PRINTED: 08/31/2022 FORM APPROVED

| CENTERS FOR MEDICARE & MEDICAID SERVICES |  |  |                     |  | OMB NO. 0938-039                        |  |
|--|--|--|---------------------|--|---|--|
|  | NT OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPLE CO    |  | (X3) DATE SURVEY  COMPLETED  08/04/2022 |  |
| AND PLAN                                 | OF CORRECTION  | IDENTIFICATION NUMBER  155354  | A. BUILDING B. WING | 00   |   |  |
|  | PROVIDER OR SUPPLIE  |  | 10466 F             | ADDRESS, CITY, STATE, ZIP COD POLLACK AVE  |   |  |
| NEWBUR                                   | RGH HEALTH CAF   | ₹E<br>   | NEWBU               | JRGH, IN 47630   | <u> </u>                                |  |
| (X4) ID<br>PREFIX                        | (EACH DEFICIE  | ' STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL             | ID<br>PREFIX        | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT   |   |  |
| TAG                                      | REGULATORY O   | R LSC IDENTIFYING INFORMATION  | TAG                 | DEFICIENCY)  | DATE                                    |  |
| F 0000<br>Bldg. 00                       | This visit was for t   | the Investigation of Complaint   | F 0000              |  |   |  |
|  | _  | 15996: Substantiated.<br>iencies related to the<br>and at F0623.       |                     | Preparation and or execution of this plan of Correction general or any other corrective action set forth herein,   |   |  |
|  | Survey dates: August 3 & 4, 2022  Facility number: 000245 Provider number: 155354 AIM number: 100290800  Census bed type: SNF/NF: 55 Total: 55 |  |                     | in particular, does not constitute an admission or agreement by Newburgh Healthcare of the facts allege the conclusions set forth in the Statement of Deficiencies. The Plan of Correction and specific corrective actions are prepared and / or executed solely becau of provisions of Federal and / or | d or                                    |  |
|  | Census payor type<br>Medicare: 6<br>Medicaid: 27<br>Other: 22<br>Total: 55   | :<br>flects State findings cited in                                    | State law.          |  |   |  |
| <b>-</b> 0000                            |  | npleted on August 9, 2022.   |                     |  |   |  |
| F 0623<br>SS=D<br>Bldg. 00               | Before a facility to resident, the facil   | ents Before<br>ge<br>tice before transfer.<br>ransfers or discharges a |                     |  |   |  |

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

representative(s) of the transfer or discharge and the reasons for the move in writing and in

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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|                   |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER  | A. BUILDING <u>00</u> |  |      | X3) DATE SURVEY<br>COMPLETED |  |
|-------------------|--|--|-----------------------|--|------|------------------------------|--|
|                   |  | 155354   | B. WING 08/04/2022    |  | 2022 |                              |  |
|                   | PROVIDER OR SUPPLIER   |  | 10466 F               | ADDRESS, CITY, STATE, ZIP COD<br>POLLACK AVE<br>JRGH, IN 47630     |      |                              |  |
|                   |  |  |                       | I  |      | 975                          |  |
| (X4) ID<br>PREFIX |  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL   | ID<br>PREFIX          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |      | (X5)<br>COMPLETION           |  |
| TAG               | `  | R LSC IDENTIFYING INFORMATION  | TAG                   | CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)                   | ATE  | DATE                         |  |
|                   | a language and m facility must send representative of the Long-Term Care (ii) Record the readischarge in the reaccordance with presentation; and (iii) Include in the reaccordance with presentation; and (iii) Include in the reaccordance with presentation; and (iii) Include in the reaccordance with presentation; and (c)(5) §483.15(c)(4) Tim (i) Except as spectand (c)(8) of this stransfer or discharsed and (c)(8) of this section must be made and the section of the safety of its would be endanged (i)(C) of this section; (C) The resident's to allow a more impresentation; (D) An immediate required by the resident parasection; or (E) A resident has for 30 days. | anner they understand. The a copy of the notice to a the Office of the State Ombudsman. Isons for the transfer or esident's medical record in paragraph (c)(2) of this notice the items described of this section.  In of this section.  In of the notice of rege required under this nade by the facility at least resident is transferred or emade as soon as transfer or discharge when-individuals in the facility red under paragraph (c)(1) on; health improves sufficiently mediate transfer or discharge is sident's urgent medical agraph (c)(1)(i)(A) of this in the facility when the facility of t |                       |  |      |                              |  |
|                   | - ' ' ' '  | cified in paragraph (c)(3) of  |                       |  |      | 1                            |  |

