

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155753	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2012
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NAME OF PROVIDER OR SUPPLIER HAMPTON OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 966 N WILSON RD SCOTTSBURG, IN 47170
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F0000	<p>This visit was for Investigation of Complaint IN00102101.</p> <p>Complaint IN00102101 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F315, F385, and F502.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: 1/18 and 1/19/12</p> <p>Facility number: 004902 Provider number: 155753 AIM number: 200813130</p> <p>Survey team: Jennie Bartelt, RN</p> <p>Census bed type: SNF: 19 SNF/NF: 43 Residential: 24 Total: 86</p> <p>Census payor type: Medicare: 22 Medicaid: 31 Other: 33 Total: 86</p> <p>Sample: 4</p>	F0000		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 23, 2012 by Bev Faulkner, RN</p>			
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F0157 SS=D	<p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified timely when a resident had little to no urinary output for almost 24 hours. The deficient practice affected 1 of 4 residents reviewed related to physician notification in a sample of 4. (Resident</p>	F0157	<p>1) Resident had F/C placed and immediately return of 1000cc of clear/yellow urine. Resident was assessed and had no urinary output during an 8 hour shift. MD was notified several times to request an order for a foley catheter.2) All new residents have been assessed for urinary</p>		02/09/2012		

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	<p>D)</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 1/18/12 at 2:20 p.m.</p> <p>The physician's hospital discharge orders, dated 11/23/11 included, but were not limited to, "D/C [discharge] to ECF [extended care facility]" and "D/C [discontinue] Foley [urinary catheter]."</p> <p>Nurse's Notes for 11/23/11 at 9:45 [a.m. or p.m. not indicated] indicated the resident was admitted to the facility and was "...incont B&B [bowel and bladder]...."</p> <p>The next entries related to urinary output was in Nursing notes/comments on the Skilled Nursing Assessment and Data Collection note for 11/24/11 and indicated, "10 AM ...Res has voided only sm [small] amt [amount] urine. Bladder very distended. Message left [symbol for with] [name of Nurse Practitioner] to return call r/t [related to] res voiding...11 A [11:00 a.m.] [name of Nurse Practitioner notified. [symbol for no] response, leave message. Awaiting will cont to monitor... 1:30 p.m., "[Name of nurse practitioner] notified...res [symbol for no] output since this AM [morning].</p>		<p>retention and adequate urinary output. H&P reviewed for previous diagnoses of urinary retention.3) All nursing staff was educated by DHS or designee on the facility guideline for monitoring I&O's for all new admits and assessments after catheter removal. 4) Audits of all records for all new residents will be conducted 5x/week x 6 months or until 100% compliance obtained and results will be reviewed during QA.</p>				

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	<p>Abd [abdomen] soft, distended. [Symbol for no] response, leave message. Awaiting."</p> <p>Documentation on nursing documentation forms failed to indicate further attempts to contact the physician related to the bladder distension and lack of voiding until Nurse's Notes, dated 11/24/11 at 8:00 p.m., indicated, "MD notified regarding [symbol for no] voiding in 2 shift. N.O. [new order] to straight cath [catheterize], if more than 300 cc, anchor Foley."</p> <p>Nurse's Notes, dated 11/24/11 at 8:15 p.m., indicated, "Foley placed due to 1000 cc urine return...."</p> <p>During interview on 1/19/12 at 12:55 p.m., the Director of Nursing indicated she would expect the nurse to notify the physician after eight hours if there was no urinary output. The DON indicated she would pull the Caretracker report which would indicate the resident's urinary output from the time of admission to the insertion of the Foley catheter.</p> <p>The Caretracker report was provided on 1/19/12 at 1:25 p.m. The Caretracker report indicated the first entry for the resident was at 3:07 a.m. on 11/24/11. The Caretracker indicated the resident had</p>						

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	<p>no urinary output between 11/24/11 at 3:07 a.m. and 9:11 p.m.</p> <p>During interview on 1/19/12 at 3:45 p.m., the Administrator indicated the nurse could contact the facility's medical director if the resident's physician did not respond to calls.</p> <p>This federal tag relates to Complaint IN00102101.</p> <p>3.1-5(a)(3)</p>			
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F0225 SS=D	<p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure bruising of unknown source was reported and investigated for 1 of 1 resident reviewed</p>	F0225	<p>1) Resident was noted to be combative and kicking at staff and family. All interventions were in place. Bruising had been noted to the Left Thigh area</p>	02/09/2012			

