STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: October 21, 22, 23, 28, 29, 30, 31, 2013 Facility number: 000245 Provider number: 155354 AIMS number: 100290800 Survey team: Barbara Fowler RN TC Diane Hancock RN 10/21, 10/22, 10/23, 10/28, 10/29, 10/30, 2013 Denise Schwandner RN 10/28, 10/29, 10/30, 10/31, 2013 Diana Perry RN 10/22, 10/23, 10/28, 10/29, 10/30, 10/31, 2013 Anna Villain RN Census bed type: SNF/NF 112 Total 112 Census payor type: Medicare 7 Medicaid 76 Other 29 Total 112 These deficiencies reflect state findings cited in accordance with 410	F000000	Preparation and or execution of this Plan of Correction general, or any other corrective action set forth herein, in particular, does not constitute an admission by Newburgh Healthcare of the facts alleged or the conclusions set forth in the Statement of Deficiencies. The Plan of Correction and specific corrective actions are prepared and/or executed soley because of provisions of Federal and State law.	

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
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
	IAC 16.2.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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, in accordance with the comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to ensure care was provided to assess for complications post dialysis for 1 of 1 sampled resident reviewed for dialysis. (Resident #124) Findings include: Resident #124 was observed on 10/22/13 at 8:35 a.m. lying in bed. Resident #124 indicated she received dialysis on Monday, Wednesday, and Friday of each week. Resident #124 indicated she had a catheter in her right upper chest for dialysis. The clinical record for Resident #124 was reviewed on 10/30/13 at 10:43 a.m. The clinical record indicated Resident #124 had a diagnosis of, but was not limited to, End Stage Renal Disease. The most recent MDS (Minimum Data Set) assessment, dated 10/1/13, indicated Resident #124 received	F000309	I. The facility is unable to make corrections for resident # 124. This resident has discharged home from the facility. The concern was revewied with the nurse who documented the assessments routinely.II. There are currently no other residents who receive dialysis treatment that reside in the facility.III. An inservice was held on 11/7/13 for licensed nurses to review the facility policy for post dialysis treatment and assessment. The facility will continue to review this process with nurses whenever a resident is admitted to the facility with this condition.IV. The assessment data will be moniotred by the unit manager daily. These findings will be entered onto the QAPI worksheet monthly for three (3) months. This monitor will continue for another month, if one post assessment is missing and per month thereafter based on the same criteria.V. The completetion date is 11/30/13	11/30/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
	dialysis. During an interview with LPN #4 on 10/30/13 at 3:25 p.m., LPN #4 indicated a resident who receives dialysis should be assessed upon return from dialysis, but she was not sure what was entailed as she had not taken care of a resident who received dialysis for a while. During an interview with LPN #3 on 10/30/13 at 3:45 p.m., LPN #3 indicated the resident should be assessed post dialysis by the nursing staff. LPN #3 indicated a form titled "Dialysis Communication Note" and the nursing notes are the forms the nursing staff would document on when a resident returns from dialysis. The clinical record lacked documentation which indicated Resident #124 had a complete post-dialysis assessment on 9/23/13, 9/25/13, 9/27/13, 9/30/13, 10/2/13, 10/7/13, 10/9/13, 10/16/13, 10/21/13, 10/23/13, and 10/25/13. A policy titled, "Hemodialysis - Resident's Transferring From Facility to Treatment Center," dated 11/16/12 and obtained from the DoN (Director of Nursing) on 10/30/13 at 1:25 p.m.,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
	indicated for assessment after treatment, the access site is to be assessed for bleeding , the resident is to have a head to toe assessment, and the resident's vital signs are to be obtained. 3.1-37(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
F000312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on interview, observation, and record review, the facility failed to provide nail care in 1 of 4 residents reviewed in a total sample of 38 residents who met the criteria for activities of daily living. (Resident #67) Findings include: During an observation on 10/22/13 at 9:06 a.m., Resident #67 was noted to have chipped nail polish on her fingers and one fingernail on her left hand was long and curled under. Resident #67 was observed in exercise class on 10/29/13 at 10:00 a.m., sitting in a wheel chair and dressed appropriately. Residentt #67 conversed briefly before class. Resident #67 was very pleasant and slightly confused. Resident #67 was observed on 10/29/13 at 2:45 p.m. fully dressed and asleep in bed.	F000312	I. The facility purchased a special pair of nail clippers and the licensed nurse trimmed the fingernail as this service is not provided by an outside contract.II. All residents will be assessed for thickened nails and will be trimmed by a licensed nurse if needed.III. The facility policy and procedure was reviewed with all nursing satff on 11/7/13 and will be reveiwed again by 11/30/13. Resident's with this type nail will be checked monthy by a licensed nurse for the need to trim.IV. The charge nurse and unit manager will monitor weekly. This monitor will be ongoing. Findings will be noted onto the QAPI worksheet for the upcommig quarter. The monitor will continue for another month if there are any negative findings.V. The completetion date is 11/30/13	11/30/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