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this section must include the following:

Event ID:

T0RS11

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                       | (X2) MULTIPLE CONSTRUCTION    |                       |           | (X3) DATE SURVEY   |           |            |
|--|-----------------------|-------------------------------|-----------------------|-----------|--|-----------|------------|
| AND PLAN   | OF CORRECTION         | IDENTIFICATION NUMBER         | A. BUILDING <u>00</u> |           |  | COMPLETED |            |
|  | 155354 B. WING        |                               |                       | 08/04/    | /2022  |           |            |
|  |                       |                               |                       | CTD FFT A | ADDRESS SITE OF STATE OF   |           |            |
| NAME OF F  | ROVIDER OR SUPPLIER   | 8                             |                       |           | ADDRESS, CITY, STATE, ZIP COD  |           |            |
| NIE/M/DI IE  | RGH HEALTH CAR        | Г                             |                       |           | POLLACK AVE  |           |            |
| NEWBUR   | RGH HEALTH CAR        | E                             |                       | INEVVDC   | JRGH, IN 47630   |           |            |
| (X4) ID  | SUMMARY               | STATEMENT OF DEFICIENCIE      |                       | ID        | PROVIDER'S PLAN OF CORRECTION  |           | (X5)       |
| PREFIX   | (EACH DEFICIEN        | ICY MUST BE PRECEDED BY FULL  |                       | PREFIX    | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE        | COMPLETION |
| TAG  | REGULATORY OF         | R LSC IDENTIFYING INFORMATION |                       | TAG       | DEFICIENCY)  |           | DATE       |
|  | ` '                   | transfer or discharge;        |                       |           |  |           |            |
|  | (ii) The effective d  | ate of transfer or discharge; |                       |           |  |           |            |
|  | (iii) The location to | which the resident is         |                       |           |  |           |            |
|  | transferred or disc   | charged;                      |                       |           |  |           |            |
|  | (iv) A statement o    | f the resident's appeal       |                       |           |  |           |            |
|  | _                     | ne name, address (mailing     |                       |           |  |           |            |
|  |                       | elephone number of the        |                       |           |  |           |            |
|  | -                     | ves such requests; and        |                       |           |  |           |            |
|  |                       | w to obtain an appeal form    |                       |           |  |           |            |
|  |                       | completing the form and       |                       |           |  |           |            |
|  |                       | peal hearing request;         |                       |           |  |           |            |
|  | , ,                   | dress (mailing and email)     |                       |           |  |           |            |
|  | •                     | mber of the Office of the     |                       |           |  |           |            |
|  | _                     | Care Ombudsman;               |                       |           |  |           |            |
|  |                       | cility residents with         |                       |           |  |           |            |
|  |                       | evelopmental disabilities or  |                       |           |  |           |            |
|  |                       | , the mailing and email       |                       |           |  |           |            |
|  |                       | hone number of the agency     |                       |           |  |           |            |
|  | -                     | e protection and advocacy     |                       |           |  |           |            |
|  |                       | developmental disabilities    |                       |           |  |           |            |
|  | established under     |                               |                       |           |  |           |            |
|  |                       | sabilities Assistance and     |                       |           |  |           |            |
|  | -                     | of 2000 (Pub. L. 106-402,     |                       |           |  |           |            |
|  |                       | .C. 15001 et seq.); and       |                       |           |  |           |            |
|  |                       | acility residents with a      |                       |           |  |           |            |
|  |                       | r related disabilities, the   |                       |           |  |           |            |
|  | _                     | address and telephone         |                       |           |  |           |            |
|  | _                     | ency responsible for the      |                       |           |  |           |            |
|  | •                     | vocacy of individuals with a  |                       |           |  |           |            |
|  |                       | stablished under the          |                       |           |  |           |            |
|  |                       | vocacy for Mentally III       |                       |           |  |           |            |
|  | Individuals Act.      |                               |                       |           |  |           |            |
|  | \$400 4E/-\/C\ CI-    | ongo to the notice            |                       |           |  |           |            |
|  | - ' ' ' '             | anges to the notice.          |                       |           |  |           |            |
|  |                       | in the notice changes prior   |                       |           |  |           |            |
|  | _                     | insfer or discharge, the      |                       |           |  |           |            |
|  |                       | te the recipients of the      |                       |           |  |           |            |