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	<p>related to bruising of unknown source in a sample of 4. (Resident D)</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 1/18/12 at 2:20 p.m. The record indicated the resident was admitted to the facility on 11/23/11 following hospitalization after a stroke.</p> <p>Physician's orders, dated 11/23/11, included the following anticoagulants related to the stroke: Lovenox and Plavix.</p> <p>"Nursing notes/comments" on the Skilled Nursing Assessment and Data Collection note for 11/26/11 indicated, "1 P [1:00 p.m.] CNA reported a dark purple bruise to L [left] thigh [symbol for approximately] 9 X 5 cm. Res [resident] was very combative, hitting & kicking staff yest [yesterday] may cause bruise. Denies pain to area. MD notified [symbol for no] N.O. [new order]. Family aware - will cont monitor."</p> <p>"Nursing notes/comments" on the Skilled Nursing Assessment and Data Collection note for 11/27/11 indicated, "10:30 A [a.m.]...Noted res bruise to L thigh [arrow pointing up] 14 X 6 cm and new bruise noted to R [right] thigh [symbol for approximately] 5 X 4 cm. Denies pain to</p>		<p>which did increase over a period of 24 hours. Resident was on Lovenox and Plavix as ordered by MD related to recent CVA. Resident was noted to be hitting legs against the wall and thrashing about. Interventions were in place to attempt to protect Resident from harming himself.2) All A&O residents were interviewed and all denied any mistreatment or abuse. Skin sweeps performed resulting in no suspicious or unreported and substantiated skin impairments including but not limited to bruising.3) All nursing staff were educated by DHS or designee on the Guidelines for reporting changes in condition. All nursing staff was educated by DHS or designee on the Abuse Policy and incidents of unknown origin. 4) Audits of all incident/accident reports and skin circumstance sheets will be done 3x/week for 4 weeks, 2x week for 4weeks, 1x/week for 4 monhs or until 100% compliant and results to be reviewed in QA. Random skin sweeps and interviews of A&O residents will be done 1x/ week x 6 months or until 100% compliant and results will be reviewed in QA.</p>				

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	<p>area...."</p> <p>An Other Skin Impairment Assessment form, dated 11/26/11, indicated an X mark on the left inner thigh on the front side of an anatomical drawing of a person.</p> <p>An Other Skin Impairment Assessment form, dated 11/27/11, indicated an X mark on the right inner thigh on the back side of an anatomical drawing of a person.</p> <p>Skin Impairment Circumstance Investigations, dated 11/26/11 and 11/27/11, indicated the bruises to the left thigh on 11/26/11 and to the right thigh on 11/27/11. On both forms, the section for Environmental Equipment Inspection indicated "Yes" to each of the following questions: Does resident have positioning devices, does the resident have pressure reducing devices, is the resident compliant with care interventions? and is equipment in good repair. On both forms, the section for Personal Inspection indicated "No" for each of the following questions: Is the resident independently mobile, has the resident had recent labs drawn, has the resident had a recent medical decline, has the resident had a recent fall, does resident have new or exacerbation of diagnosis, does the resident have and IV, is the resident incontinent, was there a recent altercation,</p>			
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	<p>does the resident have a history of self infliction. On the 11/26/11 form, in the section for "Other possible contributing factors" was handwritten: "Res [resident] was very combative [symbol for with] staff yest. [yesterday]." On the 11/27/11 form, in the section for "Other possible contributing factors" was handwritten: "Restless, attempt to pull F/C [Foley catheter] multiple X's."</p> <p>Documentation in Nurse's Notes, Skilled Nursing Assessment and Data Collection notes, and Skin Impairment Circumstance Investigation failed to indicate the bruising was reported to the supervisor, Director of Nursing, or Administrator.</p> <p>During interview on 1/19/12 at 1:10 p.m., the Administrator indicated the facility had no policy related to the size of injuries of unknown source to be reported, but that the two criteria in the regulation related to injury of unknown source would be required for reporting. The Administrator indicated the size to report would be based on nursing judgement.</p> <p>The facility's policy for Abuse and Neglect Procedural Guidelines was provided by the Director of Nursing (DON) on 1/19/12 at 4:40 p.m. Review of the policy at this time indicated, "...Injuries of Unknown Source - means</p>						

