

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155670	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2014
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF NEWBURGH	STREET ADDRESS, CITY, STATE, ZIP CODE 5233 ROSEBUD LN NEWBURGH, IN 47630
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F000000	<p>This visit was for the Investigation of Complaint IN00144440.</p> <p>Complaint IN00144440 Substantiated - Federal/State deficiencies related to the allegations are cited at F315 and F323.</p> <p>Survey dates: February 20 and 21, 2014</p> <p>Facility number: 011049 Provider number: 155670 AIM number: 200258520</p> <p>Survey team: Anne Marie Crays, RN</p> <p>Census bed type: SNF/NF: 81 Total: 81</p> <p>Census payor type: Medicare: 13 Medicaid: 60 Other: 8 Total: 81</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with</p>	F000000	<p>This Plan of Correction is submitted under the State and Federal Regulations and Statues applicable to long-term care providers. This Plan of Correction does not constitute an admission on part of the facility. We request this Plan of Correction serve as our credible allegation of compliance. We have submitted an IDR request for F 323 as required at time of plan of correction submisson.Should you have any questions, please feel free to contact me at (812) 473-4761. Sincerely,Fairley (Lee) R. Taylor Jr., HFA, Administrator</p>	

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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F000315 SS=D	<p>410 IAC 16.2.</p> <p>Quality review completed on February 24, 2014, by Jodi Meyer, RN</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <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 observation, interview, and record review, the facility failed to catheterize a resident 3-4 x per day, as ordered by the physician, and instead re-inserted a foley catheter, for 1 of 3 residents reviewed with foley catheters, in a sample of 4. Resident A</p> <p>Findings include:</p>	F000315	Resident A still has a foley catheter and the order was given by the urologist with the primary physician in agreement related to a diagnosis of urinary retention. The family is aware of the current physicians order. 2. Each resident with a catheter order has been reviewed by the DON/ADON for appropriate diagnosis pertaining to the catheter (Exhibit A). There were no other issues found. All residents had a pertinent diagnosis and all had a catheter assessment completed. 3. The licensed nursing staff will be re-educated by 3/03/13 on	03/03/2014			

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	<p>On 9/20/14 at 9:20 A.M., CNA assignment sheets were received from the Administrator and reviewed. The assignment sheets indicated Resident A had a foley catheter.</p> <p>On 2/20/14 at 1:20 P.M., Resident A was observed sitting in a wheelchair with a foley catheter bag hanging from the wheelchair frame.</p> <p>The clinical record of Resident A was reviewed on 2/20/14 at 1:30 P.M. Diagnoses included, but were not limited to, urinary tract infection (UTI), Parkinson's disease, and history of CVA.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 1/22/14, indicated Resident A scored a 6 out of 15 for cognition, with 15 indicating no memory problems. Urinary continence was "Not rated, resident had a catheter...."</p> <p>Documentation indicated the resident had a consultation with a urologist on 2/6/14 regarding his frequent UTI's. A physician's order, dated 2/6/14, indicated, "Stop Foley use Friday 2/7/14. Start Sterile intermittent cath 3-4 times a day</p>		<p>appropriate diagnosis of a catheter, transcription of physician orders, physician notification, and following physicians orders (Exhibit B). This will be completed by the SDC. The Unit Managers/designee will complete an audit (Exhibit C) and a catheter assessment on any resident that is admitted with a catheter or that receives a new order for a catheter and will attempt to discontinue if an appropriate diagnosis is not present. All new orders will be audited each day by Unit Manager/designee for correct transcription to the MAR/TAR. Any change of condition on the 24 hour report will be audited for appropriate physician notification and follow up. Each resident with an existing catheter will have a catheter assessment completed quarterly and with significant change to determine that the catheter is still necessary based on the resident current condition and diagnosis. These audits will be turned in to the DON as they are completed. 4. The DON will forward the results of the audits to the monthly Quality Assurance Committee for further review and recommendation. The audits will continue daily for 30 days, twice weekly for 30 days, weekly for 30 days and then monthly for 3 months to ensure continued compliance.</p>		

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	<p>(May increase times per day if residual greater than 500 cc)."</p> <p>The February Treatment Record indicated the order was written as "Stop Foley 2/7/14. Start sterile intermittent catheter 3-4 x day. May reanchor if residual >500 cc."</p> <p>Nurse's Notes included the following notations:</p> <p>2/7/14 (untimed) "Day shift": "F/C [foley catheter] dc'd [discontinued] this AM, patient has voided incontinent at least moderate amount x 3 this shift, did perform PRN [as needed] I/O [in/out] cath to check residual, 100 cc yellow urine...Will monitor."</p> <p>2/8/14 (untimed) "Night shift": "Resident's F/C was D/C'd today and we are monitoring his output...."</p> <p>2/8/14 (untimed) "Day shift": "Res alert. [Up] in w/c for meals. Voided [urinated] x 3...."</p> <p>2/18/14 (untimed) "Evening shift": "Alert. Voided x 2...."</p> <p>There was no documentation regarding a catheterization being performed on any of the 3 shifts on</p>			