|  |                       | practicable once the          |                       |           |  |           |            |
|  | upaatea informatio    | on becomes available.         |                       |           |  |           |            |
|  |                       |                               | 1                     |           |  |           |            |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354 |   | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED  B. WING 08/04/2022  |                     |   |                      |
|---|---|--|---------------------|---|----------------------|
|   | PROVIDER OR SUPPLIER  |  | 10466               | FADDRESS, CITY, STATE, ZIP COD<br>S POLLACK AVE<br>BURGH, IN 47630  |                      |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)   | (X5) COMPLETION DATE |
|   | closure In the case of facil who is the adminis provide written no impending closure Agency, the Office Care Ombudsmar and the resident re the plan for the tra relocation of the re 483.70(I). Based on interview failed to ensure a no supplied in writing representative for 2 hospitalizations. The the area ombudsmar transfer/discharges for hospitalizations. Resident D )  Findings include:  1. During record rev an Admission/Discl Resident B was disc hospital on 7/6/22.  Resident B's nurse's limited to, a progres alerted nurse that re Called [physician] from the called [family] [name of hospital]. sent with [resident In [diagnoses], allergical orders." | for 3 of 3 residents reviewed (Resident B, Resident C, view on 8/3/22 at 10:30 A.M., narge Report indicated charged to an acute care | F 0623              | table class="Table TableStaticStyles Ltr TableWordWrap SCXW2065- BCX0" border="1" data-table data-tablelook="1696" aria-rowcount="1" >div > p class="Paragraph SCXW20654436 BCX0" xml:lang="EN-US" paraid="2005965285" paraeid="{0a05469a-33c1-4a 4f-a09f41a008a5}{24}" >  p class="Paragraph SCXW20654436 BCX0" xml:lang="EN-US" paraid="886757352" paraeid="{fd354d7c-0da3-473 1-0abbd0e1fbbd}{155}" >- Wicorrective action(s) will be accomplished for those reside found to have been affected it deficient practice; | 37-b7  3d-adf nat    |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                        | (X2) MU                          | (X2) MULTIPLE CONSTRUCTION |                |  | (X3) DATE SURVEY |            |  |
|--|------------------------|----------------------------------|----------------------------|----------------|--|------------------|------------|--|
| AND PLAN   | OF CORRECTION          | IDENTIFICATION NUMBER            |                            | A. BUILDING 00 |  |                  | COMPLETED  |  |
|  |                        | 155354                           | B. WI                      | NG             |  | 08/04/           | /2022      |  |
| NAME OF I  | DROWIDED OF CUIDNITE   |                                  |                            | STREET A       | ADDRESS, CITY, STATE, ZIP COD  |                  |            |  |
| NAME OF F  | PROVIDER OR SUPPLIER   |                                  |                            |                | POLLACK AVE  |                  |            |  |
| NEWBU  | RGH HEALTH CAR         | E                                |                            | NEWBU          | JRGH, IN 47630   |                  |            |  |
| (X4) ID  | SUMMARY                | STATEMENT OF DEFICIENCIE         |                            | ID             | PROVIDER'S PLAN OF CORRECTION  |                  | (X5)       |  |
| PREFIX   | (EACH DEFICIEN         | CY MUST BE PRECEDED BY FULL      |                            | PREFIX         | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE               | COMPLETION |  |
| TAG  |                        | LISC IDENTIFYING INFORMATION     |                            | TAG            | DEFICIENCY)  |                  | DATE       |  |
|  |                        | for indicated the staff nurse    |                            |                | The facility's Social Service  |                  |            |  |
|  | 1                      | ce of transfer/discharge with    |                            |                | Director has revised the proce   | SS               |            |  |
|  | the resident at the ti | me of discharge.                 |                            |                | for notifying the  |                  |            |  |
|  | NT 1 ' 1' 4            | 1D '1 (D D '1 (D)                |                            |                | State Ombudsman of   |                  |            |  |
|  |                        | d Resident B or Resident B's     |                            |                | Discharges/Transfers. The So   |                  |            |  |
|  | 1 -                    | ved a written notice of          |                            |                | Services director has submitte   | ed all           |            |  |
|  | transfer/discharge.    |                                  |                            |                | of Julys discharges/transfers.   |                  |            |  |
|  | During an interview    | on 8/4/22 at 9:15 A.M., the      |                            |                |  |                  |            |  |
|  |                        | ctor indicated they were told    |                            |                |  |                  |            |  |
|  | they no longer were    |                                  |                            |                | - How other residents having t   | he               |            |  |
|  |                        | nformation to the area on        |                            |                | potential to be affected by the  |                  |            |  |
|  |                        | esident discharge to the         |                            |                | same deficient practice will be  |                  |            |  |
|  | hospital.              | 8                                |                            |                | identified and what corrective   |                  |            |  |
|  | 1                      |                                  |                            |                | action(s) will be taken;   |                  |            |  |
