STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155742	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREWS HEALTH CAMPUS	1400 LAMMERS PIKE BATESVILLE, IN 47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure survey. This visit included the Investigation of Complaints IN00126782 and IN00130908. Complaint IN00126782 - Substantiated. Federal/state deficiencies related to the allegations are cited at F514. Complaint IN00130908 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157. Survey dates: July 15, 16, 17, 18, 19, 22, 23, and 24, 2013 Facility number: 004671 Provider number: 155742 AIM number: 200538760 Survey team: Diana Sidell RN, TC Chris Greeney QIDP (July 15, 16, 17, 18, and 19, 2013) Joan Laux RN (July 15, 16, 17, 18, and 19, 2013) Census bed type: SNF: 13 NF: 17	F000000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	SNF/NF: 19 Residential: 34 Total: 83 Census payor type: Medicare: 16 Medicaid: 16 Other: 51 Total: 83 Residential sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 8/01/13 by Suzanne Williams, RN			

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F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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). 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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on record review and interview, the facility failed to notify a resident's family member after a change in the resident's medication. This affected 1 of 3 residents	F000157	1.Res. #A poa was notified by DHS on 8-9-13 of change in seroquel dosage to reflect current regimen. 2. On or before Aug. 20, 2013 the DHS/Medical Records Nurse and Clinical	08/21/2013

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	reviewed for notification of 31 residents whose records were reviewed. (Resident #A) Findings include: Resident #A's record was reviewed on 7/18/13 at 9:32 a.m. The record indicated Resident #A was admitted with diagnoses that included, but were not limited to, hyperlipidemia, coronary artery disease, congestive heart failure, memory disturbance, dementia with aggressive behaviors, insomnia, and confusion. Physician's readmission orders, dated 3/21/13, indicated an order for Seroquel (antipsychotic medication) 25 mg, give 1/2 tablet by mouth daily before lunch, before dinner, and one 25 mg tablet by mouth at bedtime for dementia with aggressive behaviors. Physician's telephone orders, dated 3/22/13, indicated an order to discontinue the Seroquel given three times a day, and to start Seroquel 25 mg by mouth twice a day. No documentation was found in the resident's record that indicated his Power of Attorney (POA) had been notified of the changes made to the resident's medication for 3/22/13.		Assessment nurse audited other residents that recieve antipsychotic medications clinical records to assure their POA have been informed of any changes in antipsychotic medications. Any deficient practice identified was corrected.3. Nurses were re-educated by the DHS/Medical Records Nurse/Clinical Assessment Nurse on or before 8/20/2013 regarding policy and procedure for family notification with an emphasis on changes in antipsychotic medication.4. Changes in antipsycotic medications will be audited by the DHS/Medical Records nurse/ Unit Manager monthly.The results of the audits will be presented to the Quality Assurance Committee to be reviewed and for recommendations until compliance is reached for 3 consecutive months. The need for ongoing audits will be determined by the QA committee 5. Date August 21/2013	

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	During an interview on 7/22/13 at 9:56 a.m., the Executive Director indicated they did not have any documentation that the POA had been notified of the medication changes for 3/22/13. A Policy and Procedure for "Family Notification of Diagnostic Testing and Change in Condition", with a last review date of 1/30/13, was provided by the Executive Director on 7/23/13 at 10:00 a.m. The policy indicated, but was not limited to, "Purpose: To ensure the resident's responsible party is aware of all diagnostic testing results or change in condition in a timely manner. Procedure...2. The responsible party should be notified of change in condition or diagnostic testing results in a timely manner...5. Documentation of notification or notification attempts should be recorded in the resident medical record." This federal tag relates to Complaint IN00130908. 3.1-5(a)(3)			

