STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00228188. Complaint IN00228188 - Federal/State deficiencies related to the allegations are cited at F157 and F309. Unrelated deficiency was cited. Survey dates: April 26, 27 and 28, 2017 Facility number: 000463 Provider number: 155444 AIM number: 100290910 Census bed type: SNF/NF: 37 Total: 37 Census payor type: Medicare: 4 Medicaid: 24 Other: 9 Total: 37 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 3, 2017.	F 0000	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0157 SS=D Bldg. 00	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). Based on interview and record review, the facility failed to notify the resident's physician and/or representative when a change of condition was noted for 2 of 6 residents reviewed for notification. (Resident B and D) Findings included: 1. The closed clinical record for Resident D was reviewed on 4/26/17 at 1:08 p.m. Diagnoses included, but were not limited to, chronic kidney disease, heart failure, atrial fibrillation, hypertension and chronic obstructive pulmonary disease. Resident D was admitted to the facility on 11/2/16. Review of a current Health Care Plan, dated 11/2/16, Resident D planned to discharge to home. Another Health Care Plan, dated 12/29/16, indicated Resident D had an actual fall. Interventions included, but	F 0157	**F 157 SS=D Notify of Changes** The Residents found to be affected by the deficient practice were admitted to the hospital. Resident D was sent to the hospital on 1/9/2017 and Resident B was sent to the hospital on 4/21/2017. Both of these residents subsequently expired. Residents have the potential to be affected by the same deficient practice. LPN 3 has received individual one on one education regarding notifying the MD and Responsible party of the resident's change in condition, assessing a resident's change in condition, documentation of the assessment of resident change in condition and documenting administration of medications in regards to change in resident's condition. RN 1's employment was terminated on 5/15/2017. Nurses will be educated on the following: The regulatory verbiage for F157, the 'recognizing and responding to the acute change in condition' training module, the policy for 'covenant care operating	05/20/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	were not limited to, sensor pad to wheelchair and bed. Resident D had the following Physician Order's: aspirin tablet 81 mg daily for prophylactic use and warfarin (anticoagulant) 2 mg daily on Monday, Wednesday and Friday, as well as, 2.5 mg every Sunday, Tuesday, Thursday and Saturday. Review of a progress, dated 1/9/17 at 5:02 a.m., RN 1 indicated "...send resident to Hospital via EMS. 911 called for transport at 5:00 a.m. Resident transported via EMS at 0515." The first neurological assessment, dated 1/9/17 at 4:05 a.m., RN 1 indicated "Lethargic" as the Level of Consciousness (LOC) assessment. Resident D's pupils were not equal and the response time of both pupils were noted as "Sluggish." Resident D was unable to follow simple commands the it 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		standards for managing change of condition within PCC' policy. DON/Designee will review resident progress notes to monitor for change in resident condition five days per week. DON/Designee will review resident new Physician orders five days per week to monitor for new orders to signify change in resident condition. DON/designee to review the UDA (User defined assessments portal) within Point Click Care five day per week to monitor for any e-interact change in condition SBARS to review MD and family notification of any change in condition. Nurses will be disciplined if there is a failure to notify MD/Responsible party of change in condition. Deficiencies will be reported to Quality Assurance monthly for six months. Clinical monitoring of nurse notes, MD orders and change in condition sbars will continue daily five times per week in the clinical meeting. Training and systemic changes will be complete by May 20, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1/9/17 at 4:30 a.m., indicated Resident D 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. 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(CT) scan done on 1/9/17 6:30 a.m., indicated Resident D had a "Large left convexity and parafalcine subdural hemorrhage with significant mass effect and 1.3 cm rightward midline shift. Impending uncal herniation." A hospital progress note, dated 1/9/17 at 7:26 a.m., indicated Resident D was on warfarin for atrial fibrillation and the CT scan showed a large subdural hematoma. Resident D was intubated and sent via helicopter to a larger hospital. A hospital progress note, dated 1/9/17 at 8:18 a.m., indicated Resident D arrived at the second hospital with an altered mental status. She arrived intubated on a ventilator and sedated. Review of a hospital progress note, dated 1/9/17 at 11:54 a.m., indicated "Patient with poor prognosis. Surgery would not change her overall outcome." The Power of Attorney (POA) for Resident D, indicated she did not want to purse surgical intervention unless the patient 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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 resident to the hospital if it was an emergency without an order. She indicated herself and two CNA's got a Hoyer lift and put Resident D back into bed. Review of the documentation from 1/8/17 through 1/9/17, RN 1 did not document any telephone call to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ADON. RN 1 indicated she felt she had done everything right related to the fall. During an interview on 4/27/17 at 1:32 p.m., the ADON indicated the staff could call her and then she would notify the physician of an event. She was informed RN 1 did not document any phone call to the ADON related to Resident D's fall. No date or time was listed as the ADON being called, calling the physician or returned a call to the facility. 2. The closed clinical record for Resident B was reviewed on 4/26/17 at 11:32 a.m. