

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155203	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2014
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NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00145133 and Complaint IN00144887.</p> <p>Complaint IN00145133- Substantiated - Federal/ State Deficiency is cited at F279.</p> <p>Complaint IN00144887 - Substantiated - No deficiencies related to the allegations are cited.</p> <p>Survey Dates: March 24, 25, 26, 27, 28, 31 and April 1, 2014</p> <p>Facility Number: 000110 Provider Number: 155203 AIM Number: 100271120</p> <p>Survey Team: Gloria J. Reisert, MSW/TC Gwen Pumphrey, RN Caitlin Lewis, RN (March 24, 25, 26 and 27, 2014) Cheryl Fielden, RN (March 26, 27, and 28, 2014)</p> <p>Census Bed Type: SNF/NF: 113 Total: 113</p> <p>Census Payor Type: Medicare: 21 Medicaid: 86 Other: 06 Total: 113</p> <p>These deficiencies also reflect state findings</p>	F000000	<p>Please find the enclosed plan of correction for the survey ending in 4/1/14 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. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Due to the low scope and severity of the survey finding, please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance, feel free to contact me with any questions.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000225 SS=D	<p>cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on April 8, 2014, by Brenda Meredith, R.N. 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of</p>				

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	<p>the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to report an abuse allegation to the state agency. This affected 1 of 1 residents reviewed for abuse. (Resident #62).</p> <p>Finding includes:</p> <p>The clinical record of Resident #62 was reviewed on 3/27/2014. Resident #62 diagnoses included, but were not limited to, depressive disorder.</p> <p>A record titled, "Administrative Investigation-[Resident #62]" that was undated, indicated, "On 2/3/14 I was approached by [RN #1], concerning [Resident #135] and her roommate in room 305-1. [Resident # 135] reports that her roommate [Resident #62] reports that on 2/2/14 [CNA #1] was her C.N.A. [Resident # 135] reports that her roommate [Resident #62] had her light on and wanted to lay down. She stated that her roommate waited for [CNA #1] to come, finally she got his attention around 8pm and he said "there's three people a head of you. [Resident #135] stated, " She can't wait can't wait any longer, [CNA #1] replied " ok I will be there in a minute" [Resident #135] stated he is not very nice and seemed "put out" that she had stopped him. [Resident #135] expressed concern over how long it took to get her roommate to bed and [CNA #1's] attitude ... I interviewed [Resident #62] and she expressed that when he finally came to put her in bed that he" [sic.] "flopped" her in the bed and then pulled her up. She stated. [sic]. "She stated he needed help pulling me</p>	F000225	<p>F225 Requires the facility to have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or designated representative and to other officials in accordance with State law(including to the State survey agency) within 5 working days of the incident, and if the alleged violation is verified appropriate action is taken.</p> <p>1).What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #62 was not harmed. Initial and follow-up allegation of abuse reported to ISDH. Social Service completed a follow-up with resident as needed to make sure psychosocial needs are met.</p> <p>2).How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by this practice. Customer Care Representatives completed QIS abuse interview questions with all interviewable residents with no findings. 3).What measures will be put into place or what systemic changes will be made to ensure that the deficient practice</p>	04/16/2014

