

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155290	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2012
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NAME OF PROVIDER OR SUPPLIER ST ELIZABETH HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 ARMORY RD DELPHI, IN 46923
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F0000	<p>This visit was for the Recertification and State Licensure survey.</p> <p>Survey dates: July 23, 24, 25, and 26, 2012</p> <p>Facility number: 000187 Provider number: 155290 AIM number: 100267300</p> <p>Survey team: Michelle Hosteter RN, TC Michelle Carter RN (July 23, 25, and 26, 2012) Rita Mullen RN</p> <p>Census bed type: SNF: 17 SNF/NF : 41 Total: 58</p> <p>Census by payor source: Medicare : 11 Medicaid : 29 Other : 18 Total : 58</p> <p>Sample: 15</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 7/31/12</p>	F0000	<p>St. Elizabeth Healthcare Center (the Provider) submits this Plan of Correction (POC) in accordance with specific regulatory requirements. The submission of this POC does not indicate an admission by St. Elizabeth Healthcare Center that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of St. Elizabeth Healthcare Center. This POC shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.</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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	Cathy Emswiller RN			

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F0272 SS=A	<p>483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>Based on record review and interview, the facility failed to ensure accurate coding for pressure ulcer on the Minimum Data Set assessment (MDS) for Resident #9. This deficiency affected 1 of 15 Residents reviewed for MDS coding in a sample of 15. (Resident #9)</p>	F0272	1) Minimum Data Set assessment (MDS) modification for Section M was done for Resident #9 at time of survey.2) All residents with skin impairments are at risk for this alleged deficiency. Director of MDS and/or Designee will review all identified residents' MDS assessments, Section M related	08/25/2012

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	<p>Findings include:</p> <p>The clinical record for Resident #9 was reviewed on 7/25/2012 at 1:15 P.M.</p> <p>Diagnoses for Resident #9 included, but were not limited to, dementia with behaviors, neurogenic bladder, high blood pressure, osteoarthritis, seizures, and diabetes mellitus.</p> <p>A Quarterly MDS Assessment, dated 6/22/2012, indicated Resident #9 had a stage II pressure ulcer.</p> <p>Skin assessment sheets, dated 6/20/2012 and 6/21/2012 indicated an unstageable pressure ulcer to the "left bottom heel" was present.</p> <p>During an interview with the Director of Nursing (DON) on 7/25/2012 at 3:45 P.M., she indicated the area appeared as a stage 2 pressure ulcer.</p> <p>3.1-31(b)</p>		<p>to unhealed pressure ulcers, in comparison to skin assessment sheets for accuracy. MDS modifications will be completed as necessary.3) Director of MDS and MDS Coordinator attended "MDS training for Sections M, N, O, P & Q" hosted by the Indiana State Department of Health on 8/7/12. 4) Director of MDS and/or Designee will audit all Section M related to unhealed pressure ulcers for accuracy in comparison to skin assessment sheets prior to submission. Trends will be brought to Quality Assurance (QA) meetings monthly for review by QA Committee x 3 months or until 100% compliance as achieved.</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 clinical record review and interview, the facility failed to ensure that physician's orders were being followed for 1 of 1 resident's reviewed for physician's orders and 1 of 1 residents reviewed for care plans in a sample of 15. [Resident # 50 and Resident #29]</p> <p>Findings include:</p> <p>1. Clinical record review for Resident # 50 was completed on 7/24/12 3:00 P.M. Diagnoses included, but were not limited to, right sided heart failure and high blood pressure.</p> <p>Resident #50 was admitted from the hospital on 7/21/12. Resident #50's discharge instructions dated 7/21/12 indicated, "... continue Torsemide 5 MG Oral Tablet...Take 10 MILLIGRAMS ORAL Daily Next Dose Due: TAKE AS DIRECTED..."</p> <p>The Physician's Recapitulation (a summary of the medications the resident is to take) dated 7/21/12, indicated, "...Torsemide 5mg (and a line crossed</p>	F0282	<p>1) Resident #50 and Resident #29 had no negative outcomes. Physician was notified of Resident #50. Care plan has been updated for Resident #29.2) All residents have potential to be affected by alleged deficiency. Director of Health Services (DHS) and/or Designee will review all residents admitted within the last 30 days to ensure physician orders are being followed. Physician to be notified of any orders not being followed. Director of MDS and/or Designee will review all current residents' Activities of Daily Living care plans and care plans for Potential for alteration in Nutritional and/or Fluid Balance status for accuracy. Care plans will be updated as necessary.3) DHS and/or Designee will in-service licensed staff on process for writing admission orders which includes a second nurse verifying orders. Licensed staff will also be in-serviced on the process for identifying medication errors. Director of MDS and MDS Coordinator will be in-serviced by Home Office MDS Support on completing ADL care plans and care plans for Potential for alteration in</p>	08/25/2012	