|  | 2. During record rev   | view on 8/3/22 at 10:30 A.M.,    |                            |                |  |                  |            |  |
|  | an Admission/Discl     | narge Report indicated           |                            |                |  |                  |            |  |
|  | Resident C was dis     | charged to an acute care         |                            |                |  |                  |            |  |
|  | hospital on 7/20/22.   |                                  |                            |                | The facility's Social Service  |                  |            |  |
|  |                        |                                  |                            |                | Director has revised the proce   | ess              |            |  |
|  | Resident C's nurse's   | notes included, but were not     |                            |                | for notifying the  |                  |            |  |
|  | limited to, a progres  | ss note, dated 7/20/22,          |                            |                | State Ombudsman of   |                  |            |  |
|  | "[Spouse] notified of  | of condition change and [vital   |                            |                | Discharges/Transfers. The So   | cial             |            |  |
|  | signs]. She requeste   | ed he be sent to [Name of        |                            |                | Services director will submit a  | II               |            |  |
|  | Hospital]."            |                                  |                            |                | of August's discharges/transfe   | er at            |            |  |
|  |                        |                                  |                            |                | the end of the month.  |                  |            |  |
|  |                        | dicated Resident C arrived to    |                            |                |  |                  |            |  |
|  |                        | eartment on 7/20/22. On 7/21/22, |                            |                |  |                  |            |  |
|  | Resident C had been    | n admitted to the hospital.      |                            |                |  |                  |            |  |
|  |                        |                                  |                            |                | - What measures will be put in   |                  |            |  |
|  |                        | d Resident C or Resident C's     |                            |                | place and what systemic chan   | •                |            |  |
|  | 1 -                    | ved a written notice of          |                            |                | will be made to ensure that the  |                  |            |  |
|  | transfer/discharge.    |                                  |                            |                | deficient practice does not rec  | ur;              |            |  |
|  | During an interview    | on 8/4/22 at 9:15 A.M., the      |                            |                |  |                  |            |  |
|  | _                      | ctor indicated they were told    |                            |                |  |                  |            |  |
|  | they no longer were    |                                  |                            |                | The facility's Social Service  |                  |            |  |
|  | 1 -                    | nformation to the area on        |                            |                | Director has revised the proce   | ess              |            |  |
|  | _                      | esident discharge to the         |                            |                | for notifying the  |                  |            |  |
|  | hospital.              | -                                |                            |                | State Ombudsman of   |                  |            |  |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354 |  | (X2) MULTIPLE C A. BUILDING B. WING  | CONSTRUCTION  00    | (X3) DATE SURVEY COMPLETED 08/04/2022   |                                  |
|--|--|--|---------------------|---|----------------------------------|
|  | PROVIDER OR SUPPLIER   |  | 10466               | ADDRESS, CITY, STATE, ZIP COD<br>POLLACK AVE<br>BURGH, IN 47630   |                                  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)   | DATE                             |
|  | an Admission/Discl   | view on 8/3/22 at 10:30 A.M., narge Report indicated charged to an acute care  |                     | Discharges/Transfers. The So Services director will submit a of the discharges/transfer at t end of the month, each month   | all<br>he                        |
|  | admitted to the hosp 7/22/22.  During an interview Social Service Directhey no longer were transfer/discharge in | dicated Resident D was obtal on 7/6/22 and discharged on 8/4/22 at 9:15 A.M., the etor indicated they were told required to send information to the area on esident discharge to the |                     | - How the corrective action(s) be monitored to ensure the deficient practice will not recui.e., what quality assurance program will be put into place and   | ır,                              |
|  | State Ombudsman provider letter dated providers to notify the and the local Ombutransfer on a month              | provided a copy of the d April 8, 2021 instructed the state LTC Ombudsman dsman of the acute emergency ly bases.  ates to Complaint IN00385996.                                      |                     | The facility's Social Service Director has revised the proof for notifying the State Ombudsman of Discharges/Transfers. The So Services director will submit a of the discharges/transfer at t end of the month, each month The Social Services Director bring the binder of "Notice of Discharge/Transfer to Ombudsman" to the monthly meetings for the next 5 month and as needed thereafter. | ocial<br>all<br>he<br>n.<br>will |
|  |  |  |                     | - by what date the systemic changes for each deficiency to be completed.  | vill                             |
|  |  |  |                     | 9/1/2022  |                                  |