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	<p>up in the bed" [sic.] I asked [Resident #62] if she felt [CNA #1] intentionally tried to hurt her. She stated "No, I don't think he meant to hurt me he just didn ' t take his time he seemed like he was in a hurry to get me in the bed." "...Ten residents were interviewed and no other residents were interviewed and no other residents reported a concern about this employee.... "</p> <p>During an interview on 03/24/2014 at 1:40 p.m., Resident #62 indicated while a CNA was changing her, he "pounced me in the bed." This was reported to staff and the CNA no longer works at the facility.</p> <p>During an interview on 03/27/2014 at 9:16 a.m., the Executive Director (E.D.) indicated the roommate of Resident # 62 has a lot of mental issues. She likes to create issues. When the E.D. interviewed Resident #62 and the resident indicated the incident did not happen. Resident # 62's roommate (Resident #135) reported the allegation to the staff. Resident #135 "put it into her [Resident #62's] head." The E.D. interviewed the resident after the allegation was reported to the staff. The E.D. delegated 10 resident interviews to social services. CNA #1 resigned due to poor attendance. "If I ever have a concern I always investigate and interview other residents. If the resident confirmed it [the abuse] I absolutely would have reported it [the abuse] immediately."</p> <p>During an interview on 03/27/2014 at 10:26 a.m., the Director of Nursing (DON) indicated Resident # 62's roommate (Resident # 135) makes false allegations and "puts things into" Resident # 62's head. She could not recall any reporting of verbal abuse. Resident #135 told the DON, CNA #1 put Resident #62</p>		<p>does not recur: Abuse Prohibition, Reporting, and Investigation Policy and Procedures reviewed with no changes made. The E.D. will consult with Director of Operations to ensure any allegations are reported to ISDH per policy. All staff in-serviced on the above policy by Clinical Education Coordinator on or before 4/16/14. Any resident concerns which allege rude, rough or abusive behavior by staff will be reported to ISDH per protocol by Executive Director or Designee. 4). How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; to ensure compliance, the ED or designee is responsible for completion of the CQI Reporting Requirements Audit weekly times 4 weeks, then monthly x3 months then quarterly for at least 6 months. The audits will be reviewed during the facility's CQI meetings and issues will be addressed and the above plan will be altered accordingly as needed.</p>	

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F000226 SS=D	<p>into bed too rough. Resident # 62 indicated she did not think this was abuse. "We always side with the patient, anyway." " We are very proactive when it comes to reporting." "We report [abuse] if we suspect there is actual abuse." Abuse is reporting immediately.</p> <p>During an interview on 03/27/2014 at 1:37 p.m., Resident #62 indicated she was not abused, but was "tormented." A CNA "stuck me down in a bed." She demonstrated by pushing her open hand onto her chest and indicated, "like this." This was not abuse because he was just in a hurry so he was "rough" with the resident. The resident's roommate witnessed this and informed the resident that the CNA had "abused" her. The resident was unaware of her roommate reporting any of this to staff.</p> <p>3.1-28(c) 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to implement their own policy and procedure related to reporting an allegation of abuse. This affected 1 of 1 residents reviewed for abuse. (Resident #62).</p> <p>Findings include:</p> <p>The clinical record of Resident #62 was reviewed on 3/27/2014. Resident #62 diagnoses included, but were not limited to,</p>	F000226	F226 Requires the facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 1).What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #62 was not harmed. Initial and follow-up allegation of abuse reported to				

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	<p>depressive disorder.</p> <p>A record titled, "Administrative Investigation-[Resident #62]" that was undated, indicated "On 2/3/14 I was approached by [RN #1], concerning [Resident #135] and her roommate in room 305-1. [Resident #135] reports that her roommate [Resident #62] reports that on 2/2/14 [CNA #1] was her C.N.A. [Resident # 135] reports that her roommate [Resident #62] had her light on and wanted to lay down. She stated that her roommate waited for [CNA #1] to come, finally she got his attention around PM and he said " there's three people a head of you. [Resident #135] stated, "She can't wait can't wait any longer, [CNA #1] replied " ok I will be there in a minute" [Resident #135] stated he is not very nice and seemed "put out" that she had stopped him. [Resident #135] expressed concern over how long it took to get her roommate to bed and [CNA #1's] attitude ... I interviewed [Resident #62] and she expressed that when he finally came to put her in bed that he" [sic.] "flopped" her in the bed and then pulled her up. She stated. [sic]. "She stated he needed help pulling me up in the bed" [sic.] I asked [Resident #62] if she felt [CNA #1] intentionally tried to hurt her. She stated "No, I don't think he meant to hurt me he just didn't take his time he seemed like he was in a hurry to get me in the bed." "...Ten residents were interviewed and no other residents were interviewed and no other residents reported a concern about this employee.... "</p> <p>During an interview on 03/24/2014 at 1:40 p.m., Resident was #62 indicated while a CNA was changing her, he "pounced me in the bed." This was reported to staff and the CNA no longer works at the facility.</p>		<p>ISDH. Social Service completed a follow-up with resident as needed to make sure psychosocialneeds are met. 2). How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:Customer Care Representatives completed QIS abuse interview questions withall interviewable residents with no findings. 3).What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Abuse Prohibition, Reporting, and Investigation Policy and Proceduresreviewed with no changes made.The E.D. will consult with Director of Operations to ensure any allegations are reported to ISDH per policy. All staff in-serviced on the above policy by Clinical Education Coordinator on or before 4/16/14. Any resident concerns which allege rude, rough or abusive behavior by staff will be reported to ISDH per protocol byExecutive Director or Designee. 4).How the corrective action will be monitored to ensure the deficient practice will no to ensure compliance, the ED or designee is responsible for completion of the CQI Reporting Requirements Audit weekly times 4 weeks, then monthly x3 months then quarterly for at least 6 months. The audits will be reviewed during the facility's CQI</p>				

