STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155535		03/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CROSSING HEALTH & REHABILITATION CENTER	3550 CENTRAL AVE COLUMBUS, IN 47203

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00169820. Complaint IN00169820 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309, F315, F328, and F441. Survey dates: March 30 and March 31, 2015. Facility number: 000572 Provider number: 155535 AIM number: 100267710 Survey team: Tammy Forthofer, RN-TC Julie Dover, RN Census bed type: SNF/NF: 59 Total: 59 Census payor type: Medicare: 7 Medicaid: 43 Other: 9 Total: 59 Sample: 5	F 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.			
F 0309 SS=G Bldg. 00	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. Based on observation, record review and interview, the facility failed to ensure the necessary treatment and services were provided related to pain assessment and pain control, resulting in the resident yelling out in pain during treatment. This deficient practice affected 1 of 5 residents reviewed for pain control. (Resident # D) Findings include: On 3/30/2015 at 9:20 A.M., Resident # D was observed yelling out in pain during a dressing change and treatment of a coccyx pressure wound. The resident asked the Registered Nurse (RN) # 1 why the treatment had to hurt so much. RN #	F 0309	F309 Requires the facility to ensure the necessary treatment and services were provided related to pain assessment and pain control.1. Resident D had a pain assessment completed. New order was obtained from the primary physician to administer pain medication 30 minutes prior to dressing change. Resident's hydrocodone was obtained and administered per physician's order. 2. All residents have the potential to be affected. Pain assessments were completed on all residents. All complete assessment of resident's pain medications were completed and all medications were present. No concerns were noted. See below	04/10/2015

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	1 advised the resident that the pain medication (Tramadol) did not have enough time to take effect and indicated the resident should start to feel better soon. During an interview, on 3/30/2015 at 9:34 A.M., RN # 1 indicated she knew the resident's pain medication (Tramadol) was not strong enough to control the resident's pain. She indicated the resident had an order for hydrocodone / acetaminophen and the facility was unable to obtain the medication since 2/21/2015. RN # 1 was not able to explain why the medication was not available for the past month for Resident # D. She indicated no pain scale assessment sheets were completed for the resident. Resident # D's clinical record was reviewed on 3/30/2015 at 9:50 A.M. A physician's order, dated 12/01/2014, indicated the resident was to receive hydrocodone / acetaminophen 5-325 milligrams (mg) as needed every 4 hours for pain. Medication Administration Record (MAR) indicated the resident had received hydrocodone / acetaminophen 5-325 (mg) on 24 occasions in January, 4 occasions in February, and 0 occasions in March.		for corrective measures.3. The pain medication policy and procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the above procedure as well as educated on the need for staff to assess for pain while providing care and if the resident verbalizes pain or if pain is witness to immediately provide pain medication per physician's order. the staff was also inserviced on the need to ensure all pain medications are present in the facility for administration.4. The DON or her designee will complete a minimum of three pain assessments as well as review all prn pain flowsheets to ensure resident's pain is being controlled daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) If a resident has noted pain, that is not controlled, the primary physician will be notified immediately for a new order. The DON or her designee will also complete audits to ensure all pain medications are present in the facility for administration daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B). The audits will be	

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	The Quarterly Minimum Data Set (MDS) assessment, dated 2/17/2015, indicated the resident was not cognitively intact with a Brief Interview for Mental status (BIMS) score of 06. The care plan for pain, dated 3/03/2015, indicated Resident # D had a goal of pain to be less than 3 on a scale from 0 to 10. The interventions were to monitor for signs of pain, such as facial grimacing, moaning, and restlessness. Pain medications were to be administered as ordered and monitored for efficacy. No pain scale assessment sheets were located for Resident # D. The current policy and procedure for Pain Assessment provided by the Director of Nursing (DON), on 3/30/2015 at 3:11 P.M., indicated the purpose was to identify those residents who utilized routine medications for pain or who utilized frequent PRN "as needed" pain medications in an effort to ensure adequate pain control was achieved... "3. Any change in condition affecting pain and/or pain medication shall be evaluated by the interdisciplinary team during care plan review and notification shall be made to the physician accordingly. 4. Should, following admission, the resident exhibit pain which was not sufficiently controlled by current pain medication		reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted.5. The above corrective measures will be completed on or before April 10, 2015	