	The clinical record for Resident #67 was reviewed on 10/29/13 at 4:30 p.m. Diagnoses included, but were not limited to, dementia, coronary artery disease, and diabetes mellitus type 2. A care plan, revised 10/18/13, for alteration in functional status related to assistance with ADL's included interventions of being dressed in street clothes when up, cue and assist with showers in the morning, and set up personal grooming supplies and assist as needed to complete tasks for Resident #67. During an interview on 10/30/13 at 1:11 p.m,. LPN #3 indicated that she had attempted to trim the resident's left little fingernail, but was unsuccessful. She also indicated that she would look at the nail and attempt to cut it again. During an interview on 10/30/13 at 2:15 p.m., LPN #3 indicated social services was contacted and social services had left a message with the podiatrist's office concerning the fingernail. During an interview with SSD (social services designee) on 10/30/13 at 3:25 p.m., the SSD indicated that			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
	LPN #3 had trimmed the fingernail. A policy and procedure, dated 5/2001 and titled "Nails (finger and toe), Care of," was obtained from the DoN (Director of Nursing) on 10/30/13 at 4:00 p.m. It indicated the purpose of fingernail care is, "provide cleanliness, prevent spread of infection, comfort the resident, and prevent skin procedures." The procedure included to trim and clean nails and to file nails smoothly. 3.1-38(a)(3)(E)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING _____ B. WING 00	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure 1 of 3 residents reviewed for falls, in the sample of 3 who met the criteria, received assistance and supervision to prevent accidents, in that she was transferred with one assist and required two assist and was lowered to the floor. (Resident #123) Finding includes: LPN #2 indicated during interview on 10/22/13 at 10:59 a.m., Resident #123 had experienced a fall with no injury in the past 30 days. Resident #123's clinical record was reviewed on 10/28/13 at 2:00 p.m. The Minimum Data Set (MDS) assessment, dated 5/13/13, indicated the resident needed extensive assist of two staff for transfers and for toileting. The quarterly MDS assessment, dated 8/12/13, indicated the resident	F000323	I. As stated, the CNA was counseled for this action.II. Residents with the potential to be affected will continue to be identified through assessment of physicial function and the Fall Risk Assessment. No othere residents have been affecetd.III. The facility policy for transfers was reviewed with nursing staff on 11/7/13. The policy will be reviewed to determine if changes are necessary.IV. Unit managers and charge nurses will monitor on an ongoing basis and follow up with CNA's to ensure appropriate assistance. This monitor will be noted on the QAPI worskheet and reviewed in the next quarterly meeting. Any negative findings will result in continuation of the monitor for another quarter.V. The completetion date is 11/30/13	11/30/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
	required extensive assist of two for transfers and toileting. The resident had a care plan for being at high risk for falls related to confusion and cerebrovascular accident with hemiplegia, dated 5/29/13, reviewed on 8/16/13. Interventions included, but were not limited to, the following: Proper foot wear Call light in reach Extensive assist of two staff for transfers Therapy screen after each fall Nurses' notes dated 9/25/13 at 5:30 a.m., indicated, "res. [resident] lowered to the floor by CNA. See fall report." The fall report, dated 9/25/13 at 5:30 a.m., indicated the fall was a "near fall," and the CNA witness stated, "I slid res. to the floor." The resident was discovered "sitting on floor in front of toilet." The fall report indicated the resident was transferring on/off the toilet, and had bare feet at the time. The immediate intervention documented was "Staff education." During interview with the Director of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
