

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 04/17/2014
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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 IN00147117 and IN00147565.</p> <p>Complaint IN00147117- Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F309, F312, and F385.</p> <p>Complaint IN00147565-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: April 15, 16, and 17, 2014</p> <p>Facility number: 000253 Provider number: 155362 AIM number: 100266660</p> <p>Survey team: Regina Sanders, RN-TC</p> <p>Census bed type: SNF/NF: 139 Total: 139</p> <p>Census Payor type: Medicare: 16 Medicaid: 100 Other: 23 Total: 139</p> <p>Sample: 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 21, 2014,</p>	F000000		

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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F000157 SS=D	<p>by Janelyn Kulik, RN. 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify a resident's physician of a high blood sugar for 1 of 3 resident's</p>	F000157	F157 The facility failed to ensure the resident's responsible party was promptly notified of a change in	05/17/2014

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	<p>reviewed for diabetes mellitus, in a total sample of 8. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's record was reviewed on 04/15/14 at 12:20 p.m. The resident's diagnoses included, but were not limited to, hypertension, dementia, and diabetes mellitus (type 1).</p> <p>A Physician order, dated 10/05/13, indicated to monitor the resident's blood glucose before meals and at bedtime.</p> <p>A Physician's order, dated 11/27/13, indicated to give Lispro (insulin) 10 unit before meals.</p> <p>A Physician's order, dated 11/15/13, indicated to give 15 units of Levemir (insulin) every morning and at bedtime.</p> <p>A) The Medication Administration Record, dated 03/14, indicated the resident's blood sugar on 03/16/14 at 11 a.m. was 461.</p> <p>There was a lack of documentation to indicate the resident's Physician had been notified of the resident's high blood sugar.</p> <p>B) A Nursing Change of Condition Note, dated 03/22/14 at 6 a.m., indicated the resident's blood sugar reading was, "Hi" (high) (over 400), the Physician was notified and an order was received for a one time dose of 15 additional units of Lispro.</p> <p>A Nurses' Note, dated 03/22/14 at 6:26 a.m., indicated the resident's blood sugar still read, "hi" (high)</p>		<p>condition related to excoriation.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>We are unable to correct the alleged deficient practice related to resident B.</p> <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> <p>All other residents with blood sugar checks will be audited to ensure appropriate parameters are in place for contacting the MD.</p> <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> <p>Licensed staff will be re-educated on notifying the physician when blood sugars fall outside of specified parameters.</p> <p>Unit managers will complete a blood sugar audit 5 times a week for 4 weeks, 2 times a week for 4 weeks and then weekly.</p>	

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	<p>There was a lack of documentation to indicate the resident's Physician had been notified of the continued high blood sugar.</p> <p>C) The Medication Administration Record, dated 04/14/14, indicated the resident's blood sugar on 04/07/14 at 4 p.m. was 481.</p> <p>There was a lack of documentation to indicate the resident's Physician had been notified of the resident's high blood sugar.</p> <p>During an interview with the D-Unit Manager, on 04/16/14 at 11:20 a.m., she indicated the Physician had not been notified of the high blood sugars and indicated the Physician should have been notified.</p> <p>A Professional Resource, AAFP.org (American Family Physician's), titled, "Lispro", indicated the insulin's onset time is 15 minutes and peak time is 30-90 minutes.</p> <p>An undated facility policy, received from the Assistant Director of Nursing on 04/16/14 at 2:05 p.m., titled, "Notification of Change in Resident Health Status", indicated, "...Acute illness or a significant change in the resident's...status (...deterioration in health...life-threatening conditions or clinical complications.) Criteria:...Appropriate notification time: immediate...(C) A need to alter treatment significantly...Depending on the nursing assessment appropriate notification may be immediate to 48 hours..."</p> <p>This Federal Tag relates to complaint IN00147117.</p> <p>3.1-5(a)(2)</p>		<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> <p>Blood sugar Audits will be reviewed by DNS or ADNS weekly to identify any trends or patterns. Results of audits will be brought to QAPI monthly for a minimum of 6 months.</p> <p><i>The DNS or designee will oversee this process</i></p> <p>By what date the systemic changes will be completed? <i>May 17, 2014</i></p>	