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	ordered, a pain Assessment shall be completed and any necessary interventions implemented accordingly." This Federal tag relates to the Investigation of Complaint IN00169820. 3.1-37(a)			
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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. Based on record review and interview, the facility failed to ensure the necessary treatment and services were provided to prevent a urinary tract infection leading to hospitalization for 1 of 4 residents reviewed for urinary catheter care. (Resident # G)	F 0315	F315 Requires the facility to ensure the necessary treatment and services are provided to prevent urinary tract infections. 1. Resident G had an order for catheter care every shift. Catheter care was completed by nursing staff every shift per physician's order. 2. All	04/10/2015

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	Findings include: During an interview, on 3/30/2015 at 9:04 A.M., Complainant # 1 indicated that on 3/17/2015, Resident # G was sent from the facility by ambulance to the emergency department. The complainant indicated that on this date, the resident's catheter tubing was covered with a thick, yellow crusted substance and the catheter drainage bag contained dark yellow, cloudy urine. On 3/30/15, Resident G's clinical record was reviewed at 10:15 A.M. Lab results indicated the following: "Urine Culture" report, dated 3/10/2015, indicated no growth. "Urine Culture", report, dated 3/17/2015, indicated a positive culture result of 80,000 colony forming units of Providencia stuartii. An assessment plan, dated 3/17/2015, indicated Resident # G was experiencing a decline in mental status likely from an infection, suspected UTI (urinary tract infection). A document titled, "Catheter Assessment", dated 3/11/2015, provided		residents have the potential to be affected. All catheter orders were reviewed. Catheter care is being completed per physician's order. No concerns were noted. See below for corrective measures. 3. The Catheter Care policy and procedure was reviewed with no changes made. (See attachment C) The staff was inserviced on the on the above procedure. 4. The DON or her designee will observe staff providing catheter care per physician's order. Three catheter care observations will be completed daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The DON or her designee will ensure documentation of catheter care is completed per physicain's order daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before April 10, 2015. **F315-IDR Rationale** Per the 2567, "The facility failedto	

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	by the Director of Nursing, on 3/30/2015 at 9:00 A.M., indicated catheter care was to be performed every shift and the catheter was to be changed monthly. Resident # G's clinical record contained no documentation that catheter care was being performed as ordered. Social Service Progress note dated 3/05/2015 indicated Resident # G was alert and able to voice his needs and wants. On 3/17/2015 the resident's clinical documents indicated the resident was lethargic and not speaking. This Federal tag relates to the Investigation of Complaint IN00169820. 3.1-41(a)(2)		ensure the necessary treatment and services were provided to prevent a urinary tract infection leading to hospitalization for 1 of 4 residents reviewed for urinary catheter care (Resident # G). The facility respectfully disagrees with this allegation, and requests the following information be considered. Resident G was admitted to Clark Memorial Hospitalon 02-17-2015 for Respiratory Failure and Septic Shock, which had required intubation. (See Attachment 1) Resident G was then admitted to Willow Crossing on 03-05-2015 with diagnosis of Hypertension, Dyslipidemia, Congestive Heart Failure, IV antibiotic administration, wound care management, Diabetes, Chronic Obstructive Pulmonary Disease, Cirrhosis , Hepatitis C, Left side Venous Port. (See Attachment 2). At this time, the resident had a previously anchored indwelling catheter for which he was receiving catheter care every shift with further orders to change the indwelling catheter monthly and PRN (Attachment3). The catheter was in place due to Urinary Retention. Admission orders included an IV antibiotic order of Micafungin 100 mg every 24 hours times 5 doses via left venous port. (Refer to Attachment2) On 03-09-2015, Resident was sent to Columbus Regional Hospital for complaints of chest pain, coarse lungs and	