	Nurses on 10/28/13 at 3:05 p.m., she indicated the fall on 9 /25/13 was when only one CNA transferred the resident and staff education was provided due to the resident requiring two staff for transfers. Resident #123 was observed on 10/30/13 at 9:06 a.m. to be in her room in her wheelchair. The resident was unable to use her right arm or right leg. 3.1-45(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, interview and record review, the facility failed to ensure 1 of 5 residents reviewed for unnecessary medications received non-pharmacological interventions for anxiety prior to being given an antianxiety medication, and failed to ensure a pulse was obtained prior to administration of a cardiac	F000329	I. Resident # 31 was reviewd. Documentation for interventions is unable to be corrected. The attending physician was notified and orders received to continue the medication routinely. The instructions on the MAR (medication administration record) for the antihypertensive will be separated.II. Residents who receive as needed antipsychotic medication will be reviewed for nonpharmacologial interventions prior to use. Residents who receive antihypertensive medication that	11/30/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
	medication. (Resident #31) Findings include: Resident #31's clinical record was reviewed on 10/21/13 at 11:49 a.m. The record indicated he was receiving Ativan (an antianxiety medication) as needed for anxiety. The resident's clinical record was reviewed again on 10/29/13 at 9:42 a.m. He was admitted to the facility on 4/29/10 with diagnoses including, but not limited to, cardiovascular disease, hypertension, history of prostate cancer, depression, senile dementia, hyperlipidemia, anxiety, chronic pain, edema, Parkinson's disease, and history of encephalopathy. The record contained physician's orders, signed 10/9/13, and included, but were not limited to, the following: Lopressor (medication for high blood pressure and heart conditions) 12.5 milligrams by mouth twice a day, "hold for SBP [systolic blood pressure] < [less than] 90 or HR [heart rate] < [less than] 56." Ativan (antianxiety medication) 0.5 milligrams by mouth every 4 hours as needed for anxiety or agitation. Resident #31's quarterly Minimum Data Set (MDS) assessment, dated		require a pulse rate will have their MAR (medication administration record) reveiwed to separate the blood pressure from the pulse / heart rate to ensure ease of reading.III. Nursing staff was inserviced on 11/7/13 and reveiwed non pharmacologial interventions for antipsychotic medication administration. The current facility policy will be reviewed for possible revisions.IV. The unit manager will monitor via shift report and review documentation of a resident who have received as needed antipsychotics. The data entry nurse will monitor the input of pulse / heart rate on the MAR for residents who receive anthypertensive medication. This will be montiored monthly QAPI meeting for two quarters. Any negative findings will result in repeating the monitor for another quarter.V. The completetion date is 11/30/13.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
	10/14/13 indicated no mood or behavior problems. The Brief Interview for Mental Status indicated a score of 1 out of 15, severe cognitive impairment. The MDS indicated he was receiving an antipsychotic medication, an antianxiety medication, and an antidepressant. Resident #31 had a care plan for a history of minimal mood indicators, initiated 1/14/13 and reviewed 10/24/13. Interventions included, but were not limited to, the following: Medicate as ordered by the physician Notify physician of any changes in moods or behaviors Offer diversional activities or change in location. He also had a care plan for "Occasional disruptive behavior. [Resident] repeatedly removing seat belt while in wheelchair, becomes verbally aggressive and argumentative." Interventions included, but were not limited to, the following: "Approach in a non-threatening manner. Talk slowly, calmly, using short sentences and concrete images. At the time of the episode, explain firmly but gently that this behavior is			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
	not acceptable. Attempt to redirect [resident's] behavior. Avoid commands using 'don't' and 'no'. Use positive terms such as 'do' and 'let's." Medicate as ordered by MD. Monitor and record response. Monitor and record behavior each time it occurs. Offer alternate activity (TV, 1:1 visits). Take to a different location." On 10/30/13 at 9:15 a.m., the resident's current Medication Administration Record (MAR) was reviewed. The record contained a psychoactive medication monthly flow record identifying target behavioral symptoms of anxiety. The facility documented the target behavior on every evening and night shift except for 10/1, 10/4, 10/6, 10/20, 10/28, 10/29/13. The MAR indicated the resident received Ativan 0.5 milligrams, ordered to be given as needed, for anxiety or agitation every day but 10/9, 10/12, 10/19, 10/20, 10/22, and 10/24/13. Nurses' notes included, but were not limited to, the following: "7/6/13 2125 [9:25 p.m.] Restless, has been going into other resident's room, staff assisted to bed per			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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's request then approx. 