

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  11/09/2012
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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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F0000	<p>This visit was for the Investigation of Complaint IN00118263 and Complaint IN00118520.</p> <p>Complaint IN00118263 -- Substantiated. Federal/state deficiency related to the allegations is cited at F282.</p> <p>Complaint IN00118520 -- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: November 7, 8 and 9, 2012</p> <p>Facility number: 004671 Provider number: 155742 AIM number: 200538760</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF/NF: 34 SNF: 18 Residential: 34 Total: 86</p> <p>Census payor type: Medicare: 14 Medicaid: 26</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>Other: 46 Total: 86</p> <p>Sample: 4</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on November 19, 2012 by Bev Faulkner, RN</p>				

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure a resident with a laceration to the right lower extremity had physician orders for the care of the laceration/wound. This deficient practice affected 1 of 4 residents reviewed for physician orders in a sample of 4. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 11-7-12 at 3:10 p.m. His diagnoses included, but were not limited to right lower extremity cellulitis (skin infection), urinary outlet obstruction with indwelling suprapubic catheter, coronary artery disease, high blood pressure and history of UTI's (urinary tract infection).</p> <p>Review of the "Discharge Summary" from the hospitalization prior to the admission to the facility, dated 10-4-12, indicated he was being followed by the local Wound Clinic for a laceration/wound when the cellulitis developed and was subsequently admitted for antibiotic therapy. The document</p>	F0282	<p>1. Resident #A was discharged prior to this visit.2. All resident's with wounds were assessed by the DHS/designee by 12/8/12 to assure phycians orders were obtained for wound care.3. Licensed staff are inserviced by 12/8/12 on obtaining phycians orders for wound care by the DHS/Designee.4. New admissions will be audited by DHS/Designee daily during ccm meeting, and quarterly during peer review audit to assure all new admissions with wounds have appropriate wound orders. Audits will be reviewed during monthly QA meeting and will continue until 100% compliance is met x 3 months.5. Date: 12/8/12</p>	12/08/2012			

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	<p>indicated he would continue on IV antibiotics at the facility and the Wound Center would follow the laceration/wound. The discharge summary did not indicate what specific measures were to be followed for the dressing in place on the right lower extremity.</p> <p>Review of the Nursing Admission Assessment, dated 10-5-12, indicated the resident had a laceration to the right lower extremity which measured 2.5 centimeters (cm) in length by 0.5 cm wide with a depth of 0.3 cm with an intact dressing in place. The admission notation did not indicate the dressing was changed. A notation on the same date for the 10:00 p.m. to 6:00 a.m. shift indicated the dressing was changed, but no details were indicated regarding the dressing change or the appearance of the wound.</p> <p>Review of the initial physician orders, dated 10-5-12 to 10-9-12, indicated no care instructions for the right lower extremity laceration/wound or dressing changes.</p> <p>In interview with the Corporate Nurse on 11-8-12 at 3:50 p.m., she indicated she could not find any information prior to the written telephone order on 10-10-12 for dressing change instructions, following a</p>				

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	<p>visit to the local Wound Clinic on 10-9-12. She indicated the admitting nurse should have sought clarification from the resident's physician or the Wound Clinic for how to care for the resident's wound. She indicated the facility does "...not have a specific policy that says to get a doctor's order for a dressing. That's basic nursing principle."</p> <p>In interview with the Director of Health Services (DHS) on 11-8-12 at 10:38 a.m., she indicated, "The resident's wound was followed by the Wound Clinic. Yes, it would have been more clear to have [physician's] orders about the dressing change, even if it is to just reinforce the dressing and when he was to go back to the Wound Clinic."</p> <p>In interview with the Wound Clinic nurse on 11-9-12 at 8:48 a.m., she indicated Resident #A has a history of very fragile skin and has received care at the Wound Clinic over the last several years. She indicated the facility staff can reach Wound Clinic staff after normal business hours via the local hospital's emergency room or via her cell phone number that the facility should have available.</p> <p>This Federal tag relates to Complaint IN00118263.</p>			

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	3.1-35(g)(2)			

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F0315 SS=D	<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 ensure a resident with an indwelling urinary catheter had physician orders for the care of the urinary catheter and a resident with an indwelling urinary catheter did not have the catheter's tubing and bag lying on the floor for 2 of 3 residents reviewed for indwelling urinary catheters in a sample of 4. (Resident #C and #D)</p> <p>Findings include:</p> <p>1. Resident #C's clinical record was reviewed on 11-7-12 at 1:55 p.m. His diagnoses included but were not limited to BPH (benign prostatic hypertrophy), dementia, coronary artery disease, congestive heart failure, high blood pressure and depression with anxiety.</p> <p>Review of the clinical record indicated on 9-2-12 at 11:00 p.m., a physician's order</p>	F0315	<p>1. On 11/7/12 Resident C received orders to provide foley catheter care q shift and to change foley cath prn for obstruction. On 11/9/12 Resident D foley catheter was placed in a dignity bag and anchored off the floor by the DHS. 2. Clinical records for residents with foley catheters were reviewed by the DHS/designee by 12/8/12 to assure orders for foley catheter care, and change orders. 3. All nursing staff were re-educated by the DHS/designee by 12/8/12 on keeping the foley catheter off the floor and in a dignity bag. Licensed nurses were reeducated on obtaining orders for foley cath care, and changing orders. 4. During morning clinical care meeting all new foley catheter orders will be audited by DHS/designee to assure orders for foley cath care and changing orders. These audits will be on going. Audits will be reviewed monthly during QA meeting to</p>	12/08/2012			