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| STATEMEN  | T OF DEFICIENCIES    | X1) PROVIDER/SUPPLIER/CLIA    | (X2) MULTIPLE CONSTRUCTION |          | ONSTRUCTION   | (X3) DATE SURVEY |            |
|-----------|----------------------|-------------------------------|----------------------------|----------|---|------------------|------------|
| AND PLAN  | OF CORRECTION        | IDENTIFICATION NUMBER         | A. BUILDING                |          | 00  | COMPLETED        |            |
|           |                      | 155354                        | B. WI                      | NG       | 08/04/202   |                  | /2022      |
|           |                      |                               |                            | STREET A | ADDRESS, CITY, STATE, ZIP COD                                       |                  |            |
| NAME OF I | PROVIDER OR SUPPLIEF | R                             |                            |          | POLLACK AVE   |                  |            |
| NEWBU     | RGH HEALTH CAR       | F                             |                            |          | JRGH, IN 47630  |                  |            |
| TIE VIDOI |                      |                               |                            | INEWBO   | 1   |                  | T          |
| (X4) ID   |                      | STATEMENT OF DEFICIENCIE      |                            | ID       | PROVIDER'S PLAN OF CORRECTION                                       |                  | (X5)       |
| PREFIX    |                      | ICY MUST BE PRECEDED BY FULL  |                            | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE               | COMPLETION |
| TAG       | REGULATORY OF        | R LSC IDENTIFYING INFORMATION |                            | TAG      | DEFICIENCY)   |                  | DATE       |
|           |                      |                               |                            |          |   |                  |            |
|           |                      |                               |                            |          |   |                  |            |
|           |                      |                               |                            |          |   |                  |            |
|           |                      |                               |                            |          |   |                  |            |
|           |                      |                               |                            |          |   |                  |            |
|           |                      |                               |                            |          |   |                  |            |
|           |                      |                               |                            |          |   |                  |            |
|           |                      |                               |                            |          |   |                  |            |
|           |                      |                               |                            |          |   |                  |            |
|           |                      |                               |                            |          | - What corrective action(s) will                                    |                  |            |
|           |                      |                               |                            |          | accomplished for those reside                                       |                  |            |
|           |                      |                               |                            |          | found to have been affected b                                       | y tne            |            |
|           |                      |                               |                            |          | deficient practice;   |                  |            |
|           |                      |                               |                            |          |   |                  |            |
|           |                      |                               |                            |          |   |                  |            |
|           |                      |                               |                            |          | Nurses have been readucate  | d an             |            |
|           |                      |                               |                            |          | Nurses have been re-educate   | u on             |            |
|           |                      |                               |                            |          | the requirements to provide a resident or resident's                |                  |            |
|           |                      |                               |                            |          |   | ı                |            |
|           |                      |                               |                            |          | representative with a bed hold notice when a resident is            | 1                |            |
|           |                      |                               |                            |          | transferred to a hospital. Pack                                     | rote             |            |
|           |                      |                               |                            |          | have been assembled and pla   |                  |            |
|           |                      |                               |                            |          | at each nurse's station to prov                                     |                  |            |
|           |                      |                               |                            |          | nurses with easier access to t                                      |                  |            |
|           |                      |                               |                            |          | Bed-hold policy and other requ                                      |                  |            |
|           |                      |                               |                            |          | paperwork when  | an ou            |            |
|           |                      |                               |                            |          | discharging/transferring reside                                     | ents             |            |
|           |                      |                               |                            |          | At the time of admission, facili                                    |                  |            |
|           |                      |                               |                            |          | bed hold policy will be verbally                                    | -                |            |
|           |                      |                               |                            |          | explained to resident's   | •                |            |
|           |                      |                               |                            |          | representative and first notice                                     | of               |            |
|           |                      |                               |                            |          | bed hold policy will be signed.                                     |                  |            |
|           |                      |                               |                            |          | the time of actual transfer, the                                    |                  |            |
|           |                      |                               |                            |          | resident/resident's representa                                      |                  |            |
|           |                      |                               |                            |          | will be notified of bed hold pol                                    |                  |            |
|           |                      |                               |                            |          | again. These forms will be ser                                      | -                |            |
|           |                      |                               |                            |          | with the resident on transfer a                                     |                  |            |
|           |                      |                               |                            |          | copy will be made to be kept in                                     |                  |            |
|           |                      |                               |                            |          | the resident's medical record.                                      |                  |            |

