if the medication was effective or not.			
	During a telephone interview on 4/27/17 at 1:20 p.m., RN 1 indicated Resident B had vomited twice more and then she figured the phenergan was working because it was not a lot. She indicated she checked on Resident B, but not every 2 hours. She indicated the last time she was in his room was approximately 3:00 a.m. She did not document any information during her shift.  Review of a current facility policy, dated October 2015, titled "COVENANT CARE OPERATING STANDARDS MANAGING CHANGE OF CONDITION WITHIN PCC," which was provided by the Director of Nursing on 4/27/17 at 9:25 a.m., indicated the			
	"Objective: To appropriately assess, document, and communicate changes of condition (COC) to the primary care provider. To provide treatment and services to address changes in accordance with patient needs and existing Advance Directive/POLST/POST/MOST.  Practice Standards:			

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	COMPL	
		155444	B. W	ING		04/28/	2017
NAME OF I	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			ADDRESS, CITY, STATE, ZIP CODE		
NODWO					NORWOOD RD		
NORWO	OD HEALTH AND I	REHABILITATION CENTER		HUNTIN	NGTON, IN 46750		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DLI ICILIAC I)		DATE
		fe-threatening events:					
		your initial assessment					
		ction is necessary, and					
		is in accordance with					
	exiting Advance	Directive					
	2 Dom dan	an ar interrentiana Cuat					
		gency interventions, first					
	aide, in accordar						
		physician of assessment					
	findings						
	<ul><li>6. Notify the responsible party.</li><li>8. Report change of condition to DON,</li></ul>						
		,					
	ED, and other m	lembers					
	Daview of a goal	and facility nation, datad					
		ond facility policy, dated					
	· ·	tled "Falls Management,"					
	_	ided by the Director of					
	Nursing on 4/27						
	indicated the fol	•					
	PURPOSE	d Interdisciplinary Team					
		factors and provide					
		minimize risk, injury,					
	and occurrences						
	and occurrences	•					
	PROCEDURE	E FOR RESPONDING					
	TO A FALL						
	_	ing the Resident, evaluate					
		nptoms of physical injury					
	or trauma.	inpoints of physical hijary					
		y emergent conditions or					
		Initiate neurological					
		nwitnessed falls, and					
	Lineaxs for any u	inwiniesseu ians, and	I				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155444		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 04/28/2017
	PROVIDER OR SUPPLIER  OD HEALTH AND REHABILITATION CENTER	3720 N	ADDRESS, CITY, STATE, ZIP CODE NORWOOD RD NGTON, IN 46750	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	falls with actual or suspected head injury or trauma.  4. Notify the Physician and Responsible Party as soon as practicable following the fall"  This Federal tag relates to Complaint			
	IN00228188.  3.1-5(a)(1) 3.1-5(a)(2)			
F 0309 SS=G Bldg. 00	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care.			
	483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155444		A. BUILDING 00 COMPLETED  B. WING 04/28/2017					
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		3720 N	ADDRESS, CITY, STATE, ZIP CODE NORWOOD RD NGTON, IN 46750		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	residents who require services, consister standards of practiperson-centered coresidents' goals and Based on record the facility failed properly transpotreatment follow residents review (Resident D). The resulted in a delawith significant of the facility also resident was assessift following in for nausea and versidents review administration for findings included.  1. The closed classification in the facility also residents review administration for findings included.  1. The closed classification in the classificati	review and interview, It to ensure a resident was red for evaluation and ing a fall for 1 of 3 ed for accidents his deficient practice ay in treatment after a fall injury. failed to ensure a essed during an entire medication administration omiting for 1 of 5 ed for medication follow-up (Resident B).	F 0.	309	F309 SS=G Provide care and service for Highest well being The Residents found to be affected by the deficient practice were admitted to the hospital. Resident I was sent to the hospital on 1/9/202 and Resident B was sent to the hospital on 4/21/2017. Both of the residents subsequently expired. Residents experiencing a change in condition have the potential to be affected by the same deficient practice. RN 1 received one on one training in regards to caring for a resident with a potential head injurthat has sustained a fall, notification of MD and responsible party immediately upon recognizing the change in condition to ensure expedient treatment, the importance of documenting assessments for follow up of changes in condition to ensure efficacy of medications administered to treat change in condition and review of the 'covenant care operating standards for managing change of condition within pcc' policy that states the nurse will appropriately assess, document and communicate changes in condition to the primary care provider. Nurse	D 1.7 see	05/20/2017
I					will be educated in the following:		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		00	COMPLETED
		155444	B. W	B. WING		04/28/2017
STREET ADDRESS, CITY, STATE, ZIP CODE			ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER			1	NORWOOD RD	
NORWO	OD HEALTH AND E	REHABILITATION CENTER			NGTON, IN 46750	
					101011, 111 40700	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG		DATE
	discharge to hom	ne.			F309 Provide care/services for	
					highest well being verbiage, the	
	Another Health (	Care Plan, dated			'recognizing and responding to the	
	12/29/16, indicat	ted Resident D had an			acute change in condition' training	
	· ·	ventions included, but			module, the 'covenant care	
	were not limited	· ·			operating standards for managing change in condition in pcc' policy,	
	wheelchair and b				the acute mental status change care	
	wheelchan and t	eu.			path and the change in condition file	
					cards.	
		he following Physician			DON/Designee will review resident	
	Order's: aspirin	tablet 81 mg daily for			progress notes to monitor for	
	prophylactic use	and warfarin (blood			change in resident condition five	
	thinner) 2 mg da	ily on Monday,			days per week. DON/Designee will	
	Wednesday and	Friday, as well as, 2.5			review all resident new Physician	
	1	y, Tuesday, Thursday and			orders five days per week to monito	r
	Saturday.	y, ruesauj, riiaisauj una			for new orders to signify change in	
	Saturday.				resident condition. DON/designee to	
	D : C !!E !	ID CITED II			review the UDA (User defined	
		l Report of Incident,"			assessments portal) within Point	
		Resident D had an			Click Care five day per week to	
	unwitnessed fall	at approximately 3:50			monitor for any e-interact change in	
	a.m. on 1/9/17.	Resident D was found in			condition SBARS to review MD and	
	her room and no	ted to have fallen from			family notification of any change in	
	her bed. The ass	essment indicated			condition.	
	Resident D was	currently on			Nurses will be disciplined if there is a failure to notify MD/Responsible	d
		erapy. Resident D was			party of change in condition.	
	unable to commi				Deficiencies will be reported to	
					Quality Assurance monthly for six	
		mental status was noted			months. Clinical monitoring of nurs	e
		The report indicated the			notes, MD orders and change in	
		er (NP) was notified of			condition sbars will continue daily	
	the fall on 1/9/17	at 4:40 a.m. via phone.			five times per week in the clinical	
	The NP indicated	d for the facility to send			meeting.	
	Resident D the tl	ne emergency room for			Training and systemic changes will	
		report indicated either an			be complete by May 20, 2017.	
		device removal. The				
	Hote ala not man	cated staff responded to	1			

