

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/19/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410
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F000000	<p>This visit was for the Investigation of Complaints IN00122314, IN00122869, and IN00124994.</p> <p>Complaint IN00122314-Substantiated. Federal/state deficiencies related to the allegations are cited at F282 and F441.</p> <p>Complaint IN00122869-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00124994-Substantiated. Federal/state deficiency related to the allegation is cited at F284.</p> <p>Survey dates: March 17, 18, & 19, 2013</p> <p>Facility number: 000253 Provider number: 155362 AIM number: 100266660</p> <p>Survey team: Janet Adams, RN, TC</p> <p>Census bed type: SNF/NF: 136 Total: 136</p>	F000000	<p>F 282</p> <p>It is the practice of this facility to ensure that services provided or arranged by the facility are provided by qualified persons in accordance with each resident's written plan of care.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <ul style="list-style-type: none"> Resident D's order for care to his PEG tube site was corrected on 1-2-13. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <ul style="list-style-type: none"> All resident's with PEG tubes, have had their physicians orders and plans of care reviewed and all orders for care of PEG tube sites are in place and showing in MAR/TAR accurately and being documented as ordered. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> Nursing staff have been in-serviced on documentation of care of PEG tube sites. Inputting of orders into EMR has been reviewed with nursing staff to ensure that 	
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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>Census payor type: Medicare: 18 Medicaid: 97 Other: 21 Total: 136</p> <p>Sample: 10</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 22, 2013, by Janelyn Kulik, RN.</p>		<p>orders flow to the correct MAR/TAR for documentation.</p> <ul style="list-style-type: none"> All new resident's or resident's who may obtain a new PEG tube will have their MAR/TAR audited by nursing management with in 24 hours to ensure that all orders related to PEG tube are input correctly and being documented on by nursing staff. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <ul style="list-style-type: none"> All resident's with PEG tubes will have their physician's orders and MAR/TAR along with plans of care audited monthly to ensure that all orders are in place and are showing correctly on the MAR /TAR. This will be an ongoing audit monthly completed by a member of the nursing management. Review of the monthly PEG tubes documentation audit will be presented to the Monthly QAPI committee x 6 months and then presented quarterly thereafter. The DNS and ED will oversee this process. <p>By what date the systemic changes will be completed?</p> <ul style="list-style-type: none"> April 11, 2013 		

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F000282 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 observation, record review, and interview, the facility failed to ensure Physician orders and plan of care were followed related to completing treatments to gastrostomy tube insertion sights for 1 of 3 residents reviewed with gastrostomy tubes in the sample of 10. (Resident #D)</p> <p>Findings include:</p> <p>During Orientation Tour on 3/17/13 at 10:10 a.m., Resident #D was observed in bed. The resident had a gastrostomy tube in place in his abdomen. There was a clear dressing placed over the skin adjacent to the gastrostomy insertion site.</p> <p>The record for Resident #D was reviewed on 3/17/2013 at 1:30 p.m. The resident's diagnoses included, but were not limited to, epilepsy, dizziness, cerebrovascular disease, and obstructive chronic bronchitis. The resident was sent to the hospital on 1/4/13 and was readmitted to the</p>	F000282	<p>F 282</p> <p>It is the practice of this facility to ensure that services provided or arranged by the facility are provided by qualified persons in accordance with each resident's written plan of care.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <ul style="list-style-type: none"> · Resident D's order for care to his PEG tube site was corrected on 1-2-13. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <ul style="list-style-type: none"> · All resident's with PEG tubes, have had their physicians orders and plans of care reviewed and all orders for care of PEG tube sites are in place and showing in MAR/TAR accurately and being documented as ordered. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> · Nursing staff have been 	04/11/2013			

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	<p>facility on 1/16/13.</p> <p>A care plan initiated on 9/20/12 indicated the resident was at risk for complications related to having a feeding tube. Care plan interventions included for staff to cleanse the site as ordered.</p> <p>Review of the 8/2012 Treatment Record indicated there was a Physician's order written on 8/9/12 to cleanse the PEG (percutaneous endoscopic gastrostomy) tube site with normal saline, pat dry, and apply a drain sponge daily. The treatment was signed out 8/9/12 thru 8/31/12. The 9/2012 thru 12/2012 Treatment Records were not provided.</p> <p>Review of the 1/2013 Physician orders indicated an order was written on 1/2/13 to cleanse the PEG tube site with normal saline, pat dry, and apply a split gauze every shift.</p> <p>Review of the 1/2013 Nursing Progress Notes indicated an entry was made on 1/2/13 at 2:22 p.m. This entry indicated red hardness was observed around the PEG tube site with bloody brown drainage. The entry also indicated tube placement was verified and change of shift Nurse was to notify the Physician. An</p>		<p><i>in-serviced on documentation of care of PEG tube sites.</i></p> <ul style="list-style-type: none"> · <i>Inputting of orders into EMR has been reviewed with nursing staff to ensure that orders flow to the correct MAR/TAR for documentation.</i> · <i>All new resident's or resident's who may obtain a new PEG tube will have their MAR/TAR audited by nursing management with in 24 hours to ensure that all orders related to PEG tube are input correctly and being documented on by nursing staff.</i> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <ul style="list-style-type: none"> · <i>All resident's with PEG tubes will have their physician's orders and MAR/TAR along with plans of care audited monthly to ensure that all orders are in place and are showing correctly on the MAR /TAR. This will be an ongoing audit monthly completed by a member of the nursing management.</i> · <i>Review of the monthly PEG tubes documentation audit will be presented to the Monthly QAPI committee x 6 months and then presented quarterly thereafter.</i> · <i>The DNS and ED will oversee this process.</i> 		