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	<p>2/8/14.</p> <p>Nurse's Notes continued:</p> <p>2/9/14 at 4:00 A.M.: "Had been attempting to get resident to drink [increased] fluids in beginning of shift and had still not voided - straight cathed and obtained 850 cc yellow, clear urine [and] foley cath #14 G [with] 10 cc water inserted per assist of two staff....."</p> <p>2/9/14 (untimed) "Day shift": "...F/C patent et draining clear yellow urine...."</p> <p>2/9/14 (untimed) "Evening shift": "...Foley cath patent et draining clear yellow urine...."</p> <p>2/10/14 (untimed) "Day shift": "F/C draining well to bedside drainage bag, yellow [with] sediment, call placed to [urologist] to clarify F/C orders, nurse reviewed MD noted orders. Stated we are not to remove F/C again at this time, we will keep for injury prevention, to focus on rehab, if patient goes home will work on d/c F/C, also has wounds to coccyx area...wife argumentative about F/C, handled [with] understanding, compassion, et education, wife stated she may have</p>			
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	<p>to call urologist herself. Will continue to monitor patient."</p> <p>On 2/21/14 at 10:00 A.M., a family member of Resident A was interviewed. The family member indicated the family was in the room with the resident when the Urologist told them that removing the foley catheter should take care of the resident's infection. The family member indicated that is why the family was so upset when the facility left the foley catheter in. The family member indicated she thought the staff wanted to leave the catheter in for their convenience, so that they wouldn't have to catheterize the resident several times a day.</p> <p>On 2/21/14 at 10:45 A.M., RN # 1 was interviewed. RN # 1 indicated she was unable to read the urologist's order on 2/6/14. She indicated the staff understood it to read "May reanchor if residual over 500 cc." RN # 1 indicated she called the physician's office on 2/10/14 to clarify the order. When queried regarding the reason for the catheter written as "injury prevention" RN # 1 indicated, "That is what the nurse said."</p> <p>On 2/21/14 at 11:00 A.M., Urology</p>						

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	<p>nurse # 1 was interviewed. She indicated she was called by RN # 1 on 2/10/14 regarding clarifying the physician's order of 2/6/14. She indicated she did not give any orders to RN #1, and did not speak to the Urologist. She indicated there was no documentation that any other staff member at the Urologist's office would have spoken to the facility. Urology nurse # 1 indicated the Urologist was out of the office at that time.</p> <p>On 2/21/14 at 12:05 P.M., RN # 1 was again interviewed. She indicated she had spoken to a nurse at the Urologist's office on 2/10/14, but did not know who she spoke to. RN # 1 indicated the nurse gave her the order to keep the foley catheter in.</p> <p>On 2/21/14 at 2:35 P.M., the Director of Nursing was interviewed. He indicated he understood the order received from the Urologist on 2/6/14 was for intermittent catheterization, and did not know why it was not done 3-4 x daily. He indicated he did receive a call from the nurse on 2/9/14, indicating the family was upset. The DON indicated he instructed the staff to notify the urologist on call, who told</p>			

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	<p>them to maintain the foley catheter that night and notify the primary urologist on 2/10/14. The DON indicated he would not have thought "injury prevention" was an appropriate diagnosis for maintianing a foley catheter.</p> <p>This Federal tag relates to Complaint IN00144440.</p> <p>3.1-41(a)(2)</p>			

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F000323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to provide the appropriate amount of assistance to a resident while ambulating, in that one (1) therapy staff ambulated the resident while holding onto a gait belt and a wheelchair at the same time, resulting in a fall and bilateral lower extremity fractures. This affected 1 of 3 residents reviewed for falls, in a sample of 4. Resident B</p> <p>Findings include:</p> <p>On 2/20/14 at 8:45 A.M., during the initial tour, the Director of Nursing (DON) indicated Resident B had fallen in the previous 2 months.</p> <p>On 2/20/14 at 9:55 A.M., Resident B was interviewed. Resident B was observed lying in her bed, with both of her legs elevated on a pillow. Resident B indicated she had fallen</p>	F000323	<p>Resident B remains in the facility and is continuing with therapy in order to return home. 2. Each resident on therapy caseload currently was re-evaluated by the therapy manager for proper assistance during transfers and ambulation while attending therapy. 3. The therapy staff will be re-educated (Exhibit D) by the therapy manager on the ambulation policy and procedure and appropriate assistance with each resident by 3/3/14. The therapy staff will use 2 person assist for ambulation with a resident if the wheelchair is being pulled behind them. The therapy manager or designee will complete a random audit up to 5 times a week to insure that the therapists are using the correct amount of assist with residents. This audit will be forwarded to the Administrator. 4. The Administrator will forward the results of the audits to the monthly Quality Assurance Committee for further review and recommendations. The audit will continue daily for 30 days, then weekly 30 days, then monthly for</p>	03/03/2014