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	AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155444  A. BUILDING  00  B. WING			COMPLETED 04/28/2017	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	3720 N	ADDRESS, CITY, STATE, ZIP CODE NORWOOD RD NGTON, IN 46750	
(X4) ID PREFIX TAG	(EACH DEFICIENC	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	1/9/17 at 4:05 a.r "Lethargic" as the Consciousness (I Resident D's pupthe response time noted as "Sluggis unable to follow was noted the LC the resident.  The second neurodated 1/9/17 at 4 Resident D remanded sluggish left and The third neurologish left and the response resident. The pural neurological completed by RN Review of a progen 5:02 a.m., RN 1 is resident to Hospifor transported via Editorial states.	ils were not equal and e of both pupils were sh." Resident D was simple commands the it DC was "Abnormal" for cological assessment, 20 a.m., RN 1 indicated ined "Lethargic" with right pupils.  Degical assessment, dated m., indicated Resident D commands was abnormal for the pils remained sluggish. assessments were N 1.  Degress, dated 1/9/17 at indicated "send tal via EMS. 911 called 200 a.m. Resident			
		28/17 at 11:28 a.m.			

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	OF CORRECTION  OF CORRECTION  155444	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/28/2017
	PROVIDER OR SUPPLIER OD HEALTH AND REHABILITATION CENTER	3720 N	ADDRESS, CITY, STATE, ZIP CODE NORWOOD RD NGTON, IN 46750	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Review of an EMS transportation report, indicated the initial call was received from the facility on 1/9/17 at 4:51 a.m. EMS was dispatched at 4:52 a.m. to the facility.  The "Scene Information," indicated Resident D was found laying in bed, in the supine (face up) position.  The "History of Present Illness" information, indicated Resident D was found around 3:50 a.m. on the floor next to her bed. The resident was put back into bed and the physician was called. The neurological exam indicated Resident D was confused and non-responsive.  The "Initial Physical Findings," indicated Resident D had a "half dollar size contusion to her R [right] forehead."  The "Impression/Diagnosis" report, indicated when the night nurse was asked how long before the "patient" was checked on, the nurse stated approximately 2 hours prior. The nurse indicated the resident had been "going down hill" and it took several attempts to obtain what the resident's normal mental			
	status was.			