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	<p>through it and then a 10 mg written above it) (one tab) PO (by mouth) QD (daily)..."</p> <p>The MAR (Medication Administration Record) indicated by initials marked in a box on 7/22 and 7/23 that the resident received Torsemide 5 mg (one tab) PO (by mouth) QD (daily).</p> <p>The physician's order dated 7/23/12 0220 (2: 20 A.M.) Clarification: Torsemide 10 mg po dly (daily).</p> <p>In an interview with the DHS (Director of Health Services) on 7/25/12 at 3: 50 P.M. she indicated it should have been caught and they will fix it.</p> <p>2. The clinical record of Resident #29 was reviewed on 7/24/12 at 10:00 A.M.</p> <p>Diagnoses included, but were not limited to, high blood pressure, congestive heart failure and depression.</p> <p>A Quarterly Minimum Set assessment, dated 7/6/12, indicated a Brief Interview for Mental Status score of 5 (severe impairment) and required the supervision-oversight, encouragement and cueing, of one person for meals.</p> <p>A Care Plan for Activities of Daily Living, dated 11/11/11 and up dated 2/4/12, 3/9/12, 4/20/12 and 7/13,</p>		<p>Nutritional and/or Fluid Balance accurately.4)DHS and/or Designee will audit new admission charts in daily (Monday - Friday) clinical meeting for accuracy of physician orders. Director of MDS and/or Designee will audit ADL care plans and care plans completed by Registered Dietician for accuracy as they are completed based upon MDS schedule and/or with any significant change. Trends will be brought to QA meetings monthly for review by QA Committee x 3 months or until 100% compliance is achieved.</p>	

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	<p>indicated Resident #29 needed assistance with eating, bed mobility, transfers, walking, dressing, toileting, and bathing.</p> <p>A Care plan, dated and updated 7/17/11, 10/8/11, 12/8/11, 2/4/12, 3/9/12, 4/20/12 and 7/13/12, for Potential for alteration in Nutritional and/or Fluid Balance status related to: a history of unplanned weight loss, difficulty swallowing and inability to feed self. Intervention included, but were not limited to weight resident per physician order, diet per physician order, honor food preferences and vitamin supplements per physician order.</p> <p>A Nursing note, dated 6/27/12 at 3:00 P.M., indicated "Was notified by E.D. (Executive Director) that while making rounds this A.M. answered call light & res had spilled coffee on food tray and blankets. Denied burning self. Checked res skin & [no] redness noted. Did state coffee was not hot...."</p> <p>A Fax, dated 6/27/12 at 3:00 P.M., sent to (name of physician) indicated "Res (Resident) was eating breakfast in bed this A.M. Spilled coffee in bed. Was not burned coffee was not hot. Gave resident an all weather blanket to reflect any hot substance from him while eating in bed...."</p>			

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	<p>A Care Plan, dated 7/2/12, for at risk for burns related to: drinks coffee with breakfast in bed. Interventions: All weather blanket to be worn when drinking hot liquids in bed, assist PRN and monitor for any injuries with hot liquids daily.</p> <p>During an interview with the Director of Nursing, on 7/25/12 at 9:30 A.M., she indicated Resident #29 did not need assistance eating. Only one CNA (Certified Nursing Assistant) had entered information into the system indicating Resident #29 needed assistance with meals.</p> <p>3.1-35(g)(2)</p>				

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F0309 SS=D	<p>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.</p> <p>Based on record review and interview, the facility failed to ensure a thorough skin assessment was completed after a resident spilled coffee and developed blisters. This impacted 1 of 2 residents reviewed for skin assessments after spilling coffee on themselves in a sample of 15. (Resident #57)</p> <p>Findings include:</p> <p>The clinical record of Resident #57 was reviewed on 7/23/12 at 9:30 A.M.</p> <p>Diagnoses included, but were not limited to, diabetes, high blood pressure and peripheral vascular disease.</p> <p>A Significant Change Minimum Data Set assessment, dated 6/8/12, indicated Resident #57 had a BIMS (Brief Interview for Mental Status) score of 15 (no impairment).</p> <p>A Skin Impairment Circumstance Investigation, dated 5/16/12, indicated</p>	F0309	<p>1) Resident #57's skin impairment has healed.2) All residents with skin impairments are at risk by this alleged deficiency. All residents with current skin impairments will be reviewed by Director of Health Services (DHS) and/or Designee for thorough and timely skin assessment. Updates will be made as necessary.3) DHS and/or Designee will in-service licensed staff on timely and thorough documentation related to skin assessments. Wound care nurse and/or Designee to review any new skin assessments for timeliness and thoroughness. DHS and/or Designee to review new skin impairment assessments in daily (Monday-Friday_ clinical meetings for timeliness and proper documentation.4) DHS and/or Designee will audit any new skin impairments for timeliness and proper documentation as they are identified. Trends will be brought to QA meetings monthly for review by QA Committee x 3 months or until 100% compliance</p>	08/25/2012			