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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 resident received necessary care and services, related to monitoring, assessment, and re-evaluation of high blood sugars and a low blood pressure for 1 of 3 residents reviewed for diabetes and change of condition, in a total sample of 8. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's record was reviewed on 04/15/14 at 12:20 p.m. The resident's diagnoses included, but were not limited to, hypertension, dementia, and diabetes mellitus (type 1).</p> <p>A hospital History and Physical, dated 11/25/13, indicated the resident had an altered mental status at the facility, was transferred to the emergency room and had been admitted to the hospital for further treatment and management of her blood sugar, which was low at 53.</p> <p>An Internal Medicine Progress Note, dated 11/26/13, indicated the resident's diabetes mellitus type 1 was very brittle.</p> <p>An Emergency Room note, dated 12/18/13</p>	F000309	<p>F309</p> <p>The facility failed to monitor, assess, and re-evaluate resident related to blood sugar and blood pressure.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>We are unable to correct the alleged deficient practice related to Resident B.</p> <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> <p>All other residents with Blood sugar and Blood pressure checks have the potential to be affected. Will review all current residents that have routine blood sugar and blood pressure checks and contact MD for any changes required.</p> <p>What measures will be put into</p>	05/17/2014

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	<p>indicated the resident's blood pressure at the facility was 69/46 and the resident's blood sugar was 60 (normal 70-115).</p> <p>A hospital History and Physical, dated 12/18/13, indicated the resident had a decreased blood pressure and a decreased blood sugar and was transferred to the Emergency Room for further evaluation.</p> <p>An Internal Medicine Progress Note, dated 12/20/13, indicated the resident's diabetes mellitus was very brittle.</p> <p>An Emergency Room note, dated 03/26/14, indicated the resident had been transferred to the hospital due to an elevated blood sugar. The note indicated the resident's blood sugar at the facility had read, "high" (over 400), the resident received 25 units of Humalog insulin and the blood glucose came down to 352. The note further indicated the resident's blood glucose was 429 when obtained by the Emergency Management Service. The diagnosis indicated the resident had uncontrolled diabetes mellitus.</p> <p>A Physician order, dated 10/05/13, indicated to monitor the resident's blood glucose before meals and at bedtime.</p> <p>A Physician's order, dated 11/27/13, indicated to give Lispro (insulin) 10 unit before meals.</p> <p>A Physician's order, dated 11/15/13, indicated to give 15 units of Levemir (insulin) every morning and at bedtime.</p> <p>A Care Plan, dated 09/23/13, indicated the resident had an alteration in blood glucose. The interventions included to observe for</p>		<p>place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Licensed staff will be re-educated on assessment and re-evaluation of abnormal findings with documentation.</p> <p>Unit managers will complete audits of blood sugars and blood pressures 5 times a week for 4 weeks, then 2 times a week for 4 weeks and then weekly.</p> <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> <p>Blood sugar and blood pressure Audits will be reviewed by DNS or ADNS weekly to identify any trends or patterns. Results of audits will be brought to QAPI monthly for a minimum of 6 months.</p> <p>The DNS or designee will oversee this process</p> <p>By what date the systemic changes will be completed? May 17, 2014</p>	

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	<p>high blood sugar symptoms-increased thirst, increased hunger, increased urinary output.</p> <p>A) The Medication Administration Record, dated 03/14, indicated the resident's blood sugar on 03/16/14 at 11 a.m. was 461.</p> <p>There was a lack of documentation to indicate the resident's Physician had been notified of the resident's high blood sugar, an assessment of the resident's condition had been completed, and a re-check of the resident's blood sugar after the routine dose of insulin had been administered.</p> <p>B) A Nursing Change of Condition Note, dated 03/22/14 at 6 a.m., indicated the resident's blood sugar reading was, "Hi" (high) (over 400), the Physician was notified and an order was received for a one time dose of 15 additional units of Lispro.</p> <p>A Nurses' Note, dated 03/22/14 at 6:26 a.m., indicated the resident's blood sugar still read, "hi" (high)</p> <p>There was a lack of documentation to indicate the resident's Physician had been notified of the continued high blood sugar, an assessment of the resident's condition had been completed, and a re-check of the resident's blood sugar had been completed prior to the routine blood sugar check at 11 a.m., which the resident's blood sugar remained high at 326.</p> <p>During an interview with LPN #1 on 04/17/14 at 8:50 a.m., she indicated she may have re-checked the resident's blood sugar but had just not written it down.</p> <p>C) The Medication Administration Record,</p>			