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	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	3720 N	ADDRESS, CITY, STATE, ZIP COD NORWOOD RD NGTON, IN 46750	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
		ed to the local hospital  a.m. She was noted as at times.				
	(CT) scan done of indicated Reside convexity and parties the morrhage with	nputerized Tomography on 1/9/17 6:30 a.m., nt D had a "Large left arafalcine subdural a significant mass effect ward midline shift.				
	7:26 a.m., indica warfarin for atria scan showed a la [A pool of blood its outermost con	ess note, dated 1/9/17 at ted Resident D was on al fibrillation and the CT arge subdural hematoma between the brain and vering]. Resident D was nt via helicopter to a				
	8:18 a.m., indicathe second hospi	ess note, dated 1/9/17 at ted Resident D arrived at tal with an altered he arrived intubated on a dated.				
	1/9/17 at 11:54 a with poor progne change her over of Attorney (PO indicated she did	pital progress note, dated n.m., indicated "Patient osis. Surgery would not all outcome." The Power A) for Resident D, I not want to purse ation unless the patient				

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	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155444	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction  00	(X3) DATE SURVEY COMPLETED 04/28/2017
	PROVIDER OR SUPPLIER  OOD HEALTH AND REHABILITATION CENTER	3720 N	ADDRESS, CITY, STATE, ZIP CODE NORWOOD RD NGTON, IN 46750	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	would have reasonable recovery and meaningful life.			
	Resident D was removed from the ventilator and expired on 1/12/17 at 4:15 a.m.			
	During an interview on 4/27/17 at 12:53 p.m., LPN 2 indicated RN 1 was coming off of duty as she was coming on around 4:00 a.m. to 4:30 a.m. on 1/9/17. She indicated RN 1 asked her to look at Resident D's pupils because they did not seem "right." LPN 2 indicated Resident D's pupils did not look right and she was unsure at that time if RN 1 had already contacted the physician. She indicated RN 1 probably called the Assistant Director of Nursing (ADON) and the ADON then probably called the physician. She indicated Resident D was normally alert and oriented, but days before her fall, she did have some changes. She indicated the moment she saw Resident D, she knew she needed to			
	be sent out to the hospital.  During a telephone interview on 4/27/17 at 1:20 p.m., RN 1 indicated she did not call the physician at the time of the fall, but called the ADON. She indicated the ADON then called back and told her to send Resident D to the hospital. She indicated the staff were able to send a			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155444		A. BUILDING B. WING	00	COM	PLETED 28/2017	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	3720 N	ADDRESS, CITY, STATE, ZIP CO NORWOOD RD NGTON, IN 46750	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES  ICY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	emergency with indicated herself Hoyer lift and pubed. Review of 1/8/17 through 1 document any te ADON. RN 1 in done everything  During an intervent p.m., the ADON call her and then physician of an error and the ADON related No date or time being called, call returned a call to Review of a faci 2010, titled "Fall was provided by on 4/27/17 at 9:2 following:  "BASIC RESPONT Nursing staff and PURPOSE To evaluate risk interventions to and occurrences."	lity policy, dated October ls Management," which the Director of Nursing 25 a.m., indicated the  ONSIBILITY d Interdisciplinary Team factors and provide minimize risk, injury,				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155444		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED  B. WING 04/28/2017					
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER		3720 N I	DDRESS, CITY, STATE, ZIP CODE NORWOOD RD IGTON, IN 46750		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	for signs and synor trauma3. Address an first-aide needs. checks for any ufalls with actual or trauma. 4. Notify the Ph Party as soon as fall"  2. The closed cl B was reviewed Diagnoses include to, Chronic Obst Disease (COPD) anxiety and atria was admitted to A 3/21/17, Quar (MDS) assessment was cognitively  Review of a currel dated 8/27/15, in problem related Reflux Disease (included, but we medications as ceffects and effects	rent Health Care Plan, ndicated Resident B had a to Gastroesophageal (GERD). Interventions ere not limited to, give ordered, document side					
		ndicating Resident B had					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155444		(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION  O  O	COM	TE SURVEY  MPLETED  28/2017	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	3720	ET ADDRESS, CITY, STATE, ZIP C O N NORWOOD RD ITINGTON, IN 46750	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
		cluded but were not red the head of bed.				
	at 10:00 p.m., LI "Resident had [intramuscular] p to treat nausea at this time per resi	vomited x one. IM phenergan [a medication and vomiting] given at dents request."				
	4/21/17 at 5:00 a "Resident noted [blood pressure]	ext progress note, dated i.m., RN 1 indicated to have decrease BP , and decreased 02 sats, is. Will not speak to				
	staff, but follows commands." Th documentation for	a [sic] aimple [sic]				
	a.m., RN 1 indic	dated 4/21/17 at 5:15 ated the ADON was ent B's condition and nysician.				
		dated 4/21/17 at 5:57 ated EMS was in the ort Resident B.				
	the last documen	NA charting on 4/21/17, station was done at 1:40 owel and bladder for				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155444		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/28/2017	
	PROVIDER OR SUPPLIER OD HEALTH AND F	REHABILITATION CENTER	3720 N	ADDRESS, CITY, STATE, ZIP CODE I NORWOOD RD NGTON, IN 46750	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	Record (MAR) f	dedication Administration for April 2017, there was in Resident B was given the medication was			
	Resident B was a 3/23/17 at 10:43 a.m., and 3/30/1	AR for March 2017, given phenergan on a.m., 3/27/17 at 9:15 7 at 11:15 p.m. The noted as effective after ion.			
	3/23/17 through physician or resp	ogress notes from 3/30/17, neither the consible party were jections or vomiting			
		ospital records were 28/17 at 11:28 a.m.			
	indicated the init from the facility	AS transportation report, ial call was received on 4/21/17/17 at 5:39 ed at the facility at 5:47			
	Resident B was arrival. They he from the door. F	rmation," indicated aying in bed on their ard audible lung sounds Resident B had a green ldle of his bottom lip that thin that was not			