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F000221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.			
	Based on observation, record review, and interview, the facility failed to assess and ensure the least restrictive restraint was utilized for a restraint, which resulted in loss of the resident's ability to independently use a wheelchair to move about the facility, for 1 of 1 resident reviewed for restraints (Resident #50). Findings include: During an observation, on 7/17/13, at 2:50 p.m., Resident #50 was seen in a chair, in a reclined angle position, being pushed down the hallway by staff. Resident #50's feet were observed to be straight out in front of the chair with no support. During an observation, on 7/18/13, at 8:35 a.m., Resident #50 was observed sitting in the same chair that was reclined at an angle which caused the resident to lay back. Her feet could not touch the floor. A "Fall Circumstance, Assessment	F000221	1. Resident # 50 was reassessed by OT on 7/18/13 for least restrictive device which will promote highest level of independance. On 7/18/13 res. # 50 was placed in a different w/c that assures she can reach the w/c wheels to self propel with arms. OT currently working with res. on self propeling. 2. All other residents with physical retraints were reassessed by Physcial Therapy/DHS on or before 8/20/13 to assure least restrictive devices are utilized to promote independence.3. On or before 8/20/13 the DHS/ED/clinical assessment nurse/Medical records Nurse reeducated nurses and therapist regarding restraint policy and procedure with an emphysis on assessment and use of least restrictive devices that promote independence.4. ED/DHS/Therapist will audit all new restraints to assure they promote highest level of independance. This audit will be completed monthly. The results of the audits will be presented to the Quality Assurance Committee to be reviewed and for recommendations until compliance is reached for 3	08/21/2013

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	and Intervention" form, dated 5/17/13, indicated Resident #50 "Fell forward out of wheelchair...skin tear, bruising right side, right forehead." A "Fall Circumstance, Assessment and Intervention" form, dated 5/23/13, indicated Resident #50 "Stood up in wheelchair...Hematoma/swelling to face, breast." A "Fall Circumstance, Assessment and Intervention" form, dated 5/30/13, indicated Resident #50 was in her wheelchair and "Leaned forward from wheelchair to open door to room...fell-hit head on door...Injury Hematoma (right) side of forehead...Therapy to evaluate w/c (wheelchair) for correct seating...Prevention update: Therapy evaluation." A physician's order, dated 5/30/13, indicated "Therapy to evaluate chair for proper fitting." A form entitled "Restraint/Enabler Circumstance, Assessment and Intervention" dated 5/30/13, indicated "Broda Chair...Medical condition for use...decline in cognition...Device considered is a restraint (Y) (yes circled)."		consecutive months. The need for ongoing audits will be determined by the QA committee 5. August 21,2013	

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	Review of physician's orders dated 5/31/13 indicated an order for "Resident in Broda chair while up, D/C (discontinue) chair alarm." A subsequent physician's order, dated 6/9/13, indicated "D/C (discontinue) Wanderguard." A June 10, 2013, "Resident First Conference Note", indicated Resident #50 "uses a 'Broda Chair'...unable to ambulate." Resident #50's record was reviewed, on 7/19/13 at 3:40 p.m. An Annual Minimum Data Set Assessment (MDS), dated 6/4/13, indicated Resident #50 was severely impaired in cognitive skills for daily decision making. The MDS assessment indicated the resident had no physical or verbal behaviors directed at others and "other behavioral symptoms not directed at others" as well as rejection of care and wandering were not exhibited. The assessment further indicated the resident's current behavior status was "improved" when compared to the prior assessment. The MDS assessment indicated the resident used a walker and a wheelchair for mobility, and the wheelchair used did not "prevent (the resident) rising."			

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	Review of Resident #50's most recent physical therapy "Progress and Discharge Summary", dated 1/7/2012, indicated the resident's current level of functioning as "The patient requires front-wheeled walker with moderate assistance for safe ambulation for 10 feet." There were no other physical therapy notes in the resident record. Review, on 7/19/13 at 4:15 p.m., of the facility's "Guidelines for Restraint/Enabler Use", with a last review date of 1/30/13, indicated the purpose was "To ensure completion of assessment and evaluation for appropriate and safe use of restraints." The guidelines further indicated "The Interdisciplinary team shall...develop measures to minimize the risks and resident decline." The guidelines further indicated a comprehensive plan of care shall be developed that "...addresses safety issues...identifies measures to minimize the risk of resident decline and maintain strength and mobility." An interview with the Director of Health Services (DHS), on 7/18/13, at 8:50 a.m., indicated: "No assessment has been done by therapy with regard to the Broda chair. We have the chair			