35 min later, was trying to get up [without] assist, setting off alarms, then when up wants to roam hallways et again went into other resident's rm. Ativan prn given at this time." "8/27/13 00:00 [midnight] Resident [up] OOB [out of bed] X 2 before 00:00, very shaky and nervous, [increased] anxiety noted. Did set up in w/c [wheelchair] at nurses station for a short period, PRN [as needed] Ativan 0.5 mg administered et resident put to bed at approx. [approximately] 01:00 a.m." "8/28/13 23:00 [11:00 p.m.] Resident [up] OOB [out of bed] [increased] anxiety noted, hands shaking, [increased] confusion, talking about getting in the water, propelling self around in resident lounge/dining room on North Unit. PRN Ativan 0.5 mg i po [by mouth] administered to help resident calm/relax for bed..." Resident #31 was observed in his wheelchair in the dining room/lounge on 10/30/13 at 10:00 a.m. LPN #1 had just trimmed his fingernails. He was smiling and attempting to interact. The use of the Ativan was reviewed with the Director of Nurses on 10/30/13 at 4:30 p.m. She indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
	she understood and they were working on it. Resident #31's MAR also included the order for Lopressor 12.5 mg tab po BID (twice a day) "***Hold for SBP [systolic blood pressure] < [less than] 90 and HR [heart rate] < [less than] 56." Documentation on the MAR indicated they were checking the blood pressure twice a day, but not the heart rate. 3.1-48(a)(3) 3.1-48(a)(4)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
F000371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure food was stored at the proper temperature and utensils were sanitized between uses during 2 of 2 observations of the kitchen. This had the portential to affect 112 residents. Finding includes: 1. On 10/29/13 at 10:09 a.m., Cook #1 was observed preparing the pureed food for the lunch meal. After she finished pureeing the meat, she used the 3 compartment sink to wash and sanitize the food processor components. She quickly washed, rinsed, and placed the lid and blade in the sanitizer, then quickly washed, rinsed, and exposed the bowl of the food processor to the sanitizer solution for less than 30 seconds. She dried the bowl out with a paper towel and proceeded to puree corn for the lunch meal. During the process, she needed to use a tablespoon that was soiled. She	F000371	I. Cook # 1 was re informed of the procedure immeditaely.II. All resiednts have the potential to be affected.III. All dietary staff will be inserviced on proper food temperatures. A new food temperature log has been implemented. The policy and procedure for proper sanitation was reveiwed with dietary staff. There has been a timer installed above the rinse sink to be set at one minute to ensure adequate timing for sanitation. IV. The dietary manager will monitor daily for compliance. The facility administrator will complete a random check for one (1) meal two (2) times a week. The results will be entered on the QAPI worksheet and reviewed in the next quarterly meeting. Any negative findings will result in the monitor being continued for another month.V. The completetion date is 11/30/13	11/30/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
	washed and rinsed the spoon in the 3 compartment sink, then exposed the spoon to the sanitizer for less than 5 seconds, dried it with a paper towel, and proceeded to use it. A measuring cup also needed to be used after soiled; she washed, rinsed, and sanitized it for less than 5 seconds, dried it with a paper towel and proceeded to use it. The Dietary Service Manager provided the policy and procedure for Cleaning Dishes - Manual Dishwashing, dated 2010, on 10/29/13 at 2:35 p.m. The sanitizing instructions included, but were not limited to, the following: "Place the dishes in the sanitizing sink. Allow to stand according to the manufacturer's guidelines for sanitizer." For quaternary ammonium, the contact time indicated, "per manufacturer." Observed above the sink was a poster indicating the product used by the facility required contact with the sanitizing solution for at least one minute. 2. On 10/29/13 at 11:31 a.m., Cook #1 was observed checking temperatures on the steam table. The temperature of the puree alternate and the regular diet alternate were 130 degrees. Cook #1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
	was asked what the temperature was supposed to be and she indicated it should be 140 degrees. She then finished taking temperatures and proceeded to serve the lunch meal. Individual bowls of cole slaw were observed ready to be served. The temperatures of the cole slaw were not measured until requested. The Dietary Service Manager checked the temperature of the slaw. It was 49 degrees Fahrenheit. She went to find another thermometer. Cook #1 indicated the creamy cole slaw had been made that morning and put in the cooler at around 8:30 a.m. The Dietary Manager and the Assistant Dietary Manager were observed with several thermometers in a cup with ice water. They indicated they were calibrating the thermometers. They were waiting for the thermometers to read zero degrees to ensure it was calibrated. They indicated they had been trained the thermometer should read zero degrees in the ice water. 3.1-21(i)(2) 3.1-21(i)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
F000428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.			