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	AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:  155444		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/28/2017		
NAME OF PROVIDER OR SUPPLIER  NORWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  3720 N NORWOOD RD  HUNTINGTON, IN 46750					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD B  CROSS-REFERENCED TO THE APPROPE			
	flowing, as well urine.	as, a strong smell of					
	complained to st epigastric pain. B refused Maalo Resident B had b received pheners	icated Resident B had aff "last night" of Staff indicated Resident ox. Staff indicated been vomiting and had gan. Staff indicated inued to vomit until					
	indicated Reside	/Diagnosis" report, ent B's hands were cold to s oxygen saturation was normal range]. Oxygen L/min.					
	4/21/17 at 6:51 a	st X-ray completed on a.m., Resident B was lateral infiltrates in both					
	a.m., indicated the Resident B was a organism and attributed at response to the contributed at the contribut	he dated, 4/21/17 at 7:08 he primary diagnosis for sepsis, due to unspecified rial fibrillation with rapid onse. Resident B was easures only by his red on 4/21/17.					
		one interview on 4/27/17 PN 3 indicated she left					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155444	(X2) MUI A. BUII B. WIN	DING	NSTRUCTION  00	(X3) DATE COMPL <b>04/28</b> /	ETED
NAME OF PROVIDER OR SUPPLIER  NORWOOD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  3720 N NORWOOD RD  HUNTINGTON, IN 46750				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	but put it on the	esident B the phenergan, 24 hour report. She I not document if the effective or not.					
	at 1:20 p.m., RN had vomited twice figured the phenomenature it was not she checked on I 2 hours. She indowns in his room a.m. She did not information during Review of a curroctober 2015, the CARE OPERATE OPERATE OPERATE MANAGING CONDITION We provided by the state of the provi	ng her shift.  Tent facility policy, dated tled "COVENANT"  TING STANDARDS					
	communicate ch (COC) to the pri provide treatmer	Γ/POST/MOST.					

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155444	X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		COMP	(X3) DATE SURVEY  COMPLETED  04/28/2017	
NAME OF PROVIDER OR SUPPLIER  NORWOOD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  3720 N NORWOOD RD  HUNTINGTON, IN 46750				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF THE APPRO		ILD BE	(X5) COMPLETION DATE	
	1. Call "911" is indicates such a this intervention exiting Advance  2. Render eme aide, in accorda5. Notify the findings  6. Notify the results8. Report charter in ED, and other results	rgency interventions, first ance physician of assessment esponsible party. ange of condition to DON,					

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