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	<p>an injury that occurs when both the following conditions are met: i. The source of the injury is not observed by any person or the source of the injury could not be explained by the resident AND ii. The injury is suspicious in nature because of the extent of the injury or the location of the injury (e.g. the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time of the incidence of injuries over time.) The facility's policy for Abuse and Neglect Procedural Guidelines also indicated staff was required to report concerns, incidents and grievances to the manager, the Director of Health Services (DON), or Executive Director (Administrator). The policy also indicated the Executive Director was responsible to investigate and report to the ISDH and other agencies as required by law.</p> <p>During interview at the time the policy was provided, the DON indicated she was not the DON at the time of Resident D's bruising. She indicated she would have assumed the bruising was due to the resident's combativeness. The DON indicated the resident was unable to indicate the source of the bruising and the injury was not observed. The DON indicated she could understand that the location of the injury might not be an area</p>			
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	<p>vulnerable to trauma.</p> <p>During interview on 1/19/12 at 4:45 p.m., the DON indicated she had checked with the Administrator, and the last incident reported by the facility to the ISDH was in February 2011.</p> <p>3.1-28(c) 3.1-28(d)</p>			
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F0226 SS=D	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure its policy related to bruising of unknown source was followed for reporting and investigating for 1 of 1 resident reviewed related to bruising of unknown source in a sample of 4. (Resident D)</p> <p>Findings include:</p> <p>The facility's policy for Abuse and Neglect Procedural Guidelines was provided by the Director of Nursing (DON) on 1/19/12 at 4:40 p.m. Review of the policy at this time indicated, "...Injuries of Unknown Source - means an injury that occurs when both the following conditions are met: i. The source of the injury is not observed by any person or the source of the injury could not be explained by the resident AND ii. The injury is suspicious in nature because of the extent of the injury or the location of the injury (e.g. the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time of the incidence of injuries over time.) The facility's policy for Abuse and Neglect Procedural Guidelines also indicated staff</p>	F0226	<p>1) Resident was noted to have a bruise on Right and Left thigh area. Bruise was determined to be a result of combativeness toward staff and family members. Resident was witnessed kicking legs at staff and family members. Resident was admtted with substantial bruising due to behavior in the hospital. Resident was relieving Lovenox and Plavix per MD order related to recent CVA.2) Skin sweep performed for all residents resulting in no suspicious or unreported areas. All A&O residents interviewed and denied any and all abuse or mistreatment from staff.3) All nursing staff educated by DHS or designee on the abuse policy and reporting procedures. All staff educated on incidents of unknown origin.4) Audits of all incident and accident reports will be done to ensure thourough investigations are done to find root cause of incident x 6 months or until 100% compliance and results to be reviewed in QA. Random interviews of A&O residents will be done 1x/ week x 6 months or until 100%compliant and results to be reviewed in QA.</p>	02/09/2012			

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	<p>was required to report concerns, incidents and grievances to the manager, the Director of Health Services (DON), or Executive Director (Administrator). The policy also indicated the Executive Director was responsible to investigate and report to the ISDH and other agencies as required by law.</p> <p>The clinical record for Resident D was reviewed on 1/18/12 at 2:20 p.m. The record indicated the resident was admitted to the facility on 11/23/11 following hospitalization after a stroke.</p> <p>Physician's orders, dated 11/23/11, included the following anticoagulants related to the stroke: Lovenox and Plavix.</p> <p>"Nursing notes/comments" on the Skilled Nursing Assessment and Data Collection note for 11/26/11 indicated, "1 P [1:00 p.m.] CNA reported a dark purple bruise to L [left] thigh [symbol for approximately 9 X 5 cm. Res [resident] was very combative, hitting & kicking staff yest [yesterday] may cause bruise. Denies pain to area. MD notified [symbol for no] N.O. [new order]. Family aware - will cont monitor."</p> <p>"Nursing notes/comments" on the Skilled Nursing Assessment and Data Collection note for 11/27/11 indicated, "10:30 A</p>						