	Based on observation, record review, and interview, the facility failed to provide the necessary services to maintain a resident's physical and mental well-being in 1 of 5 residents reviewed for pharmacy review in that a laboratory test was duplicated and no gradual dose reduction for an antidepressant was attempted for a resident. (Resident #23) Findings include: Resident #23 was observed on 10/21/13 at 4:30 p.m., to be sitting in a wheelchair in her room watching television. Resident #23 was observed on 10/28/13 at 9:15 a.m., to be sitting in a wheelchair in her room drinking a soft drink. Resident #23 was observed on 10/31/13 at 10;10 a.m., to be sitting in a wheelchair in her room drinking a	F000428	I. The physician was notified and decreased the Celexa for resident # 23 from 20mg to 10 mg daily. II. All residents who require gradual dose reduction for pyschotic medications will be reviewed for dose reduction and corrected if needed.III. The Gradual Dose Reduction team will continue to meet monthly to review a unit each month. Each unit is reviewed at least three (3) times a year. A drug reduction grid will be implemented that will list ecah resident's name, medication to be reviewed, date of reduction, physician refusals, and date of discontinuation. IV. The facility Social Worker will review the dose reduction log quarterly to ensure all have been reveiwed timely. This monitor is ongoing. Results will be entered into each monthly and quarterly QAPI meeting.V. The completion date is 11/30/13.	11/30/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
	soft drink. The clinical record of Resident #23 was reviewed on 10/30/13 at 10:43 a.m. Resident #23 had diagnoses including, but not limited to, aphasia, depressive disorder, CVA (cerebral vascular accident), and atherosclerosis. The clinical record indicated Resident #23 had a physician's order, dated 3/9/11, for lipids (a laboratory test) to be obtained every 3 (three) months in March, June, September, and December. Resident #23 had a physician's order dated 2/12/13 for lipids to be obtained every 3 months in February, May, August, and November. The clinical record of Resident #23 indicated the resident had the lipid test done in August and September, 2013. Resident #23 had a physician's order, dated 3/7/12,for Celexa 20 mg tablet 1 (one) po (orally) daily for depressive disorder. Resident #23 had addtional pharmacy reviews, from 1/7/13 through 10/2/13, with no irregularities regarding the use of Celexa. The monthly pharmacy reviews from			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
	1/7/13 through 10/2/13 indicated no irregularities or the use of irregularities were noted and no gradual dose reductions were attempted. The "Behavior Tracking" form for the month of September, 2013, indicated Resident #23 had not had any behavior issues. During an interview on 10/29/13 at 9:05 a.m., LPN #3 indicated the resident should not have the lab test ordered twice and she would notify the resident's physician. LPN #3 indicated the pharmacist reviews the clinical records monthly and is usually good about noticing duplicate orders. During an interview on 10/29/13 at 9:30 a.m., the SW (Social Worker) indicated the resident had not had any behaviors and Resident #23 had not had a GDR (gradual dose reduction) for the Celexa . The SW indicated she did not remember when Resident #23 had last had a GDR for her Celexa. 3.1-25(i)			