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2022 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155354                             | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | onstruction<br><u>00</u>   | (X3) DATE SURVEY COMPLETED 08/04/2022 |
|--------------------------|------------------------------------|---|--|--|---------------------------------------|
|                          | ROVIDER OR SUPPLIE                 |   | 10466                                      | ADDRESS, CITY, STATE, ZIP COD<br>POLLACK AVE<br>URGH, IN 47630   |                                       |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE                      | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)   | (X5) COMPLETION DATE                  |
|                          |                                    |   |  | - How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;   | e<br>e                                |
|                          |                                    |   |  | Nurses have been re-educate the requirements to provide a resident or resident's representative with a bed hole notice when a resident is transferred to a hospital. Pack have been assembled and plat each nurse's station to pronurses with easier access to Bed-hold policy and other recepaperwork when discharging/transferring resid At the time of admission, facilibed hold policy will be verball explained to resident's representative and first notice | kets aced vide the quired lents. lity |
|                          |                                    |   |  | bed hold policy will be signed<br>the time of actual transfer, the<br>resident/resident's representa<br>will be notified of bed hold po<br>again. These forms will be se<br>with the resident on transfer a<br>copy will be made to be kept  | e<br>ative<br>dicy<br>ent<br>and a    |

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|                          | T OF HEALTH AND HU<br>R MEDICARE & MEDIC   |   |   |  |                                  | RM APPROVED<br>B NO. 0938-039         |  |
|--------------------------|--|---|---|--|----------------------------------|---------------------------------------|--|
| STATEME                  | NT OF DEFICIENCIES OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155354 |   |  |                                  | (X3) DATE SURVEY COMPLETED 08/04/2022 |  |
|                          | PROVIDER OR SUPPLIE  |   | 10466   | ADDRESS, CITY, STATE, ZIP COD<br>POLLACK AVE<br>URGH, IN 47630   |                                  |                                       |  |
| (X4) ID<br>PREFIX<br>TAG | EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP |   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE  | (X5)<br>COMPLETION<br>DATE       |                                       |  |
|                          |  |   |   | the resident's medical record.   |                                  |                                       |  |
|                          |  |   |   | - What measures will be put in<br>place and what systemic char<br>will be made to ensure that the<br>deficient practice does not rec   | nges<br>e                        |                                       |  |
|                          |  |   |   | Nurses have been re-educate the requirements to provide a resident or resident's representative with a bed hold notice when a resident is transferred to a hospital. Pack have been assembled and plat at each nurse's station to provinurses with easier access to the Bed-hold policy and other requipaperwork when discharging/transferring resident At the time of admission, the facility bed hold policy will be verbally explained to resident' representative and first notice bed hold policy will be signed the time of actual transfer, the resident/resident's representative will be notified of bed hold policy will be ser with the resident on transfer a copy will be made to be kept if the resident's medical record. | d kets aced vide the uired ents. |                                       |  |