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	<p>dated 04/14/14, indicated the resident's blood sugar on 04/07/14 at 4 p.m. was 481.</p> <p>There was a lack of documentation to indicate the resident's Physician had been notified of the resident's high blood sugar, an assessment of the resident's condition had been completed, and a re-check of the resident's blood sugar had been completed after the routine dose of insulin had been administered.</p> <p>D) A Physician's Order, dated 03/31/14, indicated Hydralazine (anti-hypertensive) 50 mg (milligrams), give one tablet three times a day, hold if systolic blood pressure (top number) is less than 100.</p> <p>An e-MAR (electronic Medication Administration Record) note, dated 04/10/14, indicated the resident's Hydralazine, 50 mg had been held at 4:48 p.m. due to a blood pressure of 86/55.</p> <p>There was a lack of documentation to indicate an assessment had been completed for the low blood pressure and a re-check of the resident's low blood pressure had been completed. The resident's next blood pressure check was on 04/11/14 at 9 a.m., which the blood pressure was 142/76.</p> <p>During an interview with the D-Unit Manager, on 04/16/14 at 11:20 a.m., She indicated the Physician had not been notified of the high blood sugars and indicated the Physician should have been notified. The D-Unit Manager indicated the resident's blood pressure had not been re-checked on 04/11/14.</p> <p>During an interview on 04/17/14 at 9:10 a.m.,</p>			

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F000312 SS=E	<p>the Director of Nursing indicated there was no documentation to indicate the resident was assessed, the Physician was notified, and the resident's blood sugars and blood pressure had been re-evaluated on the above dates.</p> <p>This Federal Tag relates to complaint IN00147117.</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on record review and interview, the facility failed to provide the necessary assistance with bathing for 5 residents in the sample of 8 which required assistance on staff for showering. (Residents #B, #D, #E, #F, and #H)</p> <p>Findings include:</p> <p>1. Resident #B's record was reviewed on 04/15/14 at 12:20 p.m. The resident's diagnoses included, but were not limited to, hypertension, dementia, and diabetes mellitus (type 1).</p> <p>A Quarterly MDS (Minimum Data Set) Assessment, dated 03/16/14, indicated the</p>	F000312	F 312 The facility failed to provide assistance with bathing for residents B, D, E, F and H. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. We are unable to correct the alleged deficient practice related to Residents B, D, E, F and H. How other residents having the potential to be affected by the	05/17/2014			

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	<p>resident required limited assistance of one staff member for showers.</p> <p>The D-Wing, Resident Report Sheet, dated 01/14, received from the ADoN (Assistant Director of Nursing) as current on 04/16/14, indicated the resident's showers were on day shift on Tuesdays and Fridays.</p> <p>The calendar for March 2014 indicated Tuesdays and Fridays were March 4, 7, 11, 14, 18, 21, 25, and 28 and April 2014 were April 1, 4, 8, 11, and 14.</p> <p>The Bathing Type Detail report, dated 03/01/14 through 04/15/14, indicated the resident received a shower on March 11 and 18, 2014 and April 11 and 15, 2014.</p> <p>There was a lack of documentation in the resident's record to indicate why the showers were not completed on March 4, 7, 14, 21, 25, and 28, 2014 and April 1, 4, and 8, 2014.</p> <p>2. Resident #D's record was reviewed on 04/16/14 at 3:15 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and congestive heart failure. The resident was admitted into the facility on 03/24/14.</p> <p>The Admission MDS assessment, dated 03/31/14, indicated the resident required total dependence of one assistance for bathing.</p> <p>The Shower Schedule, received from the ADoN on 04/16/14 at 1 p.m., indicated the resident's showers were scheduled for day shift on Tuesday and Fridays.</p> <p>The calendar for March 2014 indicated Tuesdays and Fridays were March 25 and 28</p>		<p>same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>All other residents who require assistance with bathing have the potential for being affected. Reviewed all bathing schedules.</p> <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> <p>Licensed staff and CNA's will be re-educated on documenting completion of bathing or refusals.</p> <p>Unit managers will complete bathing audits to ensure residents are assisted with bathing and documentation is present of bathing or resident refusals. Audit to be completed daily for 4 weeks, three times weekly for 4 weeks and then weekly .</p> <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> <p>Shower audits will be reviewed by DNS or ADNS weekly to identify any trends or patterns. Results of audits will be brought to QAPI monthly for a</p>	