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	<p>[a.m.]...Noted res bruise to L thigh [arrow pointing up] 14 X 6 cm and new bruise noted to R [right] thigh [symbol for approximately] 5 X 4 cm. Denies pain to area...."</p> <p>An Other Skin Impairment Assessment form, dated 11/26/11, indicated an X mark on the left inner thigh on the front side of an anatomical drawing of a person.</p> <p>An Other Skin Impairment Assessment form, dated 11/27/11, indicated an X mark on the right inner thigh on the back side of an anatomical drawing of a person.</p> <p>A Skin Impairment Circumstance Investigations, dated 11/26/11 and 11/27/11, indicated the bruises to the left thigh on 11/26/11 and to the right thigh on 11/27/11. On both forms, the section for Environmental Equipment Inspection indicated "Yes" to each of the following questions: Does resident have positioning devices, does the resident have pressure reducing devices, is the resident compliant with care interventions? and is equipment in good repair. On both forms, the section for Personal Inspection indicated "no" for each of the following questions: Is the resident independently mobile, has the resident had recent labs drawn, has the resident had a recent medical decline, has the resident had a</p>						

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	<p>recent fall, does resident have new or exacerbation of diagnosis, does the resident have and IV, is the resident incontinent, was there a recent altercation, does the resident have a history of self infliction. On the 11/26/11 form, in the section for "Other possible contributing factors" was handwritten: "Res [resident] was very combative [symbol for with] staff yest. [yesterday]." On the 11/27/11 form, in the section for "Other possible contributing factors" was handwritten: "Restless, attempt to pull F/C [Foley catheter] multiple X's."</p> <p>Documentation in Nurse's Notes, Skilled Nursing Assessment and Data Collection notes, and Skin Impairment Circumstance Investigation failed to indicate the bruising was reported to the supervisor or Administrator.</p> <p>During interview on 1/19/12 at 1:10 p.m., the Administrator indicated the facility had no policy related to the size of injuries of unknown source to be reported, but that the two criteria in the regulation related to injury of unknown source would be required for staff to report the injury. The Administrator indicated the size to report would be based on nursing judgement.</p> <p>During interview on 1/19/12 at 4:40 p.m.,</p>						

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	<p>the DON indicated she was not the DON at the time of Resident D's bruising, but she would have assumed the bruising was due to the resident's combativeness. The DON indicated the resident was unable to indicate the source of the bruising and the injury was not observed. The DON indicated she could understand that the location of the injury might not be an area vulnerable to trauma.</p> <p>During interview on 1/19/12 at 4:45 p.m., the DON indicated she had checked with the Administrator, and the last incident reported by the facility to the ISDH was in February 2011.</p> <p>3.1-28(a)</p>			
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F0315 SS=D	<p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review and interview, the facility failed to ensure a resident with known history of urinary retention and benign prostatic hypertrophy was provided timely services to prevent bladder distention caused by urinary retention. After a urinary catheter was placed, the resident acquired a urinary tract infection. The deficient practice affected 1 of 3 residents reviewed related to management of care of the urinary tract in a sample of 4. (Resident D)</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 1/18/12 at 2:20 p.m. The record indicated the resident was admitted to the facility on 11/23/11.</p> <p>The hospital's History and Physical, dated 11/12/11, indicated the resident's diagnoses included, but were not limited to, benign prostatic hypertrophy/urinary retention in the past.</p>	F0315	<p>1) Resident D's foley catheter was removed prior to arrival to the facility. Resident had a history of urinary retention. Resident had no urinary output for 8 hours and abdomen was distended. Several attempts made to contact MD and obtain an order to place foley catheter. F/C was placed immediately after order was obtained.2) F/C care observations have been performed and skill check offs per Guidelines on all nursing staff. New admits were assessed for bladder distention and history reviewed for urinary retention diagnoses.3) All nursing staff was educated on the Guideline for assessing for urinary retention. F/C care and insertion. Notification of MD and guidelines for if there is no prompt response. If there is no response by on call MD within two hours nursing staff will contact medical director for necessary interventions.4) Audits of all MD Notifications will be done 5x/week x 4 weeks, 3x/week x 4 weeks, 1x/week x 4 months or until 100%</p>	02/09/2012			