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	<p>During an interview on 03/27/2014 at 9:16 a.m., the Executive Director (E.D.) indicated the roommate of Resident # 62 has a lot of mental issues. She likes to create issues. When the E.D. interviewed Resident #62 and the resident indicated the incident did not happen. Resident # 62's roommate (Resident #135) reported the allegation to the staff. Resident #135 "put it into her (Resident #62's) head. "The E.D. interviewed the resident after the allegation was reported to the staff. The E.D. delegated 10 resident interviews to social services. CNA #1 resigned due to poor attendance. "If I ever have a concern I always investigate and interview other residents. If the resident confirmed it [the abuse] I absolutely would have reported it [the abuse] immediately. "</p> <p>During an interview on 03/27/2014 at 9:23 a.m., the E.D. indicated she is the contact person for abuse and in her absence the Director of Nursing (DON) becomes the abuse contact person. If abuse is reported the staff protects and assesses the resident. The staff involved in the allegation are immediately suspended. If the staff is not working they are called an informed of the investigation. The staff immediately start the investigation process including interviews with staff and residents.</p> <p>During an interview on 03/27/2014 at 10:26 a.m., the DON indicated Resident # 62's roommate (Resident # 135) makes false allegations and "puts things into" Resident # 62's head. She could not recall any reporting of verbal abuse. Resident # 135 told the DON CNA #1 put Resident #62 into bed too rough. Resident # 62 indicated she did not think this was abuse. "We always side with the patient,</p>		meetings and issues will be addressed and the above plan will be altered accordingly as needed recur, i.e. what quality assurance program will be put into place;	

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	<p>anyway." "We are very proactive when it comes to reporting." "We report [abuse] if we suspect there is actual abuse." Abuse is reporting immediately.</p> <p>During an interview on 03/27/2014 at 1:37 p.m., Resident #62 indicated she was not abused, but was "tormented." A CNA "stuck me down in a bed." She demonstrated by pushing her open hand onto her chest and indicated, "like this." This was not abuse because he was just in a hurry so he was "rough" with the resident. The resident's roommate witnessed this and informed the resident that the CNA had "abused" her. The resident was unaware of her roommate reporting any of this to staff.</p> <p>On 3/24/14 at 11:00 a.m., the Executive Director provided the a record titled, " Abuse Prohibition, Reporting, and Investigation Policy and Procedure, "dated October 2013, and indicated the policy was the one currently used by the facility. The policy indicated: "The Executive Director/designee will report all unusual occurrences, which include allegations of abuse, immediately, to the Long Term Care Division of the Indiana State Department of Health. Upon completion of the investigation, which must occur within 5 working days of the reporting of an occurrence, a report of the investigation must be forwarded to the Long Term Care Division of the Indiana State Department of Health. Copies of the completed investigation must also be sent to Adult Protective Services, Ombudsman, and Director of Operations ...It is the responsibility of the Administrator/Director of Nursing to report the abuse, or allegations of abuse, immediately to the Indiana State Department of Health. The Administrator/Director of</p>						

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F000279 SS=D	<p>Nursing will report the final results of the investigation to the Indiana State Department of Health within five working days...."</p> <p>3.1-28(c) 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop a care plan which addressed a resident with a tracheostomy and the risks associated with its use (Resident #25) and for a resident's family who was experiencing difficulty in complying with set fluid textures due to swallowing problems (Resident #155) for 2 of the 3 sampled residents whose care plans were reviewed.</p>	F000279	<p>It is the practice of this provider to use the results of the assessments to develop, review and revisethe residents comprehensive plan of care. The comprehensive plan of careincludes measurable objectives and timetable to meet athe residents medical, nursingand mental and psychosocial needs that are identified in the comprehensive</p>				