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	leaning back, which does cause her feet to be off the floor, but it is for comfort." The DHS indicated it is a restraint. "When she was in a wheelchair she would lean forward and fall out." The DHS also indicated Resident #50 could no longer independently move around the facility due to the implementation of the Broda chair. She is dependent on staff to move her chair throughout the building. The DHS further indicated there had been no assessment for the use of the restraint and no care plan had been developed which incorporated the use of the restraint as an intervention while ensuring the resident would not lose skills attained. 3.1-3(w) 3.1-26(o)			

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on observation, record review, and interview, the facility failed to ensure care plans were developed to address the need for a restraint and for a recurring open area on the chin for Resident #50, and to address edema and the use of a diuretic for Resident #78. This affected 2 of 29 residents whose care plans were reviewed. Findings include: 1.a. During an observation, on 7/17/13, at 2:50 p.m., Resident #50	F000279	1. Res. # 50 care plan was updated on 7/19/13 and 8/1/13 by the clinical Assessment nurse to include the current positioning devices and dx of chronic picking of the skin to include the chin area. , Res. # 78 care plan was updated on 8/1/13 to include dx of Congestive Heart Failure and diuretic use.2. On or before 8/20/13 the clinical Assessment Nurse/DHS/Medical Records Nurse audited other residents care plans to assure they address current care needs.3. On or before 8/20/13 the Clinical Assessment Support/Clinical Support re-inserviced nurses on	08/21/2013

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	was seen in a wheeled chair, in a reclined angle position, being pushed down the hallway by staff. Resident #50's feet were observed to be straight out in front of the chair with no support. During an observation, on 7/18/13 at 8:35 a.m., Resident #50 was observed sitting in a the same chair that was reclined at an angle which caused the resident to lay back. The resident's feet did not touch the floor. Resident #50's record was reviewed on 7/19/13, at 3:40 p.m. An Annual Minimum Data Set (MDS), dated 6/4/13, indicated the resident had a BIMS (Brief Interview of Mental Status) score of 7 on a scale of 1-15. The MDS assessment indicated the resident had no physical or verbal behaviors directed at others and "other behavioral symptoms not directed at others" as well as rejection of care and wandering were not exhibited. The assessment further indicated the resident's current behavior status was "improved" when compared to the prior assessment. The MDS assessment indicated the resident used a walker and a wheelchair for mobility, and the wheelchair used did not "prevent (the resident) rising."		care plan policy to assure compliance.4. Five care plans will be audited weekly by the DHS/Clinical Assessemnt Nurse/Medical records. The results of the audits will be presented to the Quality Assurance Committee to be reviewed and for recommendations until compliance is reached for 3 consecutive months. The need for ongoing audits will be determined by the QA committee 5. Date 8/21/2013	

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	A June 10, 2013 Resident First Conference Note indicated Resident #50 "uses a Broda Chair...unable to ambulate." A form entitled "Restraint/Enabler Circumstance, Assessment and Intervention, dated 5-30-13, indicated "Broda Chair...Medical condition for use...decline in cognition...Device considered is a restraint (Y) (yes circled)." A form, dated 5/30/13, and entitled, "Fall Circumstance, Assessment and Intervention" indicated Resident #50 was in her wheelchair and "Leaned forward from wheelchair to open door to room...fell-hit head on door...Injury Hematoma (right) side of forehead" Therapy to evaluate w/c (wheelchair) for correct seating". Prevention update: Therapy evaluation. A "Fall Circumstance, Assessment and Intervention form, dated 5/23/13, indicated Resident #50 "Stood up in wheelchair...Hematoma/swelling to face, breast." Also, a 5/17/13 Fall Circumstance, Assessment and Intervention form indicated Resident #50 "Fell forward out of wheelchair...skin tear, bruising right side, right forehead." Review of Resident #50's most recent Physical Therapy "Progress and			