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	<p>The physician's hospital discharge orders, dated 11/23/11 included, but were not limited to, "D/C [discharge] to ECF [extended care facility]" and "D/C [discontinue] Foley [urinary catheter]."</p> <p>Nurse's Notes for 11/23/11 at 9:45 [a.m. or p.m. not indicated] indicated, "Resident arrived via EMS [Emergency Medical Services]...incont [incontinent] B&B [bowel and bladder], cannot speak words clearly @ this time R/T [related to] CVA [cardiovascular accident]. Resident was oriented to room and call light but seems to [sic] confused to use the light. Resident is a cont [continuous] tube feed."</p> <p>The Assessment Review and Considerations, dated 11/23/11, indicated, "Assessment considerations: Bowel and bladder: The resident has the following risk factors that contribute to incontinence:" with a check mark next to "Cognition, unable to recognize the need to eliminate."</p> <p>Nurse's Notes for 11/24/11 at 4:00 a.m., indicated, "Confusion remains. Attempted multiple times to get out of bed unassisted...."</p> <p>The next clinical record entries related to urinary output were in "Nursing</p>		compliance and results will be reviewed in QA.	
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	<p>notes/comments" section on the Skilled Nursing Assessment and Data Collection note for 11/24/11 and indicated, "10 AM [10:00 a.m.] ...Res has voided only sm [small] amt [amount] urine. Bladder very distended. Message left [symbol for with] [name of Nurse Practitioner] to return call r/t [related to] res voiding...11 A [11:00 a.m.] [name of Nurse Practitioner] notified. [symbol for no] response, leave message. Awaiting will cont to monitor... 1:30 p.m., "[Name of nurse practitioner] notified...res [symbol for no] output since this AM [morning]. Abd [abdomen] soft, distended. [Symbol for no] response, leave message. Awaiting."</p> <p>Documentation on nursing documentation forms failed to indicate further attempts to contact the physician related to the bladder distension and lack of voiding until Nurse's Notes, dated 11/24/11 at 8:00 p.m., indicated, "MD notified regarding [symbol for no] voiding in 2 shift. N.O. [new order] to straight cath [catheterize], if more than 300 cc, anchor Foley."</p> <p>Nurse's Notes, dated 11/24/11 at 8:15 p.m., indicated, "Foley placed due to 1000 cc urine return. Resident was combative, cussing, and very aggitated [sic]. After Foley was placed resident was brought to nurses station for one on one with MD</p>						

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	<p>and family notified of behaviors...."</p> <p>"Nursing notes/comments" section on the Skilled Nursing Assessment and Data Collection note for 11/27/11 and indicated, "10 A [10:00 a.m.] Res restless, cont [continues] turn self abed Q [every] 15 min [minutes. 1 on 1 [symbol for with] staff. Attempt to pull GT [gastrostomy tube]. Reassure and redirect res. MD notified res combative @ X's [at times]. Spoke [symbol for with] [name of Nurse Practitioner] [symbol for with] N.O. [new order] noted CBC [complete blood count], BMP [basic metabolic profile], UA [urinalysis] Cx [culture] drainage to perineum R/T [related to] green discharge...."</p> <p>Lab results of the urinalysis, dated 11/28/11 at 6:54 p.m., indicated abnormal results in the following areas: clarity, blood, protein, nitrite, leukocytes, white blood cells, and bacteria. (The result of the urine culture report was received 11/29/11, after the resident was discharged to the hospital.)</p> <p>A physician's order, dated 11/28/11, included, but was not limited to, "Bactrim DS [antibiotic] per GT BID [twice daily] X 10 days UTI [urinary tract infection]" and "Pyridium [urinary analgesic] 200 mg per GT TID [three times daily] X 2</p>			
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	<p>days."</p> <p>Nurse's Notes on 11/29/11 at 5:00 a.m., indicated the resident had pulled out his gastrostomy tube, and a physician's order was received for "Transport to [name of hospital] to have g [gastrostomy]-tube replaced." On 11/29/11 at 8:30 a.m., Nurse's Notes indicated the resident was transferred to the emergency room. The hospital's History and Physical, dated 11/29/11, indicated, "... We will treat the patient's urinary tract infection with Rocephin [antibiotic] and replace the Foley catheter today...."</p> <p>During interview on 1/19/12 at 12:55 p.m., the Director of Nursing indicated she would expect the nurse to notify the physician after eight hours if there was no urinary output. The DON indicated she would provide the Caretracker report which would indicate the resident's urinary output from admission to the insertion of the Foley catheter.</p> <p>The Caretracker report was provided on 1/19/12 at 1:25 p.m. The Caretracker report indicated the first entry for the resident was at 3:07 a.m. on 11/24/11. The Caretracker indicated the resident had no urinary output between 11/24/11 at 3:07 a.m. and 9:11 p.m.</p>				