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			gurgling.Resident returned to facility that same evening with new orders to start Clindamycin 300 mg four times a day times 14 days. (See Attachment 4) While at the hospital, a urinalysis was completed with a “no growth” result, but one should note that the urinalysis was positive for nitrates. Resident returned with no new orders to treat the urinalysis. (See Attachment 4) On the evening of 03-09-2015, a call was placed into Willow Crossing from Dr. Hill, with orders to discontinue the Clindamycin and Augmentin due to “resistant”, and new orders were received for Doxycycline 300mg four times a day times 14 days. (See Attachment 5) On 03-10-2015, Willow Crossing obtained a urinalysis which was positive for nitrates, which the MD chose to continue to treat with Doxycycline 300 mg every 6 hours time 14 days. (See Attachment 6). Per the careplan dated 03-10-2015, resident’s urine was noted to be dark amber in color and to continue with the Doxycycline as ordered. (See attachment 7). Resident did have a care plan dated 03-05-2015 addressing care and monitoring of the Foley catheter (See Attachment 8) On 03-12-2015, the resident’s brother was approached about potential hospice services due to resident’s disease process and overall general decline. Per nurse’s note dated the same day, the brother	

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			stated “He would speak to other brother and decide and let you know” (See Attachment 9) On 03-13-2015, resident's brother spoke with administrator and agreed to meet with hospice over the weekend (See Attachment10) Staff continued to monitor resident condition and provide care as indicated. On 03-17-2015, upon receiving Blood culture results, the resident’s brother was again called to discuss resident’s overall condition and the results. (See Attachment 11) Resident’s brother said the resident was not going to receive hospice services and he (the brother) wanted everything done. Resident’s brother then agreed to allow Willow Crossing to send resident to hospital to receive treatment per the order. Upon transfer to hospital, resident was noted to have a temperature of 102.2. (See Attachment 12) The lab referenced in the 2567, stated a“urine culture report on 03-17-2015, had a positive result of 80,000 colony forming units of proviencia stuartii.” However, this was a hospital lab dated 03-18-2015,not 03-17-2015 as stated in the 2567. Thereforethe result was unavailable to Willow Crossing (See Attachment 13) Additional relevant information since admission includes, the resident’s urine had always been noted per documentation to be ranging from	

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			dark yellow to amber in color due to being treated for a UTI,fungal infection and MRSA. (SeeAttachment 2) There was also an indwelling catheter observation tool being utilized during resident's stay that consistently reflected abnormal urine appearance. (See Attachment 14) Upon admission to the facility, the social service note dated 03-09-2015, indicated Resident G was alert and able to make needs and wants known, upon interview of writer of that entry, she stated Resident G was able to answer simple "yes and no" questions, however one should note that per admission nursing note for day of admission that "Res is lethargic, nonverbal at times, oriented to self" (See Attachment 15). One should further note that resident's cognitive status was fluctuating daily per the nurse's notes. Also upon review of the nurse's notes, the MD and family was notified multiple times regarding the care of the resident as follows: *03-06-02015 at 9AM, MD was notified of resident's pain and behaviors,new orders were received with the family being notified. *03-06-2015 at 430 PM, MD was notified of need of insulin sliding scale change with family being notified *03-06-2015 at 930 PM, Nurse practioner gave order for suppository PRN with family notification. *03-07-2015 at 2 AM , new order received to	

