STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EASTGATE MANOR NURSING AND REHABILITATION	2119 E NATIONAL HWY WASHINGTON, IN 47501

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: April 15, 16, 17, 18 and 19, 2024 Facility number: 000301 Provider number: 155341 AIM number: 100289090 Census Bed Type: SNF/NF: 51 Total: 51 Census Payor Type: Medicare: 5 Medicaid: 44 Other: 2 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 22, 2024.	F 0000		
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record review, the facility failed to ensure the accuracy of the Minimum Data Set assessment for 2 of 18 residents reviewed. A urinary catheter and discharge was coded inaccurately. (Resident 52, Resident 54) Findings include:	F 0641	This plan of correction constitutes the facility's written allegation of annual survey for the efficiencies cited. The submission of the plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Department's inspection report.	05/10/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tanya Hentrup	ED	05/06/2024

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	1. Resident 52's clinical record was reviewed on 4/17/24 at 11:55 a.m. The diagnoses included, but were not limited to, obstructive and reflux uropathy, unspecified, and neuromuscular dysfunction of bladder. Physician orders, dated 4/1/24 through 4/19/24, for Resident 52 indicated "... cath [catheter] orders: Foley catheter Size: 18 Fr [french] 10 mL [milliliters] bulb ..." The start date for the Foley catheter was 3/26/24. Resident 52's Admission Minimum Data Set (MDS) assessment, dated 3/31/24, indicated the resident did not have a Foley catheter during the 7 day look back period of 3/25/24 through 3/31/24. 2. Resident 54's clinical record was reviewed on 4/17/24 at 11:56 a.m. The diagnosis included, but was not limited to, sepsis. Nursing Progress Notes, dated 1/6/24 at 9:56 a.m., for Resident 54 indicated, "Estimated discharge date: 2/6/24. Planned discharge location: home with home care and family support. Nursing Progress Notes, dated 1/17/24 at 9:36 a.m., for Resident 54 indicated, "Estimated discharge date: 2/16/24. Planned discharge location: home with family support. Nursing Progress Notes, dated 1/24/24 at 12:23 p.m., for Resident 54 indicated, "Estimated discharge date: 2/16/24. Planned discharge location: home with family support. Resident 54's Discharge MDS assessment, dated 2/5/24, indicated the resident went home to the community and the discharge was not planned.		The provider respectfully requests that this plan of correction be considered the letter of credible allegation of compliance and requests a desk review. If more information is needed to support this request, please contact the Executive Director, Tanya Hentrup at 812-254-3301. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. -Resident 52's MDS has been corrected -Resident # 54 MDS has been corrected how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. -All residents have the potential to be affected by the alleged non-compliance, The MDS coordinator audited the MDS's from last quarter to ensure accuracy on any discharged residents and residents with F/C's with no additional changes needed what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The MDSC was educated on coding of on A0310G-Discharged	

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	During an interview on 4/18/24 at 11:29 a.m., the Executive Director indicated the MDS's for Resident 52 not having a Foley catheter and for Resident 54's discharge not being planned were coded incorrectly. On 4/19/24 at 12:19 p.m., the Executive Director provided the facility's policy,"Resident Assessment (RAI) Medicare MDS Scheduling" with a reviewed date of 4/2023, and indicated it was the policy currently being used by the facility. A review of the policy did not indicate ensuring accurate coding of the MDS. 3.1-31(d)		residents and H0100A- Indwelling F/C's. DNS/Designee will review coding for discharged residents and for residents with indwelling catheters to ensure accuracy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The MDS coordinator or designee will audit accurate coding on A0310G-Discharged residents and H0100A- Indwelling F/C's to ensure accuracy weekly x 4 months then monthly x 5 months with results of these audits reviewed by QAPI committee overseen by ED audits will continue until 100% compliance is reached. by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of	

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			correction with the updated plan of correction date. DATE: May 10, 2024.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to ensure a care plan meeting was held in conjunction with the Quarterly Minimum Data Set (MDS) assessment for 1 of 2 residents reviewed for care planning. (Resident 49)	F 0657	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The Social Service Director	05/10/2024