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	<p>During interview on 1/19/12 at 3:45 p.m., the Administrator indicated the nurse could contact the facility's Medical Director if the resident's physician did not respond to calls.</p> <p>This federal tag relates to Complaint IN00102101.</p> <p>3.1-37(a)</p>			
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F0385 SS=D	<p>A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.</p> <p>The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable.</p> <p>Based on record review and interview, the facility failed to ensure a timely response by the physician to attempts to contact the physician related to the resident's care needs. The deficient practice affected 1 of 4 residents reviewed related to physician notification in a sample of 4. (Resident D)</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 1/18/12 at 2:20 p.m.</p> <p>The physician's hospital discharge orders, dated 11/23/11 included, but were not limited to, "D/C [discharge] to ECF [extended care facility]" and "D/C [discontinue] Foley [urinary catheter]."</p> <p>Nurse's Notes for 11/23/11 at 9:45 [a.m. or p.m. not indicated] indicated the resident was admitted to the facility and was "...incont B&B [bowel and bladder]...."</p>	F0385	<p>1) Several attempts per documentation were made to contact the MD regarding urinary retention and need for F/C placement. MD did respond with order for placement and F/C was placed.2) All new residents have been assessed for urinary retention and histories reviewed for history of the same. All charting has been reviewed for timelieness of obtaining necessary interventions by on call MD's. 3) All nursing staff was educated on the guideline for contacting medical director if no response is obtained by MD on call for two hours or immediately if an emergency situation. 4) Audits will be done randomly on change of conditions and lab results 5x/week for 4 weeks, 3x/week for 4 weeks, 2x/week for 4 weeks, and 1x/week for 3 months or until 100% compliance and results will be reviewed during QA.</p>	02/09/2012			