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	Discharge Summary", dated 1/7/2012, indicated the resident's current level of functioning as "The patient requires front-wheeled walker with moderate assistance for safe ambulation for 10 feet." There were no other Physical Therapy notes in the resident record. Review of Physician's orders, dated 5/31/13, indicated an order for "Resident in Broda chair while up" D/C (discontinue" chair alarm." A subsequent physician's order, dated 6/9/13, indicated D/C (discontinue) Wanderguard. A Physician's order, dated 5/30/13, indicated "Therapy to evaluate chair for proper fitting." During an interview, on 7/18/13 at 8:50 a.m., the Director of Health Services (DHS), indicated: "No assessment has been done by therapy with regard to the Broda chair. We have the chair leaning back, which does cause her feet to be off the floor, but it is for comfort." The DHS indicated it is a restraint. "When she was in a wheelchair she would lean forward and fall out." The DHS also indicated Resident #50 could no longer independently move around the facility since the implementation of the Broda chair was initiated. The DHS further indicated there was no care plan in the resident's record to			

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	address the reasons for the use of the restraint or to ensure lesser restrictive interventions are in place. A review, on 7/19/13, at 4:15 p.m., of the facility's undated Guidelines for Restraint/Enabler Use, indicated the purpose was "To ensure completion of assessment and evaluation for appropriate and safe use of restraints." The guidelines further indicated a comprehensive plan of care shall be developed that "...addresses safety issues...identifies measures to minimize the risk of resident decline and maintain strength and mobility." b. During an observation, on 7/15/13, at 3:02 p.m., Resident #50 was found to have a small red abrasion on her chin. During an interview, at the time of the observation, Resident #50 stated "I did it myself. I keep picking at it." Resident 50's Record was reviewed on 7/19/13, at 3:40 p.m. An Annual Minimum Data Set Assessment (MDS), dated 6/4/13, indicated the resident had a BIMS (Brief Interview of Mental Status) score of 7 on a scale of 1-15. The MDS assessment indicated no skin problems were present at the time of the			

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	assessment, and that the resident did not display any "other behavioral symptoms." An interview with CNA #7, on 7/18/13, at 9:35 a.m., indicated: "(Resident #50) has picked at that area of the skin for as long as I've known her. I've worked here for 6-7 months. In the past we've put band aids over it and talked to her about it." An interview with the Director of Health Services (DHS), on 7/18/13, at 9:41a.m., indicated there was nothing in the care plan for skin picking. The DHS further stated: "It is more behavior-related and the Social Service Director (SSD) might be aware of something." During an interview, on 7/18/13, at 9:55 a.m., the SSD indicated she was not aware of the skin issue with Resident #50. 2. Resident #78's record was reviewed, on 7/18/13, at 3:00 p.m. The 7/1/13 physician's order summary indicated the resident had diagnoses including, but not limited to, congestive heart failure (CHF) and edema. The summary included a physician's order for Lasix 40 mg (milligrams) daily (a diuretic) due to			

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	the diagnoses of CHF and edema. Additional review of the resident's record found no care plan to address the CHF and edema. During an interview with the Director of Health Services, on 7/18/13, at 3:15 p.m., indicated there was no care plan in place to address the identified needs of congestive heart failure and edema. 3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2)			

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F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review, and interview, the facility failed to address a resident's need for positioning assistance, after the resident experienced a decline in sitting posture for 1 of 2 residents reviewed (Resident #52) and who met the criteria for positioning issues. Findings include: During an observation of the noon meal on 7/15/13, and the breakfast meal on 7/18/13 at 8:35 a.m., Resident #52 sat in a standard wheelchair slumped over to the left side with her body leaning over the arm of the chair. During the breakfast observation, CNA #8 was in the same dining room with another resident. Resident #52's positioning was not addressed during either observation. Resident #52's record was reviewed on 7/19/13 at 9:00 a.m. A Quarterly	F000309	1. Resident #52 received an order for OT eval and treatment for positioning on 8/1/13. OT continues working with res. on correct positioning.2. All other residents were observed by OT/DHS on or before 8/20/13 to assure proper positioning. Any problems identified were corrected with recommendations executed.3. On or before 8/20/13 the DHS/OT/Medical records Nurse inserviced staff on policy and procedure on maintaining highest practicable well being with an emphasis on proper positioning.4. Five residents will be observed by the DHS/ED/OT weekly to assure proper positioning.The results of the audits will be presented to the Quality Assurance Committee to be reviewed and for recommendations until compliance is reached for 3 consecutive months. The need for ongoing audits will be determined by the QA committee.5. August 21,2013	08/21/2013