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	<p>and April 2014 were April 1, 4, 8, 11, and 14.</p> <p>The Bathing Type Detail, dated 03/26/14 through 04/15/14 indicated the resident had received a shower on 04/01/14 and 04/15/14 and a complete bed bath on 04/11/14.</p> <p>A Nurses' Note, dated 03/25/14 at 12:09 p.m. indicated the resident had refused care.</p> <p>There was a lack of documentation in the resident's record to indicate why the showers were not completed on March 28, 2014 and April 4 and 8, 2014.</p> <p>3. Resident #E's record was reviewed on 04/16/14 at 4:05 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and hypertension.</p> <p>An Annual MDS assessment, dated 01/25/14, indicated the resident required extensive assistance of one staff for bathing.</p> <p>The Shower Schedule, indicated the resident's showers were scheduled for day shift on Mondays and Thursdays.</p> <p>The March 2014 calendar indicated Mondays and Thursdays were March 3, 6, 10, 13, 17, 20, 24, 27, and 31 and April 2014 was April 3, 7, 10, and 14, 2014.</p> <p>The Bathing Type Detail, dated 03/01/14 through 04/14/14, indicated the resident received a shower on March 13 and 15, 2014 and April 3, 8, and 10, 2014.</p> <p>The Bath Refused by Day Report, dated 03/01/14 through 04/15/14, indicated the resident refused her shower on 03/11/14, 03/31/14, and 04/03/14.</p>		<p>minimum of 6 months.</p> <p><i>The DNS or designee will oversee this process</i></p> <p>By what date the systemic changes will be completed? <i>May 17, 2014</i></p>	

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	<p>There was a lack of documentation in the resident's record to indicate why the showers were not completed on March 6, 20, and 24, 2014 and April 14, 2014.</p> <p>4. Resident #F's record was reviewed on 04/16/14 at 1:45 p.m. The resident's diagnoses included, but were not limited to, stroke and diabetes mellitus.</p> <p>The resident's Annual MDS assessment, dated 02/23/14, indicated the resident was dependent on one staff member for bathing.</p> <p>The shower schedule indicated the resident's showers were scheduled for Wednesday and Saturday evening.</p> <p>The March 2014 calendar indicated Wednesday and Saturdays were March 5, 8, 12, 15, 19, 22, 26, and 29, 2014 and April were April 2, 5, 9, and 12, 2014.</p> <p>The Bathing Type Detail, dated 03/06/14 through 04/13/14, indicated the resident had not received a shower from March 6 through April 13, 2014. The form indicated the resident received a full bed bath on 03/26/14.</p> <p>There was a lack of documentation in the resident's record to indicate why the resident had not received a shower from March 6 through April 13, 2014.</p> <p>During an interview on 04/16/14 at 2:50 p.m., the Social Service Director indicated there had been no documented behaviors of the resident refusing his showers.</p> <p>5. Resident #H's record was reviewed on 04/16/14 at 2:25 p.m. The resident's</p>			

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	<p>diagnoses included, but were not limited to, hypertension and dementia.</p> <p>A Quarterly MDS assessment, dated 01/17/14, indicated the resident was dependent on one staff member for bathing.</p> <p>The shower schedule indicated the resident's shower was scheduled for Tuesday and Friday days.</p> <p>The calendar for March 2014 indicated Tuesdays and Fridays were March 4, 7, 11, 14, 18, 21, 25, and 28 and April 2014 were April 1, 4, 8, 11, and 14.</p> <p>The Bathing Type Detail, dated 03/06/14 through 04/13/14 indicated the resident received a shower on March 7 and 11, 2014, a full bed bath on 03/08/14, and showers on April 8 and 11, 2014.</p> <p>The Bath Refused by Day Report, indicated the resident refused her shower on 03/28/14.</p> <p>There was a lack of documentation in the resident's record to indicate why the resident had not received a shower on Marcy 18, 21, and 25, 2014 and April 1, 4, and 15, 2014.</p> <p>During an interview with the ADoN on 04/16/14 at 11:50 a.m., she indicated showers were to be given twice a week.</p> <p>During an interview with the ADoN on 04/16/14 at 3:30 p.m., she indicated the facility did not have a policy for giving showers.</p> <p>This Federal Tag relates to complaints IN00147117.</p>			