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			discontinue oxycontin and start oxycodone *03-08-2015 at 3AM of right lower lobe infiltrate and received a new order for Augmentin with family notification. *03-09-2015at 6AM, sputum culture received with nurse practioner notification with new order to continue with Augmentin. Dr. Hill was also notified as well as the family. *03-09-2015 at 7AM, resident was sent to hospital for gurgling, complaints of chest pain and coarse lungs, nurse practioner was notified with no order to be sent to hospital, family was notified. *03-09-2015 at 1230 PM, resident returns from hospital with new order of Clindamycin *03-09-2015 at 2PM, Dr. Hill was notified about pain management and final sputum culture and sensitivity. Sputum was with heavy growth of MRSA and was resistant to Clindamycin and Augmentin. Nurse also called office to ensure the fax was received by them. *03-09-2015 at 6 PM, new order received for CBC, CMP and UA culture if indicated, Discontinue the Clindamycin and Augmentin due to “resistant” and start Doxycycline 300 mg every 6 hours time 14 days. Discontinue the Levemir. Start MSIR 20ml-10mg (1/2 ml) per NG tubes every 4 hours PRN pain. Family was notified. *03-10-2015 at 10 AM, MD gave order to discontinue speech therapy due	

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			to decline in health and inability to participate. Call also placed to Dr.Pletcher to request a G tube to be placed. *03-10-2015at 1 PM, resident pulled out his NG tube, MD notified, at 420PM, MD gave order for x-ray to check placement of NG tube. *03-11-2015, one should note that Dr. Hill was in the facility and visited with resident. * 03-12-2015at 12PM, new order to discontinue weekly weights, give Haldol and MSIR sublingually. Family notified. *03-12-2015 at 1215PM, resident pulled his NG tube out and will send out for x-ray for proper placement. Family notified * 03-12-2015 at 130 PM, MD contacted about final MRSA sputum culture, MD stated to remain on the Doxycycline. *03-12-2015 at 215PM, former DON called to speak with family member, (the brother) to discuss resident condition and approach hospice. *03-12-2015 at 225PM, resident did not want the NG tube, MD gave order to discontinue the NG tube, speech eval, diet change to pureed with pudding thick liquids and the brother would let us know if he wanted the hospice consult. *03-12-2015- one should note that the nurse practioner was in and visited with the resident. *03-13-2015 at 300PM, MD was notified that resident was not tolerating his food, new order received to re-insert NG tube, on this day the brother agreed to	

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			speak with hospice and new order was received for hospice consult.Family was notified. *03-14-2015 at 4PM, new order received for CBC within 1 week, family notified. *03-17-2015 at 11AM, received new order to start Bactrim, sent to ER to eval and treat. Please find attached Dr. Hill's statement, the resident's primary physician, stating that the ongoing treatment of an antibiotic would have treated an infection or any potential for an infection. (See attachment 16) The closed record of Resident G had been requested by the surveyor, however, no further discussion was held with staff as to potential concerns. Lest, the above information would have been supplied, and the resident's care discussed with the surveyor at the time of survey. The facility does not agree that "The facility failed to ensure the necessary treatment and services were provided to prevent a urinary tract infection leading to hospitalization for 1 of 4 residents reviewed for urinary catheter care (Resident # G). Rather, care was being provided and resident's status monitored from the time of admission until timeof discharge to the hospital, upon the decision of the resident's brother to aggressively treat the resident's condition. The facility has in place appropriate policies, and the resident was being provided	

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			appropriate treatment and services to prevent further deterioration, although the resident was admitted with multiple co-morbid conditions and was being treated for infection at the time of admission. The facility requests the additional information be reviewed and respectfully requests F315 be deleted as a citation.	
F 0328 SS=G Bldg. 00	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.			
	Based on record review and interview, the facility failed to ensure specialized services were provided to prevent infection leading to hospitalization, related to central line care and treatment. This deficient practice affected 1 of 2 residents reviewed for venous access care. (Resident # G) Findings include: During an interview, on 3/30/2015 at 9:04 A.M., Complainant # 1 indicated that on 3/17/2015, Resident # G's central	F 0328	F328 Requires the facility to ensure specialized services were provided to prevent infection leading to hospitalization. 1. Resident G had an order for a venous port dressing change every seven days and was completed. 2. All residents have the potential to be affected. Resident with central lines were assessed to ensure no signs and syptoms of infection were present. Orders for central line dressing changes were reviewed. No concerns were noted. See below for corrective measures. 3. The nursing staff	04/10/2015