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	<p>The next entries related to urinary output were in Nursing notes/comments on the Skilled Nursing Assessment and Data Collection note for 11/24/11 and indicated, "10 AM [10:00 a.m.] ...Res has voided only sm [small] amt [amount] urine. Bladder very distended. Message left [symbol for with] [name of Nurse Practitioner] to return call r/t [related to] res voiding...11 A [11:00 a.m.] [name of Nurse Practitioner notified. [symbol for no] response, leave message. Awaiting will cont to monitor... 1:30 p.m., "[Name of nurse practitioner] notified...res [symbol for no] output since this AM [morning]. Abd [abdomen] soft, distended. [Symbol for no] response, leave message. Awaiting."</p> <p>Nursing documentation and physician's orders failed to indicate the Nurse Practitioner responded to the calls about the resident's lack of voiding and distended bladder, which the nurse made on 11/24/11 at 10:00 a.m., 11:00 a.m., and 1:30 p.m.</p> <p>Nurse's Notes on 11/24/11 at 8:00 p.m., indicated the physician was called again and ordered a urinary catheter.</p> <p>During interview on 1/19/12 at 3:45 p.m., the Administrator indicated the nurse could contact the facility's Medical</p>			
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	<p>Director if the resident's physician did not respond to calls.</p> <p>This federal tag relates to Complaint IN00102101.</p> <p>3.1-22(b)(1) 3.1-22(b)(2)</p>			
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F0502 SS=D	<p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on record review and interview, the facility failed to ensure the contracted lab services completed the analysis and reported the results of a Complete Blood Count (CBC) within the expected time frame for 1 of 1 resident reviewed for lab services in a sample of 4. When tested and reported, Resident D's CBC indicated a critically low hemoglobin level at 7.0, which had dropped to 5.8 at the time of his hospitalization the day after the blood was delivered for analysis. Resident D</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 1/18/12 at 2:20 p.m. The record indicated the resident was admitted to the facility on 11/23/11 following hospitalization after a stroke.</p> <p>Physician's orders for 11/27/11 included, but were not limited to, lab work for Basic Metabolic Profile (BMP) and Complete Blood Count (CBC) without differential.</p> <p>Results of lab work for blood obtained for tests on 11/28/11 indicated, Specimen received: 11/28/2011 at 8:18 [a.m.], Final reported: 11/28/2011 15:30 [3:30 p.m.], Specimen collected: 11/28/2011 06:06 [6:06 a.m.] Report Status: Partial." The results of the Basic Metabolic Profile were indicated on this report. Next to the CBC W/O Diff (without differential) was the word "Pending."</p>	F0502	<p>1) Lab was drawn and results were obtained for Resident D and the nurse did not follow up on the abnormal lab values timely. 2) All lab results have been audited for prompt reporting and return of results. Labs will added to lab audit per order going forward preventing untimely reporting.3) All nursing staff educated on guidelines for reporting labs timely and turn around times. Lab educated on calling critical labs to the facility when received. Lab audit revision to assure no lab not returned same day (if possible). 4) Audits will be done on all labs daily to ensure timeliness of results recieved as well as timeliness with MD notification and intervention as needed. Audits will be done 5x/week x 6 months or until 100% compliance and results will be reviewed in QA.</p>	02/09/2012			

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	<p>Results for CBC without differential were printed on another copy of the lab report and indicated, "Specimen Received: 11/28/2011 08:18 [8:18 a.m.], Final Reported: 12/02/2011 13:32 [3:32 p.m.], Specimen Collected: 11/28/2011 6:06 [6:06 a.m.]" The report indicated, "...Hemoglobin 7.0 CL [critical low]...."</p> <p>On 11/29/11 at 8:30 a.m., Nurse's Notes indicated the resident was transferred to the emergency room after dislodging his gastrostomy tube. The Emergency Department Report, dated 11/29/11, indicated, "Emergency Room Course: ...hemoglobin was 5.8...the patient was typed and crossed for 4 units of packed red blood cells and transfusion was begun as soon as available....There are large areas of ecchymosis on the patient's posterior thighs which may account for the patient's hemoglobin since his Hemocult is negative at this time...."</p> <p>Documentation in Nurse's Notes or on lab reports failed to indicate the facility contacted the lab for the results of the pending CBC later in the day on 11/28/11, when the lab would have been expected, or that the critical value was called to the facility until 12/2/11, four days after the report would have been expected.</p> <p>During interview on 1/19/12 at 2:45 p.m., RN #15 indicated blood for lab work was usually obtained in the morning and results of labs were usually reported the same afternoon. RN #15 indicated the lab usually calls the facility to report critical lab values.</p> <p>During interview on 1/19/12 at 3:10 p.m., the Administrator and Assistant Director of Nursing indicated the turn around time for labs should normally be on the same day, and that a critical lab</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155753	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2012
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NAME OF PROVIDER OR SUPPLIER HAMPTON OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 966 N WILSON RD SCOTTSBURG, IN 47170
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(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
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	<p>value should be called to the facility.</p> <p>During interview on 1/19/12 at 3:45 p.m., the Administrator indicated she had contacted a lab supervisor about Resident D's critically low hemoglobin level. The Administrator indicated the lab supervisor informed her the critical level had been telephoned to the MDS [Minimum Data Set] Coordinator on 12/2/11. The Administrator indicated she asked the lab supervisor for an explanation of a five (sic) day delay in the testing and reporting of the critical level. The Administrator indicated she was told by the lab supervisor that the supervisor would need to "QA [quality assurance]" the matter and get back with her on why the test was not completed and/or the critical lab value was not reported timely.</p> <p>This federal tag relates to Complaint IN00102101.</p> <p>3.1-49(a)</p>			
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