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	Minimum Data Set (MDS), dated 6/21/13, indicated the resident had a BIMS (Brief Interview of Mental Status) score of 14 on a scale of 1-15. The MDS assessment indicated the resident required extensive assistance with bed mobility, transfer, locomotion, dressing, toilet use and personal hygiene. An occupational therapy (OT) Discharge Summary, dated 11/27/09, indicated the resident had been discharged from OT. The document indicated "Discharge Status Other (splinting, orthosis, adaptive equipment, positioning): button aid and reacher. May be up in room with walker to encourage mobility...Resident requires prolonged time. Needs wheelchair for completion of bathing and dressing." There was no indication of positioning on that document, which was the most recent OT entry in the record. During an interview, on 7/19/13 at 9:25 a.m., LPN #9 stated "we do a pillow at times for support but lately she's been not able to push herself up as much." During an interview, on 7/19/13 at 9:30 a.m., the Therapy Department			

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	Program Director indicated there had been no occupational or physical therapy reassessments since 2009 because there was a copay involved and the family felt other needed services were more important. On 7/19/13, at 9:41 a.m., the Therapy Department Program Director returned with a document entitled "Rehabilitation Screen" dated 6/25/12. It indicated Resident #52 was "experiencing hallucinations and confusion. Patient had a fall on 6/11/12. This writer had a talk with (the resident's) POA (Power of Attorney) about therapy. POA stated they will consider it after her confusion is cleared...No skilled intervention at this time." The Program Director further indicated he "followed up with a phone call later" and that is when the family told him that due to therapy copays they wanted to do the other services they felt were more important. 3.1-37(a)			

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F000371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions			
	Based on observation and interview, the facility failed, for residents eating in the main dining room, to ensure staff serving food sanitized their hands between serving 4 residents in the dining room, (Residents #52, 25, 76, and 79) and failed to ensure food on trays was covered during transporting for 13 residents who received meal trays in their rooms. Findings include: 1. During the observation of the noon meal, on 7/15/13 from 11:45 a.m. to 12:45 p.m. Activities Assistant #2 transported Resident #52 in her wheelchair to a table in the main dining room. The assistant picked up a chair, moved it from the table over to a wall. Then she moved Resident #52's chair up to the table and locked the brakes. The assistant then walked to another table and asked Resident #25 what she wanted to drink. Without sanitizing her hands, she picked up Resident #25's glass	F000371	1. No residents were affected by deficient practice.2. All residents have the potential to be affected.3. On or before 8/20/13 the DHS/ED/Director of Food Services educated all staff on infection control policy with emphasis on hand hygiene to include washing for 20 seconds , covering of food during transport, and proper hair net usage.4. Director of Food Services/ED will observe 5 trays q week, observe 5 staff members washing their hands and observe 5 staff members for proper hair net usage q week. These audits will include all 3 shifts and all 3 meals. The results of the audits will be presented to the Quality Assurance Committee to be reviewed and for recommendations until compliance is reached for 3 consecutive months. The need for ongoing audits will be determined by the QA committee.. 5. August 21,2013	08/21/2013

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	and coffee cup from the table, filled them and returned them to the Resident #25. During the observation, LPN #10 took a tray of plated food to a table where Resident #52 was seated. The LPN served three residents sitting at that table, including resident #52. Then, without sanitizing hands between residents, took another tray of plated food to another table and served four residents, including Residents #25, #76 and #79. 2. During the noon meal on 7/15/13 between 11:50 a.m. and 12:20 p.m. the following was observed: Staff went into and out of the kitchen, to refill a glass of milk, without using hand sanitizer. Five residents were served beverages without hand sanitizer being used during or after the beverages were served. Certified Resident Care Assistant #1 and Activities staff #2, and the Director of Health Services were observed to not perform any hand hygiene between tables being served their plates, drinks, and clearing dirty plates after lunch service. Hair was observed falling out of the sides and the back of four staff			