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	<p>Findings included:</p> <p>1. Review of the closed clinical record for Resident #35 on 3/31/14 at 4:30 p.m., indicated the resident was admitted from the hospital on 10/13/13. Diagnoses included, but were not limited to: chronic pain, chronic obstructive pulmonary disease and bacterial pneumonia.</p> <p>Review of the hospital records indicated that while the resident was in the hospital in August 2013 - prior to the resident admitting to the facility in October, the resident required to have a permanent tracheostomy (trach, a tube to administer oxygen) performed.</p> <p>Review of the Medication Administration Records, between October 2013 and January 2014, indicated the staff were providing daily trach care every shift.</p> <p>During an interview with the Director of Nursing (DON) on 3/31/14 5:15 p.m., she indicated, "There should have been a care plan which addressed his having a trach as that is a long term problems. It should have been a part of his comprehensive care plans at time of admission."</p> <p>2. Review of the closed clinical record for Resident #155 on 3/31/14 at 10:40 a.m., indicated the resident was admitted to the facility from the hospital on 10/23/13 with a re-admission on 2/3/14. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, peripheral vascular disease and diabetes mellitus.</p> <p>During an interview with the DON on 3/28/14 at 9:00 a.m., she indicated that the resident had frequent episodes of aspiration</p>		<p>assessment. 1)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #35 and #155 no longer resident at the facility 2)How other residents having the potential to e affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents with specialized treatments, Procedures and Programs have the potential to be affected by the alleged deficient practice. 100% audit of care plans for residents requiring specialized treatments, procedures or programs was completed on 04/16/14 by the IDT team. The IDT team will complete the IDT care plan meeting review tool. All other resident care plans will be reviewed upon quarterly assessment, significant change and annual review. The IDT will complete the IDT care plan meeting review tool. Orders will be reviewed in clinical meeting to ensure careplan was completed as needed, Non-compliance will result in further education including disciplinary action. DNS/designee is responsible to ensure compliance. 3)What measures will be put into place or what systemic changes will be made to ensure that the efficient practice does not</p>				

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	<p>pneumonia because the spouse continued to give the resident food items the resident was unable to tolerate. She indicated that whenever staff saw the spouse giving the resident thin liquids, they would remind her about the need for thickened liquids and offer to go ahead and thicken it for the resident.</p> <p>Review of the nursing notes and therapy notes, between 10/31/13 and 2/23/14, indicated both disciplines had given the family and resident education on the resident's swallowing difficulties and need to thicken all liquids with no straw use the resident would consume on a frequent basis, especially during the Speech Therapy sessions.</p> <p>In an interview with the Speech Therapist on 3/31/14 at 1:30 p.m., he indicated: "At first, I don't think she nor the rest of the family understood about the thickened liquids as we would find cokes, water, etc but after awhile, i think it clicked for her and she started looking for the thin liquids and getting rid of them from the rest of the family when they brought it in. The straws, well she just didn't get that the resident could not use them."</p> <p>During an interview on 3/31/14 at 1:45 p.m., the DON indicated, "There should have been a care plan addressing the resident being at risk for aspiration and one of the reasons listed was because of the wife being non-complaint with using a straw and bringing in and giving res thin liquids."</p> <p>This Federal tag relates to Complaint IN00145133.</p> <p>3.1-35(a)</p>		<p>recur? Licensed nurses were in-serviced on developing plan of care for residents with special treatments, procedures and programs when completing a telephone order which indicates a change of condition. A 100% audit of care plans for residents requiring specialized treatments, procedures or programs were completed on 04/16/14 and if necessary were made. The IDT team will complete the IDT care plan meeting review tool. All other resident care plans will be reviewed upon quarterly assessment, significant change and annual review. IDT will complete the IDT care plan meeting review tool. Orders will be reviewed in clinical meeting to ensure careplan was completed as needed, Non-compliance will result in further education including disciplinary action. DNS/designee is responsible to ensure compliance. 4). How the corrective action(s) will be monitored to ensure thedeficient practice will not recur, i.e., what quality assurance program will beput into place? The CQI audit tool for care plan updating will be utilized weekly x 4 weeks, monthly x 6 months and quarterly thereafter for any resident identified from new orders, 24hour report sheets, and documentation reviewed. Findings from the CQI process will be reviewed monthly and a</p>				