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	<p>Resident #57 had burns on the buttocks and was being treated with Silvadene Cream. The form also indicated the Resident needed to sit up in bed when eating and drinking.</p> <p>An "Other Skin Impairment Assessment" form, dated 5/16/12, indicated burns on the left and right buttocks and on the back of the right thigh. The areas were red and were to be treated with Silvadene Cream TID (three times a day). The red areas measured as follows:</p> <p>Left buttocks: 15 cm. (centimeters) X 12 cm.</p> <p>Right buttocks: 18 cm. X 13 cm.</p> <p>Back of right thigh: 21 cm. X 17 cm.</p> <p>A Change in Condition Form, dated 5/16/12 at 9:30 P.M., indicated "Res (Resident) spilled hot coffee on self. Superficial skin layer peeling from buttocks. Called (name of physician) ordered Silvadene Cream TID x 2 wks." There was no assessment of the area on the buttocks where the skin had peeled off.</p> <p>An "Other Skin Impairment Assessment" forms, dated 5/17/12 (no time indicated) , indicated day 1: "Wound care nurse- no</p>		is achieved.		

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	<p>changes to Tx (treatment)." No new measurements were done on the burn areas.</p> <p>A Nursing note, dated 5/17/12 at 11:30 P.M., indicated "...Writer assessed area - still pink/red -[with] intact blisters...."</p> <p>There was no assessment of the areas that had blistered.</p> <p>An "Other Skin Impairment Assessment" forms, dated 5/18/12 (no time indicated) , indicated "See copy of documentation."</p> <p>There was no change in treatment. The Documentation indicated the following:</p> <p>Left buttock: 12 cm X 9 cm. X < (less than) 0.1 cm. with serous drainage.</p> <p>Right buttock: 17 cm X 15 cm X < 0.1 cm. with serous drainage.</p> <p>Right posterior thigh: 5 cm X .5 cm intact blister.</p> <p>Right posterior thigh: 7 cm X 2.5 cm intact blister.</p> <p>Right posterior thigh: 9 cm X 8.5 cm intact blister.</p> <p>Right upper buttock: 2 cm X 3 cm X < 0.1 cm open area.</p>			

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	<p>Left inner buttock/sacral area: 2 cm X 1 cm fluid filled blister.</p> <p>During an interview with the Director of Nursing, on 7/24/12 at 8:50 A.M., she indicated the burn area was evaluated and the physician was called. An "Other Skin Impairment Assessment" form was started and the Wound Nurse saw him on 5/17/12. There was no other assessment found regarding the blisters until 5/18/12.</p> <p>3.1-37(a)</p>				

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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 record review and interviews, the facility failed to follow up with the physician for a change in treatment order for an Urinary Tract Infection (UTI) resulting in a delay in the proper treatment for a urinary tract infection (UTI) for Resident #9. This delay in treatment affected 1 out of 15 residents reviewed for UTI's in a sample of 15. (Resident #9)</p> <p>Findings include:</p> <p>The clinical record for Resident #9 was reviewed on 7/25/2012 at 1:15 P.M.</p> <p>Diagnoses for Resident #9 included, but were not limited to, dementia with behaviors, neurogenic bladder, high blood pressure, osteoarthritis, seizures, and diabetes mellitus.</p> <p>A Change of Condition form, dated 4/13/12, and</p>	F0315	<p>1) Urinary Tract Infection (UTI) for Resident #9 has resolved with no negative outcomes.2) All residents with signs and symptoms for UTI will be identified. (Director of Health Services) DHS and/or Designee will review charts for physician notification for those who are identified. Physician will be notified as necessary.3)DHS and/or Designee will in-service licensed staff on physician notification policy and Urinary Analysis and Culture and Sensitivity (UA/C&S) tracking and follow up. 4) DHS and/or Designee will audit UA/C&S orders for timely treatment and physician notification. Trends will be brought to QA meetings monthly for review by QA Committee x 3 months or until 100% compliance is achieved.</p>	08/25/2012	