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	line was contaminated with matted hair and showed symptoms of infection (insertion site was red and dressing was loose and soiled). Resident # G's clinical record was reviewed on 3/30/2015 at 9:00 A.M., and indicated the following: "The Vital Sign Record", dated 3/05/2015, temperature of 97.4 degrees Fahrenheit. "The Vital Sign Record", dated 3/07/2015, temperature of 99.7 degrees Fahrenheit. On 3/17/2015, the clinical documentation indicated Resident # G was lethargic and unable to speak. The "Emergency Department (ED) Triage and Assessment", dated 3/17/2015, indicated the resident arrived with a temperature of 104.5 degrees Fahrenheit. The resident's central line-insertion site appearing red with a noted yellow drainage. The hospital "Clinical Document", dated 3/17/2015, indicated the resident's central line was removed in the emergency department. The resident was noted to have some purulent (milky; sometimes		was inserviced on how to properly assess a central line for signs and symptoms of infections and how to complete a central line dressing. 4. The DON or her designee will observe 2 central line sites ensuring site is free of signs and symptoms of infection. These audits will be completed daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The DON or her designee will ensure central line dressing changes are completed per physicain's order daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before April 10, 2015. **F328- IDR Rationale** Per the 2567, "the facility failed to ensurespecialized services were provided to prevent infection leading tohospitalization, related to central line care and treatment" (Resident # G) The facility respectfully disagrees with this allegation, and requests the following information be	

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	green) drainage from the opening. Hospital records indicated the central line tip was cultured on 3/17/2915, the "Central Line Culture" report indicated a growth of Proteus mirabilis. Resident # G's hospital discharge diagnosis was Polymicrobial septicemia secondary to central line infection. Resident # G's clinical record contained no documentation that central line assessments and care were being performed as ordered. This Federal tag relates to the Investigation of Complaint IN00169820. 3.1-47(a)(2)		considered. Resident G admitted to Willow Crossing on 03-05-2015with diagnosis of Hypertension, Dyslipidemia, Congestive Heart Failure, IVantibiotic administration, wound care management, Diabetes, Chronic ObstructivePulmonary Disease, Cirrhosis , Hepatitis C, Left side Venous Port. (See Attachment 1) Admission orders included an IV antibiotic order ofMicafungin 100 mg every 24 hours times 5 doses via left venous port. (SeeAttachment 1) One should note that upon admission to facility on 03-05-2015, the left side venous port was noted on the skin sheet to be clean,dry and intact with no s/s of infection. (See Attachment2) Resident was monitored for any sign and symptoms ofinfection of the left side venous port per the treatment record on admission to Willow Crossing. (See Attachment 3) Resident left venous port dressing was also changed per order and treatment record (See Attachment 3) On 03-09-2015, Resident was sent to Columbus Regional Hospital for complaints of chest pain, coarse lungs and gurgling.Resident returned to facility that same evening with new orders to startClindamycin 300 mg four times a day times 14 days (See Attachment 4) On 03-17-2015, upon receiving Blood culture results,the resident's brother was	

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			called to discuss resident's overall condition and the results. Resident's brother said the resident was not going to receive hospice services and he (the brother) wanted everything done. Resident'sbrother then agreed to allow Willow Crossing to send resident to hospital to receive treatment per the order. Upon transfer to hospital, resident was noted to have a temperature of 102.2. (See Attachment 5) Per the 2567, the "Emergency Department (ED) Triage and Assessment" dated 3/17/2015, indicated the resident arrived with a temperature of 104.5 Fahrenheit. The resident's central line –insertion appearing red with a noted yellow drainage". One should note the nursing note dated 3-17-2015, states that the resident's temperature was 102.2 (SeeAttachment 5). Furthermore, the Treatment Administration Record provides that the site was being monitored for signs and symptoms of infection from day of admission, until day of transfer to Columbus Regional Hospital (SeeAttachment 3) Upon review of the nurse's notes, the MD and family was notified multiple times regarding the care of the resident as follows: *03-06-02015 at 9AM, MD was notified of resident's pain and behaviors,new orders were received with the family being notified. *03-06-2015 at 430 PM, MD was notified of need of insulin sliding scale change with family	