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), diabetes mellitus, anxiety and atrial fibrillation. Resident B was admitted to the facility on 1/30/15. A 3/21/17, Quarterly, Minimum Data Set (MDS) assessment, indicated Resident B was cognitively intact. Review of a current Health Care Plan, dated 8/27/15, indicated Resident B had a problem related to Gastroesophageal Reflux Disease (GERD). Interventions included, but were not limited to, give medications as ordered, document side effects and effectiveness. Resident B also had a Health Care Plan, dated 6/28/16, indicating Resident B had			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a problem related to COPD. Interventions, included but were not limited to, elevated the head of bed. Review of a progress note, dated 4/20/17 at 10:00 p.m., LPN 3 indicated "...Resident had vomited x one. IM [intramuscular] phenergan [a medication to treat nausea and vomitting] given at this time per residents request." Review of the next progress note, dated 4/21/17 at 5:00 a.m., RN 1 indicated "Resident noted to have decrease BP [blood pressure], and decreased 02 sats, moist respirations. Will not speak to staff, but followa [sic] aimple [sic] commands." There was no documentation from 10:00 p.m. on 4/20/17 until 4/21/17 at 5:00 a.m. A progress note, dated 4/21/17 at 5:15 a.m., RN 1 indicated the ADON was notified of Resident B's condition and will notify the physician. A progress note, dated 4/21/17 at 5:57 a.m., RN 1 indicated EMS was in the facility to transport Resident B. Review of the CNA charting on 4/21/17, the last documentation was done at 1:40 a.m. related to bowel and bladder for Resident B.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE 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 to 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 for Resident B was sepsis, due to unspecified organism and atrial fibrillation with rapid ventricular response. Resident B was made comfort measures only by his family and expired on 4/21/17. During a telephone interview on 4/27/17 at 10:42 a.m., LPN 3 indicated she left			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 following: "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:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	For emergent life-threatening events: 1. Call "911" if your initial assessment indicates such action is necessary, and this intervention is in accordance with exiting Advance Directive.... 2. Render emergency interventions, first aide, in accordance.... ...5. Notify the physician of assessment findings.... 6. Notify the responsible party. ...8. Report change of condition to DON, ED, and other members...." Review of a second facility policy, dated October 2010, titled "Falls Management," which was provided by the Director of Nursing on 4/27/17 at 9:25 a.m., indicated the following: "BASIC RESPONSIBILITY Nursing staff and Interdisciplinary Team PURPOSE To evaluate risk factors and provide interventions to minimize risk, injury, and occurrences. ...PROCEDURE FOR RESPONDING TO A FALL 1. Prior to moving the Resident, evaluate for signs and symptoms of physical injury or trauma. ...3. Address any emergent conditions or first-aide needs. Initiate neurological checks for any unwitnessed falls, and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE 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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure a resident was properly transported for evaluation and treatment following a fall for 1 of 3 residents reviewed for accidents (Resident D). This deficient practice resulted in a delay in treatment after a fall with significant injury. The facility also failed to ensure a resident was assessed during an entire shift following medication administration for nausea and vomiting for 1 of 5 residents reviewed for medication administration follow-up (Resident B). Findings included: 1. The closed clinical record for Resident D was reviewed on 4/26/17 at 1:08 p.m. Diagnoses included, but were not limited to, chronic kidney disease, heart failure, atrial fibrillation, hypertension and chronic obstructive pulmonary disease. Resident D was admitted to the facility on 11/2/16. Review of a current Health Care Plan, dated 11/2/16, Resident D planned to	F 0309	**F309 SS=G Provide care and services for Highest well being** The Residents found to be affected by the deficient practice were admitted to the hospital. Resident D was sent to the hospital on 1/9/2017 and Resident B was sent to the hospital on 4/21/2017. Both of these 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 injury that 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. Nurses will be educated in the following:	05/20/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	discharge to home. Another Health Care Plan, dated 12/29/16, indicated Resident D had an actual fall. Interventions included, but were not limited to, sensor pad to wheelchair and bed. Resident D had the following Physician Order's: aspirin tablet 81 mg daily for prophylactic use and warfarin (blood thinner) 2 mg daily on Monday, Wednesday and Friday, as well as, 2.5 mg every Sunday, Tuesday, Thursday and Saturday. 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		F309 Provide care/services for highest well being verbiage, the 'recognizing and responding to the acute change in condition' training module, the 'covenant care operating standards for managing change in condition in pcc' policy, the acute mental status change care path and the change in condition file cards. DON/Designee will review resident progress notes to monitor for change in resident condition five days per week. DON/Designee will review all resident new Physician orders five days per week to monitor for new orders to signify change in resident condition. DON/designee to review the UDA (User defined assessments portal) within Point Click Care five day per week to monitor for any e-interact change in condition SBARS to review MD and family notification of any change in condition. Nurses will be disciplined if there is a failure to notify MD/Responsible party of change in condition. Deficiencies will be reported to Quality Assurance monthly for six months. Clinical monitoring of nurse notes, MD orders and change in condition sbars will continue daily five times per week in the clinical meeting. Training and systemic changes will be complete by May 20, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	an alarm. The first neurological assessment, dated 1/9/17 at 4:05 a.m., RN 1 indicated "Lethargic" as the Level of Consciousness (LOC) assessment. Resident D's pupils were not equal and the response time of both pupils were noted as "Sluggish." Resident D was unable to follow simple commands the it 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 1/9/17 at 4:30 a.m., indicated Resident D 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 progress, dated 1/9/17 at 5:02 a.m., RN 1 indicated "...send resident to Hospital via EMS. 911 called for transport at 5:00 a.m. Resident transported via EMS at 0515." Review of the hospital records were completed on 4/28/17 at 11:28 a.m.