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	Findings include: During an interview on 4/16/24 at 11:40 a.m., Resident 49 indicated he and his wife had not been invited to a care plan meeting for a long time and he had not been kept informed of what was going on with his plan of care or when he was going to be able to be discharged back home. Resident 49's clinical record was reviewed on 4/17/24 at 11:00 a.m. The diagnoses included, but were not limited to, incomplete lesion at C5 level of cervical spinal cord and quadriplegia. A review on 4/17/24 at 11:15 a.m., of the Care Conference Summary notes indicated Resident 49 and his wife attended a care conference meeting on 1/3/24. A care plan, initiated on 3/22/24, and current through target date 6/22/2024, for Resident 49 indicated, "... PROBLEM: Resident's discharge goal is to return to the community. Home with possible home care ... GOAL: Resident will be discharged to return home with family support and possible home care ... APPROACH: Resident and resident representative will be encouraged to participate in the discharge planning process ..." Resident 49's Quarterly MDS assessment was dated 3/20/24. The clinical record lacked documentation of a care plan meeting being held during that time. During an interview on 4/19/24 at 10:54 a.m., the Social Worker indicated Resident 49 was almost a month overdue for his care plan meeting. The meeting should have been held during the time the most recent MDS assessment was completed		immediately held a care conference with resident number 49 and spouse. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by the alleged non-compliance. The SSD did a complete audit for any missed care conferences in last quarter and scheduled them immediately. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Social Service support leader educated SSD on care plan conferences and completion of care plan summaries. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The SSD or designee will audit 5 residents/week x 4 weeks and then 5 residents/ month x 6 months on care conferences with completion of care plan summaries. Result will be brought to QAPI committee overseen by ED audits will continue until 100% compliance is reached.	

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	on 3/20/24. On 4/19/24 at 1:07 p.m., the Executive Director provided the facility's policy,"IDT Care Plan Review Guidelines" with a reviewed date of 8/2023, and indicated it was the policy currently being used by the facility. A review of the policy did not indicate how often a care plan meeting should be held. 3.1-35(d)(2)(B)		by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. **DATE:** May 10, 2024.	
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on interview and record review, the facility failed to ensure staff assisted a resident in gaining access to vision services by making appointments for 1 of 1 resident reviewed for ancillary services. (Resident 14) Finding includes: During an interview on 4/15/24 at 2:22 p.m., Resident 14 indicated her eyes were getting worse	F 0685	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Social Service director immediately spoke with resident number 14 to discuss the referral to a Retinal specialist given by internal Optometrist and resident number 14 declined any outside	05/10/2024

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	and she thought she needed new glasses. She indicated she had an eye doctor she was supposed to go see, however, she did not know when her next appointment was scheduled. On 4/16/24 at 11:12 a.m., Resident 14's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes type 2 and hypertension. A 2/7/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. A 8/29/23 Optometry Doctor (OD) assessment, indicated the patient was diagnosed with diabetic retinopathy (damage to the blood vessels in the tissue at the back of the eye), macular degeneration (loss in the center of the field of vision), pseudophakia (having an artificial lens implanted after the natural eye lens has been removed), dry eye, and presbyopia (when your eyes gradually lose the ability to see things clearly up close). The eye doctor referred the resident to be see by a retinal specialist for diabetic changes in her eyes and reduced vision. A 4/19/21 Request for Service Consent, indicated the resident requested services for eye care. An 11/13/23 Social Services Assessment, indicated the resident needed ancillary referrals for vision. During an interview on 4/19/24 at 12:33 p.m., the Executive Director (ED) indicated the Social Services Director would be responsible for setting up OD referrals after the appointment. During an interview on 4/19/24 at 12:58 p.m., the		consultation. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken All residents have the potential to be affected by the alleged an audit of ancillary vision visit reports were audited to ensure that all f/u recommendations have been addressed and have been offered optometry services. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Social Service support leader educated SSD on ancillary vision services and f/u how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and SSD or designee will review audit 5 records weekly X 4, then monthly 5 to ensure that f/u recommendations have been addressed results will be presented to the QAPI committee overseen by the ED. Audits will continue until 100% compliance is reached. by what date the systemic changes for each deficiency will be completed. After submitting an	

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	ED indicated staff talked to the resident about getting seen outside of facility for services and she refused. She indicated there were no notes which indicated the resident refused to be seen related to the OD's referral to the retinal specialist. On 4/19/24 at 1:30 p.m., the ED provided the facility policy, "Vision and Hearing Services," revised on January, 2006, and indicated it was the policy currently being used. A review of the policy indicated, "... All resident requiring vision ... services outside the facility will be assisted with the necessary arrangements ..." 3.1-39(a)(1)		acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. **DATE:** May 10, 2024.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that			

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	catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to ensure a urinary drainage bag and tubing attached to a urinary catheter was positioned off the floor for 1 of 1 resident reviewed for urinary catheters. (Resident 52) Finding includes: On 4/15/24 at 10:54 a.m., Resident 52 was observed to be sitting in her wheelchair in her room. The urinary drainage bag was observed to be touching the floor. On 4/15/24 at 3:08 p.m., Resident 52 was observed to be rolling around the hallway in her wheelchair. The urinary drainage bag was observed to be dragging the floor. On 4/17/24 at 11:10 a.m., Resident 52 was observed to be sitting in her wheelchair in her room. The urinary drainage tubing was observed to be been touching the floor. Resident 52's clinical record was reviewed on 4/17/24 at 11:55 a.m. The diagnoses included, but were not limited to, obstructive and reflux	F 0690	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The IP nurse immediately changed out F/C drainage bag on resident number 52. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents with F/C's may be affected by the alleged non-compliance. All residents with Foley catheters were audited for the potential for F/C drainage bag being contaminated. No concerns noted what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Clinical staff have been educated	05/10/2024