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F000385 SS=D	<p>3.1-38(b)(2) 483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN</p> <p>A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.</p> <p>The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable.</p> <p>Based on record review and interview, the facility failed to ensure a resident's physician responded timely after multiple attempts were made to contact the physician, related to a delay in treatment for a urinary tract infection (UTI) for 1 of 3 residents reviewed for infections in a total sample of 8. (Resident #D, Physician #2 and Physician #3)</p> <p>Findings include:</p> <p>Resident #D's record was reviewed on 04/16/14 at 3:15 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and congestive heart failure. The resident was admitted into the facility on 03/24/14.</p> <p>A Change of Condition Progress Note, dated 04/03/13 at 11:16 p.m., indicated the resident had fallen out of bed multiple times with 5 minutes apart and the Physician had been notified of the falls and had ordered a urinalysis (UA) and a urine culture.</p> <p>A Physician's order, dated 04/04/14 at 12:42</p>	F000385	F 385	05/17/2014			
			<p>The facility failed to ensure the physician responded timely.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Physician was notified and orders received on 4/7/14 at 15:26 for resident D. Unable to correct the alleged deficiency.</p> <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> <p>All other residents that require physician notification have the potential for being affected.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the</p>				

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	<p>a.m. indicated to collect a urine specimen for a UA and C&S (culture and sensitivity).</p> <p>A Social Service note, dated 04/04/14 at 9:20 a.m. indicated the resident was yelling out and was physically aggressive. The note indicated the behaviors occurred after the resident had fallen twice and the resident was being screened for an UTI.</p> <p>The Urine C&S results were received on 04/06/14 at 1:53 p.m. per fax and indicated the resident had escherichia coli (E-coli) greater than 100,000 colonies/milliliter in his urine (positive for UTI).</p> <p>The Nurses Progress Notes indicated: 04/06/14 at 6:47 p.m.-"Paged (Physician #2) x3 (three times) to notify of urine culture results, awaiting return call"</p> <p>04/06/14 at 7:15 p.m.-"(Physician #2) paged at this time r/t (related to) UA results awaiting call back."</p> <p>04/07/14 at 3:03 a.m.-"Physician #2) paged x3 this shift awaiting call back."</p> <p>04/07/14 at 3:26 p.m.-"(Physician #3) called regarding Urine (sic) culture results, received new order for Abt (antibiotic) Augmentin tab (tablet) 875 (milligram) d/t (due to) E-coli..." This was 20+ hours after the first attempt to notify Physician #2 of the resident's UTI, which delayed the treatment of the UTI.</p> <p>A Physician's order, dated 04/07/14, indicated an order for Augmentin 875-125 mg (milligrams) three times a day for urinary tract infection.</p> <p>During an interview with the Assistant</p>		<p>deficient practice does not recur.</p> <p>DNS spoke with medical director and notified of tag and that nurses will contact him as needed.</p> <p>Licensed staff will be re-educated on contacting the facility medical director if the primary physician does not respond timely. (Immediate to no longer than 24hrs per Notification policy</p> <p>Unit managers will complete Audits of physician notification 5 times weekly.</p> <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> <p>Audit of physician notification will be reviewed by DNS or ADNS weekly to identify any trends or patterns. Results of audits will be brought to QAPI monthly for a minimum of 6 months.</p> <p>The DNS or designee will oversee this process</p> <p>By what date the systemic changes will be completed? <i>May 17, 2014</i></p>	

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	<p>Director of Nursing, on 04/16/14 at 3:30 p.m., she indicated the nurses have up to 24 hours to get a hold of the Physician. She indicated the Nurse should have notified the Medical Director when Physician #2 had not returned the facility's call. She indicated the facility does not have a policy in place if the facility cannot get a response from a resident's Physician.</p> <p>An undated facility policy, received from the Assistant Director of Nursing on 04/16/14 at 2:05 p.m., titled, "Notification of Change in Resident Health Status", indicated, "...Acute illness or a significant change in the resident's...status (...deterioration in health...life-threatening conditions or clinical complications.) Criteria:...Clinical complications are such things as...recurrent urinary tract infection...Appropriate notification time: immediate..."</p> <p>This Federal Tag relates to complaints IN00147117.</p> <p>3.1-22(b)(2)</p>			