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	<p>entry made on 1/2/13 at 6:33 p.m., indicated the Physician was notified and orders were received for Keflex (an antibiotic) 500 milligrams three times a day for 10 days.</p> <p>When interviewed on 3/18/13 at 1:05 p.m., the Director of Nursing indicated the order for the above daily treatment to the PEG tube did not appear in a column on the resident's Treatment Records for the months of 9/12 thru the end of 12/31/12. The Director of Nursing indicated the ordered treatment was not signed out as completed during the above times as the treatment was not listed on the Treatment Record to be signed out. The Director of Nursing indicated the resident was hospitalized in 9/2012 and returned to the facility with the same treatment order as 8/2012.</p> <p>This federal tag relates to Complaint IN00122314.</p> <p>3.1-35(g)(2)</p>		<p>By what date the systemic changes will be completed? April 11, 2013</p>	

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F000284 SS=D	<p>483.20(I)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.</p> <p>Based on record review and interview, the facility failed to ensure the resident's post discharge plan of care included specific instructions related to medications and oxygen use upon home discharge for 2 of 3 closed records review for discharges in the sample of 10. (Residents #G and #J)</p> <p>Findings include:</p> <p>1. The closed record for Resident #G was reviewed on 3/17/13 at 12:50 p.m. The resident's diagnoses included, but were not limited to, anxiety state, chronic kidney disease, diabetes mellitus, insomnia, arthritis, and chronic obstructive asthma. The resident was admitted to the facility from the hospital. The resident was discharged from the facility on 1/31/13. The resident was discharged to home.</p> <p>Review of the January 2013 Medication records indicated there</p>	F000284	<p>F 284 It is the practice of this facility to ensure that when the facility anticipates discharge, a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <ul style="list-style-type: none"> · Resident # G was discharged home with instructions on 1-31-13 and no further action can be taken at this time. · Resident' # J was discharged home with instructions on 3-8-13 and no further action can be taken at this time. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective</p>	04/11/2013			

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	<p>were Physician orders for the resident to receive Humulin R (regular) insulin injections twice a day at 6:00 a.m. and 4:00 p.m. on Mondays and Wednesdays. The order indicated the insulin dosage was to be based on the results of the resident's blood glucose monitoring as follows:</p> <p>151-200 = 3 units 201-250 = 6 units 251-300 = 9 units 301-350 = 12 units 351-400 = 15 units 401 and above = 20 units and notify the Physician.</p> <p>There was also an order for the resident to receive Pulmicort (a medication for asthma or respiratory disorders) 0.5 milligrams/2 milliliters) by nebulizer, treatments twice a day. Another Physician order noted the resident was to receive Morphine Sulfate (a narcotic pain medication) 50 milligrams orally three times a day at 9:00 a.m., 1:00 p.m., and 5:00 p.m. Another Physician order indicated the resident was to receive Xanax (an medication for anxiety) 0.5 milligrams twice a day at 9:00 a.m. and 5:00 p.m.</p> <p>A "Discharge Summary for Anticipated Discharges" was reviewed. The top section on the</p>		<p>action(s) will be taken.</p> <ul style="list-style-type: none"> · Residents who have been discharged home prior to 3-19-13 no further action can be taken. · Any resident who is discharged home in the future will have documented teaching/instructions and discharge planning completed along with family and resident's signatures of receiving teaching/instruction and discharge planning at time of discharge. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> · A standard of practice has been implemented related to the discharge forms used when a resident is discharged home. · Members of the Interdisciplinary Team have been in-serviced on forms to be used and documentation to be completed for all residents who are anticipating discharge to home. · Nursing staff of been in-serviced on appropriate forms and documentation used for education/instructions and completion of forms at time of discharge. · Any resident who is anticipating discharge to home will be reviewed by IDT prior to 		