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			being notified. *03-06-2015 at 930 PM, Nurse practioner gave order for suppository PRN with family notification. *03-07-2015 at 2 AM, new order received to discontinue oxycontin and start oxycodone *03-08-2015 at 3AM of right lower lobe infiltrate and received a neworder for Augmentin with family notification. *03-09-2015 at 6AM, sputum culture received with nurse practioner notification with new order to continue with Augmentin. Dr. Hill was also notified as well as the family. *03-09-2015 at 7AM, resident was sent to hospital for gurgling, complaints of chest pain and coarse lungs, nurse practitoner was notified with no order to be sent to hospital, family was notified. *03-09-2015 at 1230 PM, resident returns from hospital with new order of Clindamycin *03-09-2015 at 2PM, Dr. Hill was notified about pain management and final sputum culture and sensitivity. Sputum was with heavy growth of MRSA and was resistant to Clindamycin and Augmentin. Nurse also called office to ensure the fax was received by them. *03-09-2015 at 6 PM, new order received for CBC, CMP and UA culture if indicated, Discontinue the Clindamycin and Augmentin due to “resistant” and start Doxycycline 300 mg every 6 hours time 14 days. Discontinue the Levemir. Start MSIR	

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			20ml-10mg (1/2 ml) per NG tube every 4 hours PRN pain.Family was notified. *03-10-2015 at 10 AM, MD gave order to discontinue speech therapy due to decline in health and inability to participate. Call also placed to Dr.Pletcher to request a G tube to be placed. *03-10-2015 at 1 PM, resident pulled out his NG tube, MD notified, at 420PM, MD gave order for x-ray to check placement of NG tube. *03-11-2015, one should note that Dr. Hill was in the facility and visited with resident. *03-12-2015 at 12PM, new order to discontinue weekly weights, give Haldol and MSIR sublinguinaly. Family notified. *03-12-2015 at 1215PM, resident pulled his NG tube out and will send out for x-ray for proper placement. Family notified * 03-12-2015 at 130 PM, MD contacted about final MRSA sputum culture, MD stated to remain on the Doxycycline. * 03-12-2015 at 215PM, DON called to speak with family member, to discuss resident condition and approach hospice. *03-12-2015 at 225PM, resident did not want the NG tube, MD gave order to discontinue the NG tube, speech eval, diet change to pureed with pudding thick liquids and the brother would let us know if he wanted the hospice consult. *03-12-2015- one should note that the nurse practioner was in and visited with the resident	

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			*03-13-2015 at 300PM, MD was notified that resident was not tolerating his food, new order received to re-insert NG tube, on this day the brother agreed to speak with hospice and new order was received for hospice consult.Family was notified. *03-14-2015 at 4PM, new order received for CBC within 1 week, family notified. *03-17-2015 at 11AM, received new order to start Bactrim, sent to ER to eval and treat. Please note that the resident's primary physician also noted that the MRSA in the bloodstream could have affected the indwelling venous port. (See attachment 6) The closed record of Resident G had been requestedby the surveyor, however, no further discussion was held with staff as to potential concerns. Lest, the above information would have been supplied, and the resident's care discussed with the surveyor at the time of survey The facility does not agree "the facility failed to ensure specialized services were provided to prevent infection leading to hospitalization, related to central line care and treatment" (Resident #G) Rather,care was being provided and resident's status monitored from the time ofadmission until time of discharge to the hospital, upon the decision of the resident's brother to aggressively treat the resident's condition. The facility has in place appropriate policies,	

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			and the resident was being provided appropriate treatment and services to prevent further deterioration, although the resident was admitted with multiple co-morbid conditions and was being treated for infection at the time of admission. The facility requests the additional information be reviewed and respectfully requests F315 be deleted as a citation.	
F 0441 SS=D Bldg. 00	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. (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. (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			