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ADON and Medical

Records Coordinator will monitor

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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|               | T OF DEFICIENCIES<br>OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155354 | ` ´ | JILDING       | instruction<br>00  | (X3) DATE S<br>COMPL<br>08/04/                                       | ETED               |
|---------------|------------------------------------|---|-----|---------------|--|--|--------------------|
| NAME OF P     | ROVIDER OR SUPPLIER                |   |     |               | ADDRESS, CITY, STATE, ZIP COD  |  |                    |
| NEWBUF        | RGH HEALTH CAR                     | E   |     |               | POLLACK AVE<br>JRGH, IN 47630  |  |                    |
| (X4) ID       |                                    | STATEMENT OF DEFICIENCIE                                      |     | ID            | PROVIDER'S PLAN OF CORRECTION  |  | (X5)               |
| PREFIX<br>TAG |                                    | CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION      |     | PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  | TE   | COMPLETION<br>DATE |
|               |                                    |   |     |               | on a daily basis for 60 (sixty) days. The Medical Records Coordinator will continue to monitor on an ongoing basis.  |  |                    |
|               |                                    |   |     |               | - How the corrective action(s) be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and   | ,  |                    |
|               |                                    |   |     |               | Nurses have been educated or requirements to provide a resion resident's representative will be hold notice when a reside transferred to a hospital. Pack have been assembled and plate at each nurse's station to provinurses with easier access to the Bed-hold policy and other requipaperwork when discharging/transferring resident At the time of admission, the facility bed hold policy will be verbally explained to resident's representative and first notice bed hold policy will be signed, the time of actual transfer, the resident/resident's representative in the resident of bed hold policy again. These forms will be ser with the resident on transfer a convey will be made to be kept in | dent th a nt is ets iced ide he uired ents. s of At tive icy nt nd a |                    |

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354 |                | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED  B. WING 08/04/2022 |   |  |                               |                            |
|--|----------------|---|---|--|-------------------------------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER  NEWBURGH HEALTH CARE   |                | 10466   | r address, city, state, zip cod<br>s POLLACK AVE<br>BURGH, IN 47630 |  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIODE DEFICIENCY)  | ATE                           | (X5)<br>COMPLETION<br>DATE |
|  |                |   |   | the resident's medical record.  The ADON and Medical Records Coordinator will more on a daily basis for 60 (sixty) and then weekly for 6 (six) we Any findings from ADON or Medical Records will be revie at the Monthly QAPI meeting. | uitor<br>days<br>eeks.<br>wed |                            |
|  |                |   |   | - By what date will the system changes for each be   | nic                           |                            |
|  |                |   |   | 9/01/2022  |                               |                            |
|  |                |   |   |  |                               |                            |

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