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	<p>at home "several times," and had broken both legs. Resident B indicated she was at this facility for therapy. Resident B indicated she was walking with the therapist in the hallway, and her "knee buckled and just went down." Resident B indicated the therapist had a gait belt around her and was pulling a wheelchair behind her, "but he couldn't hold me." Resident B indicated she had informed the therapist that when she has fallen she "falls down or forward, not backward, but sometimes they don't listen." Resident B indicated that she now had a broken ankle, broken toe, and 2 broken legs, and was unable to bear weight.</p> <p>The clinical record of Resident B was reviewed on 2/20/14 at 10:20 A.M. Diagnoses included, but were not limited to, fall, morbid obesity and fractured proximal fibula.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 12/26/13, indicated the resident had no memory problems, did not ambulate, and required total dependence of two+ staff for transfer.</p> <p>Physical Therapy Daily Treatment Notes included the following</p>		4 months to insure continued compliance. Please refer to the document titled "IDR Response for F 323" document for explanation of IDR request included in uploaded exhibit files.				

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	<p>notations:</p> <p>1/14/14 at 4:48 P.M.: "Fair tolerance of standing at stand frame twice, each [approximately] 5-8 minutes...."</p> <p>1/15/14 at 6:03 P.M.: "Difficulty achieving stand from WC [wheelchair] influenced by anxiety and...LE [lower extremity] weakness and vernal deconditioning...Mobility: walking and moving around functional limitation...."</p> <p>1/16/14 at 2:46 P.M.: "Pt. [patient] did transfers WC to mat. 4 times...Nursing uses hover lift [sic] for transfers in shower...."</p> <p>1/17/14 at 4:03 P.M.: "Pt. did transfers 2 times WC to mat, mod [moderate] A [assist] 2-3 p A (two to three person assist). Several attempts were made to sit to stand from WC. 3 p A [three people assist]...."</p> <p>Documentation indicated the resident did not have therapy on 1/18/14 or 1/19/14.</p> <p>A Physician's order, dated 1/18/14, indicated, "Transfer from bed to bedside commode et [and] bed to w/c with stand pivot. Lt [left] knee</p>			

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	<p>brace to be worn. Transfer w/c to bed et may cont to use hoyer [mechanical left]...."</p> <p>A PT Daily Treatment Note, dated 1/20/14 at 5:27 P.M., indicated, "Improved sit to stand at frame requiring Mod [moderate] A...still needs work on stand tolerance for more functional performance carryover."</p> <p>Nurse's Notes, dated 1/21/14 at 11:30 P.M., included the following: "Res. [resident] ambulating in the hallway [with] walker - had gait belt on, Therapist holding gait belt [with] w/c behind Res [with] leg brace on legs began to buckle and Res fell on her knees, didn't hit head, assisted Res in to w/c by Hoyer. Lt [left] ankle is swollen [with] purplish bruise...c/o [complains of] pain to BLE [bilateral lower extremities]...."</p> <p>The resident's physician was notified of the fall, and an order for X-Rays to the bilateral lower extremities was received. The resident was transferred to the hospital emergency room for evaluation and treatment on 1/21/14 at 6:30 P.M., and returned to the facility on 1/21/14 at 11:45 P.M.</p>			

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	<p>Hospital x-rays included: Left foot: "There is a nondisplaced fracture of the medial malleolus [ankle]. There is also a nondisplaced fracture of the distal shaft of the fibula [leg]. There is a stable remote fracture at the base of the fifth proximal phalanx [toe]." Right leg: "Healed fracture of the proximal right fibula. There is a nondisplaced, obliquely oriented fracture of the distal shaft of the fibula. This has an acute appearance."</p> <p>On 2/20/14 at 1:10 P.M., during interview with the Therapy Manager and PTA # 1, PTA # 1 demonstrated how he held on to the resident via gait belt while pulling the wheelchair behind him. PTA # 1 indicated the resident "was doing really well, and went straight down real suddenly." When queried why 2 staff members were not ambulating the resident, when she had not been ambulating previously, the Therapy Manager indicated, "Sometimes we men think we are stronger and are able to hold people up." The Therapy Manager indicated, "We held a meeting after this incident, and decided we would not ambulate residents anymore while pulling a wheelchair without 2 people assisting."</p>						

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