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	members' hair nets during the entire lunch service. 3. During an observation of meal trays delivered to rooms, on 7/15/13 at 12:23 p.m., the dining tray cart was stationed at the beginning of the 300 hall just off of the nurses station. Trays were served from the cart down to rooms on the 100, 200 and 300 halls during the observation. On each tray, a red dessert which appeared to look like a mousse, was uncovered on each tray as it was transported from the cart to each room. Residents were observed to be served the trays with the uncovered food. During an interview on 7/15/13 at 12:45 p.m., the Director of Health Services, who was present when room trays were served, indicated 13 residents received trays in their rooms during that meal. An interview with the Director of Food Service, on 7/17/13 at 11:50 a.m., indicated she was aware of the food served uncovered and she stated "it should not have happened. We put plastic wrap over bowls when they do not have covers." 3.1-21(i)(3)			

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F000372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. Based on observation and interview, the facility failed to ensure dumpsters where trash was stored until pick-up, remained covered when not actively being used. This affected 83 of 83 residents who were served food prepared in the kitchen. Findings include: During an observation, on 7/17/13 at 11:15 a.m., a garbage dumpster located outside the facility near the kitchen entrance had no lid on the container where trash was discarded. It appeared to have been broken off the hinges where a lid is normally on a dumpster. The dumpster contained trash and refuse. An interview with the Dietary Manager, on 7/17/13 at 11:15 a.m., indicated it should have had a lid, and the facility would have to contact the company who empties the dumpster to get it replaced. 3.1-21(i)(5)	F000372	1. No residents were affected by the deficient practise.2. All residents have the potential to be affected. 3. Dumpster lid was replaced on 8/13/13 by the Director of Enviromental Services. The ED educated the Director of Enviromental Services on infection control policy with emphasis on dumpster being covered on or before 8/20/13.4. The Director of Enviromental Services/ED will audit the dumpster 5 x week to assure dumpster lid is intact and closed. The results of the audits will be presented to the Quality Assurance Committee to be reviewed and for recommendations until compliance is reached for 3 consecutive months. The need for ongoing audits will be determined by the QA committee.5. August 21,2013	08/21/2013

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F000441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. A. Based on record review and interview, the facility failed to ensure	F000441	1. CRCA #20 and 22 were given Mantoux PPD by Medical	08/21/2013

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	2 of 10 employees reviewed for Tuberculosis Screening received a two step Mantoux PPD test upon hire. (Certified Resident Care Assistant) CRCA #20 and Environmental Assistant #22 B. Based on observation, interview and record review, the facility failed to ensure hand washing technique was followed for the prevention of infection control for 6 of 11 observations of hand washing, and 2 of 2 residents observed. (Residents #60 and 17) Findings include: A. 1. Employee records were reviewed on 7/18/13 at 10:55 a.m. The records indicated CRCA #20 had an employment start date of 6/18/13. A first step Mantoux skin test had been given on 6/7/13 at the local County Health Department. No documentation that the second step Mantoux had been given was in the employee's record. During an interview, on 7/22/13 at 2:18 p.m., Business Office Personnel #11 indicated CRCA #20 had no second step PPD. A. 2. Review of employee records for Environmental Assistant #22		Records Nurse on or before 8/20/132. A. All staff's medical record were audited by the Ed on 8/12/13 to assure compliance with PPD policy. Any deificiencies identified were corrected.2B. No residents were affected by improper hand washing. 3A. The Business Office Manager (BOM)and Medical Records Nurse/DHS were inserviced by the DHS/ED on or before 8/20/13 on TB policy and procedures. The BOM will keep a tickler file on new hires to assure compliance of 2 step ppd.3B. Staff were reinserviced on proper hand washing with an emphasis on 20 sec wash to assure compliance. This in-servicing was completed by the DHS/Medical Records Nurse/Clinical Assesment Nurse on or before 8/20/13.4A. ED/BOM will audit 5 new employee files q week for TB testing.4B. DHS/ED will audit 5 employees q week for proper handwashing. The results of the audits will be presented to the Quality Assurance Committee to be reviewed and for recommendations until compliance is reached for 3 consecutive months. The need for ongoing audits will be determined by the QA committee.5. August 21,2013	

