

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676462	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2024
NAME OF PROVIDER OR SUPPLIER St. Anthony's Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7501 Bagby Ave. Waco, TX 76712	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700</p> <p>Based on interview and record review, the facility failed to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections to the extent possible for one (Resident #1) of five residents reviewed for quality of care.</p> <p>The facility failed to carry out physician orders for a urinalysis for Resident #1 to diagnose a possible urinary tract infection.</p> <p>This failure could place residents with possible urinary tract infections at risk of sepsis, renal failure, and pain.</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet dated 5/7/2024, reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included Cerebral infarction (Stroke), Dementia, Heart Failure, Retention of Urine, Hypertension (high blood pressure), cognitive communication deficit, and Mood disorder.</p> <p>Review of Resident #1's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 3, suggesting severe cognitive impairment. Review of Section H (Bladder and Bowel) reflected Resident #1 was always incontinent.</p> <p>Review of Resident #1's care plan dated 4/26/2024 reflected the following problem: Resident has episodes of incontinence due to cognitive and physical impairments. At risk of complications related to incontinence with the intervention of observe for/document for signs/symptoms of UTI .notify MD and RP of abnormal findings</p> <p>Review of Resident #1's orders dated 4/18/2024 reflected and order for UA with C&S. Obtain specimen via in and out cath</p> <p>Review of Resident #1's progress notes dated 4/15/2024 at 1:36 PM by LVN A, reflected received order from hospice for UA with C&S via in and out catheter.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/7/2024 at 9:47 am, the FM stated Resident #1 stated he was having back pain and feeling bad and often these would be signs and symptoms of an UTI. She stated the hospice nurse was in the facility on 4/15/2024 and stated she would order a UA and communicated this to the nurse on duty, LVN A. She stated she was at the facility every day and never saw anyone collect the urine for the UA. On 4/18/2024, the hospice nurse case manager checked, and the UA specimen had still not been collected. She said no one from the facility had communicated with her regarding what was going on with the specimen collection.</p> <p>During an interview on 5/7/2024 at 2:22 PM, the hospice nurse case manager (NCM) revealed she ordered the UA with the hospice Physician's approval on 4/15/2024, and by 4/18/2024, the UA was still not been collected. She stated there was a delay in getting the UA from the facility, but she had not received any communication from the facility about any issues with collecting the specimen. She stated her expectation is that the specimen would be collected within 24 hours depending on how difficult it is and expected the facility to communicate if they had issues collecting the specimen. She stated she was in the facility assessing Resident #1 on 4/18/2024 and the specimen has still not been collected, so she discontinued the order.</p> <p>During an interview on 5/7/2024 at 2:24 PM, LVN A revealed he had been working on 4/15/2024 and had received the order to collect the UA from Resident #1 from hospice as they suspected Resident #1 had an UTI. He stated night shift nurses usually collected the UA's. So he had not made any attempt to get the urine specimen from Resident #1, he just passed it on in report to night shift. He stated when he received physician orders it was his responsibility to follow up and ensure the order was carried out - except if it is a UA. He stated for UA's it is the night shift's nurses responsibility and that's the way it's always been.</p> <p>During an interview on 5/7/2024 at 2:39 PM, the ADON stated if there is a Dr's order, the nurse that receives the order is responsible for carrying it out. She stated there was no facility policy that the night nurse always collects urine specimens for UA. She stated LVN A should have attempted to collect the specimen on his shift. ADON stated it was not acceptable that he did not attempt to follow the order and get the specimen. She stated urine specimens were collected to rule out UTI's in residents and get them treated. She stated a delay in getting a specimen could cause residents to get very sick with infection.</p> <p>During an interview on 5/7/2024 at 2:48 PM, the DON stated the nurse that received the order is responsible for making sure it is completed. She stated if a resident had an order for a UA, this could help determine if they have an infection or not. She further stated depending on the level and particular bacteria that was growing, a resident could become more ill and more symptomatic and need to be sent out for higher level of care. She stated her expectation is that the nurse should have completed the lab slip, attempted to collect the UA and then put the specimen in the refrigerator for the lab to collect in the morning. She stated if the nurse was not able to collect the specimen, they should have put in a progress note and passed the information onto the next shift. She stated there should have been documentation in the progress notes and there was not, concerning Resident #1's specimen collection. The DON stated they have an order path they follow and provided a chart Order Path Flow Chart that outlined the order process.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/7/2024 at 2:48 PM, The AD stated her expectation was that physician orders would be followed and if staff was not able to do that, they would have communicated with the DON or ADON's. She stated to her knowledge there has not been any other issues getting urine specimens collected form any other residents. She stated it is important to get specimens when ordered so the facility would know if a resident has an infection or not and start the appropriate treatment.</p> <p>During an interview on 5/8/2024 at 2:53 PM, the Hospice Physician (HP) stated he was informed the UA had never been collected and was not particularly thrilled that the order wasn't followed. He stated it was not okay if orders were not followed but a facility needs to communicate if they are having problems collecting the urine specimen so a reasonable solution can be achieved. He stated when a urine specimen collection was delayed it could delay treatment to the resident which could cause a resident to further decompensate; the infection could get worse. He further stated the C&S was very important because it told them what the organism was that was causing the infection and he wanted to know as soon as possible so he could treat the infection with the correct antibiotic. He also clarified that the Nurse Case Managers issued orders working under his directive.</p> <p>A facility policy on Physician orders related to collection of lab specimens was requested but the AD stated they did not have a policy.</p> <p>Review of undated facility Order Path Flow Chart reflected the nurse receives the order, the nurse put the order in the EMR, then the order went to the ADON for review. The ADON initials the order and sends it to the MDS nurse to update the care plan as needed.</p>		