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	<p>summary included the resident's name, address, Physician's name and phone number and was dated 1/29/13. The lower section on the summary form titled Medications/Treatments included several lines of medications. One entry under this column listed "Humulin R sliding scale 2 x day." The "Administration Times" were listed as "6, 4" and "Next Dose Due" was listed as "mon & wed" (SIC). Another medication listed on the summary was Morphine Sulfate 50 milligrams. The "Administration Times" were listed at "9, 1, 5" and the "Next Dose Due" was listed as "5 p".</p> <p>The "Medications/ Treatments" section also indicated there was a section next to the each medication to list the "Amount Sent." A total of 26 medications were listed on the form and only 9 of the 26 medications listed had the amount sent listed on the discharge summary form.</p> <p>There was also a section of the summary title "Nursing Instructions". The only documentation under this sections was "continue current meds." There was no documentation related to specific use of the nebulizer treatments, blood glucose monitoring, or insulin injections.</p>		<p><i>time of discharge to ensure that all appropriate education/instruction has been completed.</i></p> <ul style="list-style-type: none"> · <i>SS will initiate the discharge planning process and paper work and a member of nursing management will review and ensure that education has been completed and documented prior to discharge.</i> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <ul style="list-style-type: none"> · <i>The medical record for all discharged to home resident's will be reviewed/audited monthly by the medical record supervisor. A summary of this audit will be presented to the QAPI monthly committee meeting.</i> · <i>The medical record audit will be presented to QAPI monthly as an ongoing process.</i> · <i>The ED and the DNS will oversee this process.</i> <p>By what date the systemic changes will be completed?</p> <ul style="list-style-type: none"> · <i>April 11, 2013</i> 				

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	<p>Review of the 1/2013 Nursing Progress Notes indicated an entry was made on 1/31/13 at 1:04 p.m. This entry indicated the resident's daughter and son were present to pick up the resident to take her home. The entry indicated all the resident's personal effects and all medications including pain medications were given to the resident. The entry also indicated the resident was also given a new prescription to be filled for home use. There was no documentation of verification the resident was instructed in blood sugar monitoring testing and sliding scale insulin dosages.</p> <p>When interviewed on 3/18/13 at 10:00 a.m., the Director of Nursing indicated the facility had no policy addressing the protocol for sending medication home with residents upon discharge from the facility. The Director of Nursing indicated their standard protocol is if the resident is Medicare payor source they are sent home with a (3) day supply of medications and if the resident is on Medicaid all of there medications are sent home with the resident upon discharge. The Director of Nursing indicated there is no other policy specific to the discharge of a resident.</p>			
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	<p>The Direct of Nursing indicated staff can either use the hand written Discharge Form or the electronic form.</p> <p>When interviewed on 3/19/13 at 1:10 p.m., the Director of Nursing indicated she spoke with the Nurse who discharged the resident and was informed the resident was sent home with a prescription for pain medication.</p> <p>2. The closed record for Resident #J was reviewed on 3/18/13 at 11:30 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, peptic ulcer disease, cardiac pacemaker, and dementia. The resident was admitted to the facility on 2/7/13 and discharged home on 3/8/13.</p> <p>Review of the 3/2103 Progress Notes indicated there were no progress notes completed on 3/8/13. There was no documentation of the resident's discharge from the facility or of discharge instructions being given in the Nursing Progress Notes. An entry was made on 3/7/13 at 1:57 p.m. This entry was made by Social Services. This entry indicated a home health agency was contacted for the resident's home care and</p>						

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	<p>information was faxed to another company for home oxygen. A Progress Note was made by Social Service staff #1 on 3/11/13 at 9:44 a.m. This note indicated the resident's room was checked and staff observed an oxygen tank that had been sent to the facility left in the resident's room.</p> <p>A "Discharge Summary For Anticipated Discharges" was completed on 3/8/13 at 7:30 p.m. There were sections on the above discharge summary form to note the resident's functional, nutritional, psychosocial, cognitive status and sections to note the resident's dental condition, skin condition, and sensory/physical impairments at the time of discharge. There was no documentation in any of the above sections. A section for special treatments/procedures was also not completed. A total of (12) medications were listed under the "Medications/Treatments" section on the summary form. The sections listed next to each medication for "Administration Times" and "Next Dose Due" were all blank. One of the medications on the list was Lasix (a water pill) 40 milligrams to be give once a day every three days. There was no documentation related to the</p>			

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	<p>use of oxygen.</p> <p>The bottom of the form was signed by an LPN. There was a signature under the section titled "Receiving Party's Signature" and next to the signature the section titled "Relationship" was listed the name of an ambulance service.</p> <p>A Physician's order was written on 3/7/13 for the resident to have oxygen 2 liter per nasal cannula continuous in the home. Another order was written on 3/7/13 for a Home Health CNA and a Nurse.</p> <p>When interviewed on 3/19/13 at 12:30 p.m., Social Worker #1 indicated the resident was discharged home to live with her son. The Social Worker #1 indicated the son had informed her he had the needed equipment at home except for the oxygen. The Social Worker indicated she called the oxygen company and they brought the needed oxygen tanks to the facility prior to the resident being discharged. The Social Worker indicated the resident was transported home by ambulance in the evening. The Social Worker indicated the resident had portable oxygen on then the ambulance provided oxygen for the transport.</p>						