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	indicated an employment start date of 6/11/13. A first step Mantoux skin test had been given on 6/11/13. No documentation a second step had been given was in the employee's record. During an interview on 7/22/13 at 2:18 p.m., the Business Office Personnel #11 indicated Environmental Assistant #22 did not have a second step PPD. A policy and procedure for "Guidelines for TB Results Summary Documentation: Staff", was provided by the Executive Director on 7/23/13 at 10:00 a.m. The policy included, but was not limited to, "Purpose: To create a TB Results Summary for each staff member upon hire. Procedures: 1. Upon hire each employee shall receive a Two Step Mantoux PPD test to ensure they are free of tuberculosis. 2. The results of the baseline PPD test, the Mantoux test shall be recorded in the TB Results Summary and placed in the personnel file...." B. 1. During an observation of wound care, on 7/18/13 at 10:35 a.m., for Resident #60, RN #4 removed an ace wrap, a 2 inch square gauze pad, and packing from a left dorsal foot wound.			

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	RN #4 removed her gloves and placed the gloves and old dressing into a plastic bag. RN #4 washed her hands again for 17 seconds, dried her hands and used the same paper towels to shut of the faucet, applied new gloves and continued with the wound care. After she cleansed the wound she removed her gloves and washed her hands for 13 seconds, then applied new gloves. RN #4 applied the dressing to the wound, removed her gloves, washed her hands for 13 seconds, then applied new gloves. LPN #3 washed her hands for 12 seconds, applied gloves, then lifted Resident #60's leg while RN #4 wrapped an Ace wrap around the wound and foot. After care was completed, RN #4 washed her hands for 14 seconds and dried her hands using the same paper towels to shut off the faucet. LPN #3 indicated during an interview on 7/18/13 at 11:18 a.m., "You turn on the water, get your hands soapy, wash them with rubbing your hands together and your fingernails. I (LPN #3), sing ABC while I wash my hands. You should wash your hands for 3 to 4 minutes, then you rinse your hands, get some paper towels, dry your hands off with them, shut off the water with the paper towel, and throw			

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	the paper towel in the trash." RN #4 indicated during an interview on 7/18/13 at 11:24 a.m., "You wash your hands by getting lots of soap on your hands, wash them good for 20 to 30 seconds, then wash the water off, dry your hands with a paper towel, shut the water off with the paper towel and throw away the paper towel." A policy and procedure for "Guidelines for Handwashing" was provided by the Administrator in Training on 7/18/13 at 11:54 a.m. The policy indicated, but was not limited to: "Before/after having direct physical contact with residents, after removing gloves...for direct contact with excretions or secretions...wet hands with running water, allowing water to flush from wrist to fingertips. Wash well for 20 seconds (ABC or Happy Birthday song.), using a rotary motion and friction. Rinse hands well under running water, allowing water to flush from wrist to fingertips. Dry hands with paper towels. Turn off faucet with a dry paper towel to avoid recontaminating hand from the faucet." B. 2. During an observation, on 7/19/13 at 9:51 a.m., of peri-care for Resident #17, (Certified Resident			

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	Care Assistant) CRCA #6 went in to Resident #17's room, shut the door and washed her hands for 16 seconds. 3.1-18(l)			

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F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to maintain a resident's clinical record for complete and accurate documentation, in that 1 resident had incomplete documentation after an in and out catheter was utilized to obtain a urine specimen. This affected 1 of 31 residents whose records were reviewed. (Resident #C) Findings include: Resident #C's record was reviewed on 7/18/13 at 9:15 a.m. The record indicated Resident #C was admitted with diagnoses that included, but were not limited to, high blood pressure, chronic kidney disease, Alzheimer's disease, pelvic organ prolapse, osteoarthritis, and	F000514	1. Resident #c 's clinical record was updated by the DHS on or before 8/20/13 to include proper documentation of straight cath procedure. 2. All residents requiring straight catherization within the past 30 days clincial record was reviewed to asssure proper documentation of procedure. This audit was completed on or before 8/20/13 by DHS/Medical Records Nurse/Unit Manager . Any discrepancies noted were corrected3. Nurses were educated by DHS/Medical Records Nurse on or before 8/20/13 on proper documentation of procedures to include residents tolerance of procedure.4. 5 clinical records will be audited weekly by the DHS/Medical Records Nurse.The results of the audits will be presented to the Quality Assurance Committee to	08/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155742	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/24/2013
NAME OF PROVIDER OR SUPPLIER ST ANDREWS HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 LAMMERS PIKE BATESVILLE, IN 47006	