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	<p>was received to obtain a urine specimen for a urinalysis and culture and sensitivity via a straight catheterization (a non-indwelling catheter) after the licensed nurse had notified the physician of the resident's urine being "thick" and the resident having behaviors of yelling out more than usual. The nurse again notified the physician on 9-2-12 at 11:30 p.m., after obtaining the urine specimen to inform the physician of the resident having 1,375 milliliters (ml) of urine obtained during the procedure. The physician then ordered for the resident to have an indwelling urinary catheter placed due to urinary retention. The resident was subsequently treated for a urinary tract infection (UTI) with an antibiotic. On 9-11-12 at 4:15 p.m., the indwelling catheter was discontinued as indicated by the physician. On 9-12-12 at 2:30 a.m., the resident had not been able to urinate and the licensed nurse notified the on-call physician of this. The physician then ordered another straight catheterization in which 400 ml of urine was obtained. The physician was informed of the amount of urine obtained, "[Name of physician] wanted to wait to put a Foley [type of indwelling catheter] in to see if would go on his own [urinate] tonight." On 9-12-12 at 7:00 a.m., the licensed nurse notified the resident's attending physician of no urination up to that time and</p>		<p>assure compliance. These audits will continue to be audited monthly by QA committee until 100% compliance is met x 3 months. 5. Date: 12/8/12</p>		

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	<p>received an order to replace the indwelling catheter and obtained another 400 ml of urine.</p> <p>Review of the written physician's orders for 9-2-12 indicated at 11:00 p.m., an order to "straight cath" the resident for the urine specimen and to initiate antibiotic therapy for 2 days until the results of the urine test was available and at 11:30 p.m. to insert the indwelling urinary catheter. An order on 9-11-12 at 4:10 p.m., indicated to discontinue the urinary catheter. An order on 9-12-12 (untimed) indicated to replace the indwelling urinary catheter. Written physician orders for the indwelling catheter on both dates did not indicate any care or care parameters for the indwelling catheter.</p> <p>Review of the clinical record indicated a nursing care plan for "At risk for urinary tract infections as evidenced by need for: indwelling catheter," dated 9-13-12. It indicated to monitor urine for amount, color, clarity, consistency, odor, blood; provide catheter care every shift and PRN (as needed), and report any abnormality in urine or fever to MD.</p> <p>On 11-7-12 at 12:43 p.m., Resident #C was observed sitting in his wheelchair in his room. The tubing from the indwelling catheter to the drainage bag was observed</p>						

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	<p>to have pale yellow urine without sediment in the tubing. The drainage bag was obscured by a dark blue privacy cover. The urine tubing and drainage bag were not in contact with the floor.</p> <p>In interview with the Corporate Nurse on 11-8-12 at 3:40 p.m., she indicated the resident's clinical record should have contained physician orders to indicate catheter care should be provided each shift and when or why to change the catheter. She indicated on the Treatment Administration Record (TAR) for September 2012 she did find information to provide catheter care each shift, but no parameters for when or why to change the catheter. She indicated she could not find any catheter care information on the October, 2012 or November, 2012 recapitulation orders until a new written physician order was obtained on 11-7-12 for these specific issues.</p> <p>In interview with LPN #1 on 11-9-12 at 9:30 a.m., she indicated, "Typically what I see is that cath[eter] orders should say what size to anchor and have orders for cath care q-shift [each shift] and when or why to replace it, like 'change Foley monthly and prn [as needed for] leakage or obstruction.'"</p> <p>2. Resident D's clinical record was</p>				

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	<p>reviewed on 11-8-12 at 11:46 a.m. Her diagnoses included, but were not limited to Parkinson's disease, history of stroke, dementia, agitation, history of UTI's and chronic urinary tract outlet obstruction with indwelling urinary catheter.</p> <p>Observation of Resident #D on 11-9-12 at 10:33 a.m., indicated she was sitting in a recliner in her room with the indwelling urinary catheter tubing lying on the floor and the drainage bag containing urine was also lying on the floor next to the recliner. When this was brought to the attention of RN#1 at 10:35 a.m., she indicated it was the responsibility of the nursing team to ensure that the urine drainage bags are off of the floor.</p> <p>Review of Resident #D's clinical record indicated she had been treated for UTI's with antibiotics twice in August 2012 and once each in September 2012 and October 2012. She is physician ordered to receive Macrochantin 50 milligrams daily, a 250 milligram capsule of cranberry supplement daily and one tablespoon of UTI-stat daily as prophylaxis for urinary tract related problems.</p> <p>The Corporate Nurse provided a copy of a policy entitled, "Guidelines for Urinary Catheter Care," on 11-9-12 at 9:20 a.m. This document indicated the purpose of</p>				

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	<p>the policy is, "To prevent infection of resident's urinary tract." It indicated, "Determine if changes in daily urinary catheter procedures have been made (e.g., review of care plan, receipt of oral instructions from nurse supervisor, physician orders)...Be sure the catheter tubing and drainage bag are kept off of the floor."</p> <p>3.1-41(a)(2)</p>			