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	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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review and interview, the facility failed to ensure infection control practices and standards were maintained related to wound care and disinfecting of a work area after provision of care to prevent infection. This had the potential to affect 2 of 5 residents observed for infection control. (Residents #D and #H) Finding includes: 1. During an observation, on 3/30/2015 at 9:20 A.M., Registered Nurse (RN) # 1 performed wound care to Resident # D's coccyx pressure ulcer. The RN placed the box containing a tube of Santyl (medication) ointment, normal saline, wooden tongue depressor, and wound dressing directly on the resident's bed side table. The resident was rolled to the left side. RN # 1 removed the soiled dressing and cleansed the wound with normal saline. After cleansing the wound she washed her hands and donned a new	F 0441	F328 Requires the facility to ensure infection control practices and standards were maintained related to wound care and disinfecting of a work area after provision of care to prevent infection. fection leading to hospitalization. 1. Resident D and H dressing change was completed. Bedside tables and medication cart surfaces were sanitized. Staff was immediately inserviced on infection control. 2. All residents have the potential to be affected. Staff was inserviced on infection control practices. All bedside tables and medication cart surfaces were sanitized. No concerns were noted. See below for corrective measures. 3. The dressing-clean technique policy and procedure was reviewed with no changes made. (See attachment E) The staff was inserviced on the on the above procedure. 4. The DON or her designee will observe 2 dressing changes ensuring infection control practices are being followed. These audits will be	04/10/2015

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	pair of gloves. Next, she picked up the wooden tongue depressor off of the bed side table and placed a quarter size circle of Santyl on the end. After applying the Santyl to the residents wound, the RN laid the wooden tongue depressor on the bed side table. The Santyl slid off the top area of the wound and the RN picked up the previously used wooden tongue depressor, applied more Santyl to the wooden tongue depressor and reapplied the Santyl to the entire wound area. She laid the wooden tongue depressor back on the bed side table. The RN washed her hands, picked up the Santyl, threw away the wooden tongue depressor and walked out of the resident's room. The bed side table was not wiped off or disinfected. 2. During an observation of Resident # H's wound care, on 3/30/2015 at 1:18 P.M., RN # 1 gathered her supplies and placed the wooden tongue depressors, gauze pads, Santyl tube, wound cleanser, and tape in a hair cap for ease to carry into the resident's room. Prior to walking into the resident's room, the RN dropped one of the packs of gauze pads onto the floor, picked the pack up off of the floor and placed it back into the cap. The RN donned a gown and gloves and then entered the resident's room. The RN placed the cap on the resident's bed side table. The tube of Santyl was placed on		conducted daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before April 10, 2015.	

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	the table beside the cap. The resident was rolled to the left side. The RN removed the soiled dressing and cleansed the wound with normal saline. After cleansing the wound she washed her hands and donned a new pair of gloves. The RN picked up the wooden tongue depressor out of the cap and placed a small amount of Santyl on the wound. The RN repeated this procedure three times, each time the tube of Santyl was picked up and additional amounts of Santyl was added to the edge of a different wooden tongue depressor. After applying Santyl to a couple of areas, the RN would place the used tongue depressor in the resident's trash can. When the procedure was completed, the RN washed her hands, picked up the tube of Santyl and walked out of the resident's room. The RN did not clean or disinfect the bed side table. The RN placed the Santyl on the top of the treatment cart prior to placing the tube back into the top drawer of the treatment cart. She did not wipe or disinfect the top of the treatment cart prior to preparing for the next resident's treatment. During an interview, on 3/30/2015 at 1:29 P.M., RN # 1 indicated she should of placed the Santyl in a medication cup instead of taking the tube into and out of the resident's room.			

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	Record review, on 3/30/2015 at 1:45 P.M., indicate Resident # H had a diagnosis of Methicillin-resistant Staphylococcus aureus (MRSA) infection of wounds and urine. The goal was for the infection to resolve with minimal complications. The interventions included but were not limited to ..."4. observe standard precautions for infection control." This Federal tag relates to the Investigation of Complaint IN00169820. 3.1-18(a)			