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F000315 SS=D	<p>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.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents received proper assessment for the necessity of a urinary catheter use. This deficient practice affected 2 of 3 residents reviewed for urinary catheters. (Resident # 59 and Resident # 169).</p> <p>Findings include:</p> <p>1. On 3/26/14 at 1:30p.m., Resident #59 was observed to be lying in bed with a foley catheter. In an interview, Resident #59 indicated, she was admitted to the facility from the hospital with the catheter. When asked why she had the catheter, she indicated she was having difficulty walking and had an increase in her "water pill." Resident #59 indicated she has had pain and discomfort with the foley catheter.</p> <p>Resident #59's clinical record was reviewed</p>	F000315	<p>action plan will be implemented for threshold below 95%. The CQI committee will determine the need for further review</p> <p>F315 The facility must ensure a residents comprehensive assessment for catheter is based on resident clinical condition. 1).What corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #59 was reassessed for appropriateness of catheter and catheter was removed per physician order. Resident #169 was reassessed and physician validated medical necessity. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents with catheters have the potential to be affected. 3) What measures will be put into place or what systemic changes will be made to</p>	

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	<p>on 3/27/14 at 10:20a.m. Resident #59 was admitted to the facility on 7/3/13 with diagnoses including, but not limited to, morbid obesity, urinary tract infection, lymphedema, hypertension, left shoulder pain, diarrhea, and abdominal pain. The physician order for the catheter listed obesity as a diagnosis. The clinical record lacked documentation of any assessment related to Resident #59's bladder function and need to continue the foley catheter.</p> <p>2. On 3/27/14 at 9:00a.m., Resident #169 was observed lying in bed with a foley catheter. Resident #169 was unable to indicate why he had a foley catheter. In an interview at 3/27/14 at 9:17 a.m., LPN #1 indicated, " He's had the foley [catheter] since I've taken care of him. "</p> <p>Resident #169's clinical record was reviewed on 3/27/14 at 8:49a.m. He was admitted to the facility on 12/17/13, after an inpatient hospital stay from stroke. A physician's order, dated 12/17/13 and 12/31/13, indicated foley catheter for urinary retention as the diagnosis. The clinical record lacked documentation of assessment related to Resident #169's bladder function, attempts to discontinue foley catheter use, or continued necessity.</p> <p>On 3/28/14 at 2:30p.m., the Director of Nursing (DoN) indicated, "I have a nurses notes that says the catheter was put back in but it doesn't say why. I would have to call the nurse and see if he remembers what happened."</p> <p>On 3/31/14 at 8:00a.m., the Director of Nursing presented two statements. The first statement, dated 3/28/14 and untimed,</p>		<p>ensure that the deficient practice does not recur; Licensed Staff were in-serviced on Bladder Program which includes the assessment and medical necessity of the continued use of the catheter by the DNS or designee on or before 04/16/14. Residents with foley catheters were assessed for medical necessity and the outcomes recorded in the residents medical record. The physician was notified and clarification orders obtained. All residents admitted with a foley catheter will be assessed by DNS/designee for appropriateness of catheter 4) How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;? The DNS/designee will complete the catheter assessment CQI tool weekly times 4 weeks and monthly ongoing. If threshold of 95% is not obtained an action plan will be developed CQI committee will determine need for further education or action.</p>				

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	<p>indicated the DoN contacted the nurse providing care on the date in question. Per the statement, the nurse "removed the foley [catheter] in the a.m. [morning] and the resident did not void...." The nurse contacted the physician who ordered to reinsert the catheter. The nurse reported, "approximately 400-500 cc[cubic centimeter is a measure of volume] of urine upon foley insertion." The nurse "could not remember the exact amount of urine at this time."</p> <p>The second statement, dated 3/28/14 and untimed, indicated the DoN contacted the physician who indicated the resident had a "Right Hemispheric Stroke and has spinal problems as well and the resident has urinary retention resulting from the CVA."</p> <p>Resident #169's clinical record lacked documentation in to justify the need to reinsert the foley catheter. There was no assessment to confirm the resident had urinary retention. The clinical record also lacked documentation of the resident's spinal problems related to his stroke. There was no documentation to suggest the spinal problems affected urinary function.</p> <p>On 3/27/14 at 12:24p.m., the DoN provided a copy of the policy titled, "Bladder Program." The policy indicated residents with an indwelling urinary catheter will have an assessment that includes the reason. The policy also indicated "urinary retention that can not be treated medically surgically, or with alternative therapy and which is characterized by one of the following: documented post void residual volume in a range of 200 ml [milliliter is a measure of volume] or greater, inability to manage the retention with intermittent catheterization,</p>			