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	<p>The Social Worker indicated she had made home health arrangements for the resident and the unusual protocol is the home health staff was required to be out to see the resident at home in 24-48 hours.</p> <p>When interviewed on 3/19/13 at 1:10 p.m., the Director of Nursing indicated staff should have documented the resident's assessment and discharge.</p> <p>This federal tag relates to Complaint IN00124994.</p> <p>3.1-36(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/19/2013	
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F000441 SS=D	<p>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.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to</p>	F000441	F441 It is the practice of this facility to	04/11/2013			

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	<p>ensure the results of positive cultures obtained during hospitalizations were tracked on their Infection Control Logs for 1 of 3 residents reviewed for gastrostomy tubes in the sample of 10. (Resident #D)</p> <p>During Orientation Tour on 3/17/13 at 10:10 a.m., Resident #D was observed in bed. The resident had a gastrostomy tube in place in his abdomen. There was a clear dressing placed over the skin to the left skin of the gastrostomy insertion site.</p> <p>The record for Resident #D was reviewed on 3/17/2013 at 1:30 p.m. The resident's diagnoses included, but were not limited to, epilepsy, dizziness, cerebrovascular disease, and obstructive chronic bronchitis. The resident was sent to the hospital on 1/4/13 and was readmitted to the facility on 1/16/13.</p> <p>Review of a 1/15/13 hospital Physician note indicated the resident had a gastrostomy tube in place with an infection. The note indicated the infections was Methicillin-sensitive Staphylococcus aureus (a type of infection) and streptococcus (a type of infection). The Physician plan</p>		<p>ensure that the facility has established and maintained 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.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <ul style="list-style-type: none"> · Resident D's culture results from hospitalization in January 2013 where reviewed by IDT team. No further action can be taken at this time. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <ul style="list-style-type: none"> · No further action can be taken for past infection control logs. · Infection control logs for the month of March include all resident's culture results including those obtained in the facility and the results of those which were obtained in the hospital. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> · The Infection Control Nurse for the facility has been 				

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	<p>included treatment with IV (intravenous) antibiotics and then to switch to oral antibiotics.</p> <p>The 1/2013 Progress Notes were reviewed. An entry made by Nursing on 1/16/13 at 8:39 p.m., indicated the resident returned to the facility from the hospital at 5:40 p.m. The entry also indicated the resident had a PICC (peripherally inserted central catheter) line in place. A Nursing entry made on 1/17/13 at 10:56 p.m. indicated the resident's gastrostomy tube area dressing was changed and no drainage was noted and the surrounding area was light pink.</p> <p>Review of the facility antibiotic "Physician's Order Listing" indicated the resident was to receive Dicloxacillin sodium (an antibiotic) 500 milligrams. Review of the Infection control documents indicated an Infection Surveillance Data Collection Form was completed for Resident #D on 1/16/13. The form indicated the resident was to receive Dicloxacillin starting on 1/16/13 for a gastrostomy tube infection. The sections on the form for culture, culture type, culture date, and culture results were all blank.</p> <p>The facility policy titled "Elements of</p>		<p>educated on completion of the Infection Control log to include all culture results including those obtained from the hospital prior to resident's admission to facility if resident is admitted with an infection and is being treated at that time.</p> <ul style="list-style-type: none"> The monthly infection control log will include tracking of all culture results with the organism found in the culture for each resident who is being treated for an infection. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <ul style="list-style-type: none"> The summary of the Infection Control log will be reviewed with the QAPI committee each month. This review will include a summary of positive cultures and organisms including those for resident's who obtained cultures prior to admission to the facility. Review of Infection Control Log and summary will be an ongoing monthly process. The ED and DNS will overview this process. <p>By what date the systemic changes will be completed?</p>		

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	<p>an Infection Control Program Guideline" was received from the Director of Nursing on 3/18/13 at 1:50 p.m. There was no date on the policy. The Director of Nursing indicated the policy was current. The policy indicated the program was to include surveillance, monitoring , and data analysis.</p> <p>When interviewed on 3/18/13 at 2:40 p.m., the Director of Nursing indicated the resident returned from the hospital on 1/16/13 after being treated for an infection at the gastrostomy tube area. The Director of Nursing indicated the Infection Control Nurse had not been tracking the results of cultures obtained while the residents were in the hospital.</p> <p>This federal tag related to Complaint IN00122314.</p> <p>3.1-18(b)(1)</p>		<p>April 11, 2013</p>		