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE 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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 (CT) scan done on 1/9/17 6:30 a.m., indicated Resident D had a "Large left convexity and parafalcine subdural hemorrhage with significant mass effect and 1.3 cm rightward midline shift. Impending uncal herniation." A hospital progress note, dated 1/9/17 at 7:26 a.m., indicated Resident D was on warfarin for atrial fibrillation and the CT scan showed a large subdural hematoma [A pool of blood between the brain and its outermost covering]. Resident D was intubated and sent via helicopter to a larger hospital. A hospital progress note, dated 1/9/17 at 8:18 a.m., indicated Resident D arrived at the second hospital with an altered mental status. She arrived intubated on a ventilator and sedated. Review of a hospital progress note, dated 1/9/17 at 11:54 a.m., indicated "Patient with poor prognosis. Surgery would not change her overall outcome." The Power of Attorney (POA) for Resident D, indicated she did not want to purse surgical intervention unless the patient			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident to the hospital if it was an emergency without an order. She indicated herself and two CNA's got a Hoyer lift and put Resident D back into bed. Review of the documentation from 1/8/17 through 1/9/17, RN 1 did not document any telephone call to the ADON. RN 1 indicated she felt she had done everything right related to the fall. During an interview on 4/27/17 at 1:32 p.m., the ADON indicated the staff could call her and then she would notify the physician of an event. She was informed RN 1 did not document any phone call to the ADON related to Resident D's fall. No date or time was listed as the ADON being called, calling the physician or returned a call to the facility. Review of a facility policy, dated October 2010, titled "Falls Management," which was provided by the Director of Nursing on 4/27/17 at 9:25 a.m., indicated the following: "BASIC RESPONSIBILITY Nursing staff and Interdisciplinary Team PURPOSE To evaluate risk factors and provide interventions to minimize risk, injury, and occurrences. ...PROCEDURE FOR RESPONDING TO A FALL			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. Prior to moving the Resident, evaluate for signs and symptoms of physical injury or trauma. ...3. Address any emergent conditions or first-aide needs. Initiate neurological checks for any unwitnessed falls, and falls with actual or suspected head injury or trauma. 4. Notify the Physician and Responsible Party as soon as practicable following the fall...." 2. The closed clinical record for Resident B was reviewed on 4/26/17 at 11:32 a.m. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), diabetes mellitus, anxiety and atrial fibrillation. Resident B was admitted to the facility on 1/30/15. A 3/21/17, Quarterly, Minimum Data Set (MDS) assessment, indicated Resident B was cognitively intact. Review of a current Health Care Plan, dated 8/27/15, indicated Resident B had a problem related to Gastroesophageal Reflux Disease (GERD). Interventions included, but were not limited to, give medications as ordered, document side effects and effectiveness. Resident B also had a Health Care Plan, dated 6/28/16, indicating Resident B had a problem related to COPD.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Interventions, included but were not limited to, elevated the head of bed. Review of a progress note, dated 4/20/17 at 10:00 p.m., LPN 3 indicated "...Resident had vomited x one. IM [intramuscular] phenergan [a medication to treat nausea and vomiting] given at this time per residents request." Review of the next progress note, dated 4/21/17 at 5:00 a.m., RN 1 indicated "Resident noted to have decrease BP [blood pressure], and decreased 02 sats, moist respirations. Will not speak to staff, but followa [sic] aimple [sic] commands." There was no documentation from 10:00 p.m. on 4/20/17 until 4/21/17 at 5:00 a.m. A progress note, dated 4/21/17 at 5:15 a.m., RN 1 indicated the ADON was notified of Resident B's condition and will notify the physician. A progress note, dated 4/21/17 at 5:57 a.m., RN 1 indicated EMS was in the facility to transport Resident B. Review of the CNA charting on 4/21/17, the last documentation was done at 1:40 a.m. related to bowel and bladder for Resident B.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 ran down to his chin that was not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 vomiting 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 to the touch and his oxygen saturation was 73% [95%- 100% normal range]. 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 for Resident B was sepsis, due to unspecified organism and atrial fibrillation with rapid ventricular response. Resident B was made comfort measures only by his family and expired on 4/21/17. During a telephone interview on 4/27/17 at 10:42 a.m., LPN 3 indicated she left			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 following: "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:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	For emergent life-threatening events: 1. Call "911" if your initial assessment indicates such action is necessary, and this intervention is in accordance with exiting Advance Directive.... 2. Render emergency interventions, first aide, in accordance.... ...5. Notify the physician of assessment findings.... 6. Notify the responsible party. ...8. Report change of condition to DON, ED, and other members...." This Federal tag relates to Complaint IN00228188. 3.1-37(a)			