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	uropathy, unspecified, and neuromuscular dysfunction of bladder. Physician orders, dated 4/1/24 through 4/19/24, for Resident 52 indicated "... cath [catheter] orders: Foley catheter Size: 18 Fr [french] 10 mL [milliliters] bulb ..." Nursing Progress Notes, dated 3/31/24, indicated Resident 52 was being treated for a urinary tract infection. A care plan, initiated on 3/26/24, and current through target date 6/26/24, for Resident 52 indicated, "... PROBLEM: Resident requires an indwelling urinary catheter ... GOAL: Resident will have catheter care managed appropriately as evidenced by not exhibiting signs of urinary tract infection ... APPROACH: Do not allow tubing or any part of the drainage system to touch the floor ..." On 4/18/24 at 11:06 a.m., Resident 52 was observed to be sitting in her wheelchair in her room. The urinary drainage bag and tubing was observed to be touching the floor. On 4/19/24 at 11:36 a.m., Resident 52 was observed to be sitting in her wheelchair in her room. The urinary drainage bag and tubing was observed to be touching the floor. During an interview on 4/19/24 at 11:37 a.m., Certified Nursing Assistant (CNA) 1 indicated the urinary drainage bag and tubing for Resident 52 was currently on the floor and should not be. On 4/19/24 at 12:19 p.m., the Executive Director provided the facility's policy,"Nursing" with a reviewed date of 6/2023, and indicated it was the		by the DNS/Designee regarding placement of catheter bags and tubing. DNS/Designee will conduct rounds each shift to ensure foley catheters are positioned properly. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and IP nurse or designee will check residents with a F/C drainage bag to ensure infection control in place 3 x/week x 4 weeks, then monthly x 6 with results forwarded to QAPI committee overseen by ED. Audits will continue until 100% is reached. by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. **DATE:** May 10, 2024.	

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	policy currently being used by the facility. A review of the policy indicated, "... 2. Resident Care Equipment ... b. Urinary catheters should have a catheter bag cover over them or a wash basin underneath them as a barrier to prevent catheter bad or tubing from touching the ground ..." 3.1-41(a)(2)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure an environment that was safe, sanitary, and comfortable for 6 of 18 rooms observed. Walls were damaged, lights were not functional, light pull cords were not functional, and privacy curtains were not clean. (Room 106, Room 138, Room 102, Room 134, Room 133, Room 126) Findings include: 1. On 4/15/24 at 11:31 a.m., Room 106 was observed. The bathroom walls were observed to be scratched and gouged. 2. On 4/15/24 at 2:06 p.m., Room 138 was observed. The light closest to the entry door was observed to not work and the privacy curtain was observed to be stained with a dry brown substance. 3. On 4/15/24 at 2:16 p.m., Room 102 was observed. The bathroom walls were observed to be scratched and gouged.	F 0921	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Maintenance Director immediately repaired the bathroom walls in room 102, 106, and resident wall in room 134, and all overbed light cords replaced in rooms 126, 128 and 133. Housekeeping supervisor immediately removed the privacy curtains washed and replaced them in room 128. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by the alleged non-compliance a house wide environmental audit has been completed and any noted	05/10/2024

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EASTGATE MANOR NURSING AND REHABILITATION	2119 E NATIONAL HWY WASHINGTON, IN 47501

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	4. On 4/15/24 at 2:20 p.m., Room 134 was observed. Two hooks were observed protruding from the wall above the bed and multiple screws and nails were observed protruding from the entry door wall. 5. On 4/16/24 at 2:08 p.m., Room 133 was observed. The light above the bed was observed to be missing a pull cord. 6. On 4/16/24 at 2:09 p.m., Room 126 was observed. The pull cord above the bed was observed to be too short to be accessible for the resident. During an interview on 4/19/24 at 12:45 p.m., the Executive Director indicated the wall damage, light pull cords, and privacy curtain were in need of repair and cleaning. 3.1-19(f)		concerns were corrected. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Maintenance Director educated the Department leaders when rounding their care cleaning of rooms. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Housekeeping Supervisor will audit 3 rooms a weekly X 4 weeks then 3 rooms monthly x 5 months, then one room/month x 6 months. The results of these audits will be reviewed by QAPI committee overseen by the ED. Deficient practice in this will result in progressive disciplinary action. The Maintenance Director will audit 3 rooms a weekly X 4 weeks then 3 rooms monthly x 5 months. The results of these audits will be reviewed by QAPI committee overseen by the ED. what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EASTGATE MANOR NURSING AND REHABILITATION	2119 E NATIONAL HWY WASHINGTON, IN 47501

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			possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. **DATE**: May 10, 2024.	