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	<p>faxed to the physician, on 4/13/2012, indicated Resident #9 had behavior changes and "intense pain when urinating".</p> <p>A physician order, dated 4/13/2012, indicated Cipro (antibiotic) 500 mg (milligrams) BID (twice a day) and an urinalysis with culture and sensitivity.</p> <p>A Lab report, dated 4/17/2012, indicated the organism was Escherichia coli and was resistive to Cipro. The lab results were faxed to the physician on 4/17/12. The Resident continued to receive the Cipro 500 mg.</p> <p>A physician's order, dated 4/22/12, indicated discontinue Cipro 500 mg and start Macrobid (an antibiotic) 100 mg BID for 10 days for UTI. This was a five day delay in treatment for Resident#9"s UTI.</p> <p>During an interview with the Director of Nursing (DON) on 7/26/12 at 11:55 A.M. she indicated nursing staff did not follow up with the physician regarding lab results for Resident #9.</p> <p>3.1-41(a)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155290	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/26/2012
NAME OF PROVIDER OR SUPPLIER ST ELIZABETH HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 ARMORY RD DELPHI, IN 46923		
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F0465 SS=F	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure return air intakes in the dining room were free of dust. This had the potential to affect 58 out of 58 residents that eat in the dining room.</p> <p>The facility also failed to keep residents doors and door frames to rooms and bathrooms free of chipped wood, scratches and worn paint. This affected 18 out of 39 rooms in which residents resided.</p> <p>Findings include:</p> <p>The environmental tour was completed on 7/25/12 at 1:05 P.M. with the Plant Operations Supervisor and the Environmental Supervisor.</p> <p>During the environmental tour from 1:05 to 1:25 P.M., it was noted that several of the doors to the resident rooms, the door frame, and the bathroom doors and door frame were marred. The paint was also worn off of the doors and door frame.</p> <p>In an interview with the Plant Operations Supervisor on 7/24/12 at 1:30 P.M. he indicated he has been working on some of the rooms to sand the doors and frames</p>	F0465	<p>1) The air intakes in the dining room were cleaned at the time of survey. The doors and door frames had been identified and a painting schedule was in place prior to the survey.2)All residents are at risk for this alleged deficiency. An audit will be done of all residents' doors and door frames in the facility for chipped wood, scratches and worn paint. Repairs will be made as necessary.The air intakes in the dining room are the only ones in the building and have been cleaned.3) Air intakes will be put on a weekly schedule for Environmental Services staff to clean and will be documented in their Environmental Manual. Director of Plant Operations (DPO) will develop a monthly schedule of preventative maintenance for the residents' doors and door frames. DPO will provide touch up painting to residents' doors and door frames weekly or as needed.4) Director of Environmental Services and/or Designee will audit residents' doors and door frames weekly. Trends will be brought to Quality Assurance (QA) Meetings monthly for review by QA Committee x 3 months or until 100% compliance is achieved.</p>	08/25/2012	

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	<p>down and paint them.</p> <p>The following rooms had scratches, marring, chipped wood or worn paint on them:</p> <p>303: Door frame had scratches on the bottom on both sides.</p> <p>306: Bathroom door and frame nicked and scratched.</p> <p>400: Door to room marred at bottom and several places where paint worn off.</p> <p>403: Door frame had several scratches on bottom right side.</p> <p>404: The right and left side of the bottom of the door frame to the room had scratches and paint worn off.</p> <p>406: The right and left side of the bottom of the door frame to the room had scratches and paint worn off.</p> <p>408: The door to the room had several small scratches.</p> <p>500: The door to the room had several small scratches.</p> <p>501: The left and right door frame to the room and the bathroom door had kicks and scratches.</p> <p>502: A large chunk of wood was missing from the middle of the door frame on the left side.</p> <p>503: There were small scratches on both sides of the door frame.</p> <p>506: The door to the room had small amount of scratching and paint worn off.</p> <p>510: The left side of door frame to room</p>				

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	<p>had marring and the bathroom door frame on left side had kicks.</p> <p>512: The bathroom door the middle of the door had marring and the paint was worn off.</p> <p>514: The bottom left side of the door frame to room and the bathroom door in the middle and the bottom of door frame had marring and worn off paint.</p> <p>516: The bathroom door was scratched and paint worn off and the bathroom door frame on both sides were scratched.</p> <p>518: The bathroom door frame on the left side was scratched.</p> <p>520: There were scratches on the door frame and paint worn off.</p> <p>On 7/24/12 at 3:30 P.M. the dining room had two return air intakes that were visibly dusty. The air intakes were near the steamtable where food is served to residents who eat in the dining room.</p> <p>In an interview with the Environmental Supervisor at this time, she indicated she believed they were cleaned weekly and after running her finger along the vent stated it was dirty. A request was made at this time for a cleaning schedule.</p> <p>In an interview with the Executive Director 7/25/12 at 3:00 P.M., she indicated they did not have any documentation that indicated when the</p>						

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	return air ducts were cleaned last. She further indicated they do not have any tracking for when they are cleaned. 3.1-19(f)				