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	glaucoma. A physician's telephone order, dated 7/12/13, indicated "N.O. (new order) (1) May straight cath to obtain urine specimen. (2) Send specimen for UAX (urinalysis)." A form titled "Urinary Testing Results", dated 7/12/13, indicated the method of collection (for the urine specimen) was catheter, time of test: 2130 (9:30 p.m.), the test results, physician notification, orders received, and the follow up testing. No further documentation was in the resident's record for the in and out catheter. During an interview, on 7/22/13 at 3:00 p.m., RN #4 indicated the straight cath was done but not documented, and "We just sign off on the lab sheet." A policy and procedure for "Guidelines for intermittent catheterization" was provided by the Director of Health Services on 7/22/13 at 4:00 p.m. The policy indicated, but was not limited to, Purpose: To relieve the retention of urine in the bladder, to obtain a urine specimen for diagnostic purposes,		be reviewed and for recommendations until compliance is reached for 3 consecutive months. The need for ongoing audits will be determined by the QA committee.5. August 21,2013	

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	and to determine the amount of residual urine retained in the bladder. Procedure...b. check the urine for unusual appearance. Record findings, notify physician...6. The following information should be recorded in the resident's medical record: a. The date and time the procedure was performed. b. The name and title of the individual(s) who performed the procedure and is recording the data. c. The amount of urine drained. d. The character, clarity, and color of urine. e. Any observation of obstruction; evidence of blood, pus, etc. f. Any change in the resident's condition (e.g., swelling, discomfort, etc.). g. Any problems or complaints made by the resident related to the procedure. h. The resident's response to the treatment. i. All assessment data obtained during the procedure. j. If the resident refused the procedure, the reason(s) why and the intervention taken...8. Report other information in accordance with campus guidelines and professional standards of practice." This Federal Deficiency relates to complaint IN00126782. 3.1-50(a)(1)			

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F009999	3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within (1) month prior to employment. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure that 2 of 10 employees reviewed for employee physical examinations, had received a physical examination. (RN #21 and Certified Resident Care Assistant [CRCA] #23) Findings include: 1. Employee records were reviewed on 7/18/13 at 10:55 a.m. The records indicated RN #21 had a start date of 3/19/13. An "Employee Health Exam", dated 2/18/13, indicated the section to be completed by the healthcare provider providing the exam was blank, including no dates or signatures. During an interview, on 7/22/13 at 2:18 p.m., Business Office Personnel #11 indicated RN #21's physical was	F009999	1. RN#21 and CRCA#23 physical examination form was signed and dated by Medical Director on 8/13/13.2. All employee health files were audited by AP payrole to assure all physical examination forms are signed and dated any discrepancies noted were corrected by 8/20/13.3. On or before 8/20/13 the DHS/Medical Records Nurse/ED inserviced nurses, BOM, and AP payroll on state policy regarding physical exam of employees. 4. All new employees health records will be audited by the BOM weekly.The results of the audits will be presented to the Quality Assurance Committee to be reviewed and for recommendations until compliance is reached for 3 consecutive months. The need for ongoing audits will be determined by the QA committee. 5. August 21,2013	08/21/2013

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	not filled out, signed or dated by the physician. 2. CRCA #23's record indicated a start date of 10/8/12. An "Employee Health Exam", dated 10/8/12, indicated the section to be completed by the healthcare provider providing the exam did not have the date the physician signed the form. During an interview on 7/22/13, at 2:18 p.m., the Business Office Personnel #11 indicated CRCA #23's physical did not have the date when the physician signed the form. On 7/23/13 at 10:00 a.m., the Executive Director provided a policy and procedure for "Medical Examinations (Physicals), with a last review date of 1/30/2013. The policy indicated, but was not limited to, "Each prospective employee, upon receipt of a conditional offer of employment will be required to undergo a physical examination. Each active employee is required to meet applicable health regulations, which may require periodic health reviews/physical examinations...." 3.1-14(t)			