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F000441 SS=D	<p>persistent overflow incontinence, or symptomatic infection and/or renal dysfunction.</p> <p>3.1-41(a)(2) 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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</p>			

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	<p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on interview and record review, the facility failed to properly monitor residents prescribed antibiotics through the outcome surveillance process of the infection control program. This deficient practice affected 1 of 5 residents reviewed for infection control. (Resident # 59).</p> <p>Findings include:</p> <p>1. Resident #59's clinical record was reviewed on 3/27/14 at 10:20a.m. Resident #59 was admitted to the facility on 7/3/13 from the hospital with diagnoses including, but not limited to, morbid obesity, urinary tract infection, lymphedema, hypertension, left shoulder pain, diarrhea, and abdominal pain.</p> <p>Resident #59's urinalysis from the hospital, dated 6/26/13, indicated she had ESBL in her urine. (ESBL, extended spectrum beta lamataase, is a type of enzyme produced by certain bacteria that provide resistance to certain antibiotics.) According to the Center for Disease Control website retrieved on 3/27/14 at 11:00a.m., ESBL requires contact isolation precautions.</p> <p>According to the discharge summary from the hospital dated 7/3/13, Resident #59 was prescribed an antibiotic for a urinary tract infection, "Nitrofurantoin up to 7/6/13."</p> <p>Resident #59's most recent urinary tract infection, confirmed on 3/10/14, indicated she had ESBL in her urine. She was prescribed Nitrofurantoin 100 milligrams twice daily for</p>	F000441	<p>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>1).What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #59 was treated with oral antibiotics. Resident #59 urinalysis was negative on 4/12/14. Physician was notified of the results no new orders were received. The Infection Control Nurse is monitoring residents with orders for antibiotic therapy through the outcome surveillance program. 2).How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected by this practice. 100% audit was conducted of all residents lab results to ensure all infectious processes are identified. Any lab identified as infectious will be recorded on the Surveillance log for monitoring. The physician was notified and appropriate treatments were ordered. 3). What measures will be put into place or what systemic changes</p>	04/16/2014			

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	<p>ten days.</p> <p>The infection control log was reviewed on 3/27/14 at 12:00p.m. The log lacked documentation of tracking Resident #59's urinary tract infection on 7/3/13, including the treatments and the follow up as to whether the symptoms had resolved. The log had incomplete documentation of Resident #59's urinary tract infection on 3/10/14, including cultures and infection criteria.</p> <p>On 3/27/14 at 2:51p.m., RN #2 indicated she, "takes the guidelines from the CDC[Center for Disease Control] and determine if [the resident] has an actual infection. If its an actual infection I monitor in the log."</p> <p>In an interview on 3/27/14 at 3:09p.m., the DoN indicated, the log was not being updated on a consistent basis. She indicated there was no infection control nurse and some residents infections may have not been tracked. She was not aware of Resident#59's infection in the urine. She indicated an infection control nurse was hired January 2014.</p> <p>A copy of the policy titled, "Infection Control and Prevention Program" was provided by the Assistant Director of Nursing on 3/31/14 at 11:14a.m. The policy indicated, "...the facility shall have surveillance system that investigates, controls, and prevents infections...."</p> <p>3.1-18(b) (1)(A)</p>		<p>will be made to ensure that the deficient practice does not recur Licensed staff will be in-serviced by the DNS or designee on or before 4/16/14 on the policy and procedure for managing infectious processes. The Infection Control Nurse was be in-serviced by the DNS on the Infection Control Surveillance Program on 4/16/14. The Infection Control Nurse reviews physician orders during the morning meeting to identify any new infectious process and documents findings on the Infection Control Surveillance Log. A 100% audit was conducted of all residents lab results to ensure all infectious processes are identified. 4)How the corrective action will be monitored to ensure the deficient practice will not recur, ie , what quality assurance program will you put into place. The DNS/designee will complete the CQI Infection Control tool weekly times 4 weeks and monthly ongoing. If threshold is below 95% an action plan will be developed. The CQI committee will determine need for further action.</p>		