STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMOND-WHITING CARE CENTER	1000 114TH ST WHITING, IN 46394

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F0000	This visit was for the Investigation of Complaints IN00108766 and IN00109409. Complaint IN00108766-Substantiated. Federal/state deficiencies related to the allegations are cited at F441. Complaint IN00109409-Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F281, F315, & F514. Survey dates: June 12, 13, & 14, 2012 Facility number: 000365 Provider number: 155423 AIM number: 100287460 Survey team: Janet Adams, RN Census bed type: SNF/NF: 73 Total: 73 Census payor type: Medicare: 24 Medicaid: 34 Other: 15 Total: 73	F0000	The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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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	Sample: 8 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on June 21, 2012 by Bev Faulkner, RN			

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F0157 SS=D	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). 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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on observation, record review, and interview, the facility failed to notify the Physician of multiple Foley (urinary) catheter changes and the incorrect insertion of a Foley catheter for 1 of 3	F0157	1.The Director of Nursing notified resident D's physician on June 14, 2012 of the numerous foley catheter changes, improper insertion on May 24, 2012 and orders received to change foley	07/13/2012

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	residents reviewed for the use of urinary catheters in the sample of 8. (Resident #D) Findings include: During orientation tour on 6/12/12 at 2:34 p.m., Resident #D was observed in bed. The resident had a Foley catheter in place. The record for Resident #D was reviewed on 6/13/12 at 8:09 a.m. The resident's diagnoses included, but were not limited to, coronary artery disease, dementing illness, high blood pressure, and insomnia. Review of the 6/2012 Physician Order Statement indicated there was an order for the resident to have a urinary catheter in place and an order indicating the urinary catheter could be changed as needed for leakage or dislocation not to exceed 1x per month. The order also indicated the Physician was to be called if the above occurred. These above orders were initially written on 10/27/2011. The 4/2012 Nurses' Notes indicated the resident's Foley (urinary) catheter was changed on 4/12/12 and 4/17/12. There was no documentation of the Physician being notified of the catheter being changed more than one time a month in 4/2012. The 5/2012 Nurses' Notes		as needed. The Director of Nursing also notified Resident D's responsible party of the new physician order on June 14, 2012. 2.The Director of Nursing on June 27, 2012 to verify that physician orders were being followed and no issues were noted completed an audit of residents with foley catheters. 3.Licensed nurses will be in serviced by the Director of Nursing on notification of physician and family member when there is a change of condition or a reason to change a physician order on June 27, 2012 4.An audit will be completed Monday through Friday in Change of Condition by DON/designee of 95% of new physician orders to ensure that proper notification of physician is completed. On Mondays, the weekend documentation will be reviewed for the same. This will continue weekly times six weeks, monthly for one quarter, and quarterly thereafter for one year. Audits will be reviewed at our monthly PI meeting. 5.Date Certain is July 13, 2012.	

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	indicated the resident's Foley catheter was changed on 5/3/12 and 5/10/12. There was no documentation of the Physician being notified of the catheter being changed more then one time a month in May 2012. When interviewed on 6/13/12 at 10:00 a.m., the Director of Nursing indicated the resident's Foley catheter was changed several times due to leakage. The Director of Nursing indicated the Physician was probably not notified each time as per the Physician's orders. The Director of Nursing also indicated when the resident's Foley catheter was changed last a LPN inserted the catheter into the resident's rectum instead of the urinary meatus. The Director of Nursing indicated this occurred on 5/24/12 and there was no documentation of the above in the Nurses' Notes. The Director of Nursing indicated the Physician should have been notified. This federal tag relates to Complaint IN00109409. 3.1-5(a)(2)			

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F0281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.			
	Based on observation, record review, and interview, the facility failed to ensure a licensed nurse was trained and competent in skills related to insertion of indwelling urinary catheters for 1 of 1 licensed nurses reviewed. This deficient practice affected Resident #D. (LPN #1) (Resident #D) Findings include: During orientation tour on 6/12/12 at 2:34 p.m., Resident #D was observed in bed. The resident had a Foley catheter in place. The record for resident #D was reviewed on 6/13/12 at 8:09 a.m. The resident's diagnoses included, but were not limited to, coronary artery disease, dementing illness, high blood pressure, and insomnia. Review of the 6/2012 Physician Order Statement indicated there was an order for the resident to have a urinary catheter in place and an order indicating the urinary catheter could be changed as needed for leakage or dislocation not to exceed 1x (one time) per month.	F0281	1.LPN #1 completed competency/skills checklist on foley catheter insertion by the Staff Development on May 30, 2012. She has been educated on her responsibility to report to nurse in charge if there is a task for her to complete that she has not been checked off on in order for an experienced nurse to oversee her and verify competency. 2.The Director of Nursing completed an audit of residents with foley catheters.to verify that there was urine return. 3.An audit of nursing files was completed by the Staff Development Coordinator on 6/26/12 to verify that nurses had completed competency/skills checklist within 90 days of hire and annually thereafter. Any nurse who did not have competency/skills checklist completed will have completed by July 6, 2012. Staff Development Coordinator was educated on June 15, 2012 by the Executive Director on competency checklists with new hires and annually, and her role in determining if a staff member is ready to come off of orientation. 4.An audit will be completed on new hires weekly times six	07/13/2012

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	When interviewed on 6/13/12 at 10:00 a.m., the Director of Nursing indicated when the resident's Foley catheter was changed last a LPN inserted the catheter into the resident's rectum instead of the urinary meatus. The Director of Nursing indicated this occurred on 5/24/12 and there was no documentation of the above in the Nurses' Notes. The Director of Nursing indicated she was notified of the Foley catheter being inserted incorrectly on the evening it occurred. The Director of Nursing indicated she was informed the Foley catheter was inserted into the resident's rectum. When interviewed on 6/13/12 at 10:20 a.m., LPN #1 indicated she was the nurse assigned to care for the resident on 5/24/12 for the day shift. The LPN indicated she worked the day shift from 6:00 a.m. to 2:30 p.m. The LPN indicated a CNA informed her Resident #D's catheter came out while staff were transferring the resident from the chair into her bed. LPN #1 indicated she gathered the supplies needed to insert a new catheter and went into Resident #D's room and LPN #2 was also with her. LPN #1 indicated she had inserted a Foley catheter in a mannequin in nursing school, but had not done so on a person. LPN #1 indicated she did not inform LPN #2 she		weeks, monthly for one quarter, then quarterly for one year by the Executive Director/designee. Audit results will be reviewed in monthly PI meeting. 5.Date Certain is July 13, 2012.	

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	had not inserted a Foley catheter on an individual. LPN #1 indicated LPN #2 was present and held the resident's legs during the procedure and after the catheter was inserted no urine flow was noted from the catheter into the tubing. The LPN indicated when she first entered the room the resident's brief was wet just prior to the inserting the catheter. LPN #1 indicated she found out later that the Foley catheter was inserted into the resident's rectum. The LPN indicated this occurred at the end of the shift and she did not go back to the resident's room to observe the functioning of the device. When interviewed on 6/13/12 at 10:25 a.m., LPN #2 indicated she was working the evening shift on the above date and she and LPN #1 went into Resident #D's room right after getting report at change of shift "close to 3:00 p.m." LPN #2 indicated she assisted LPN #1 by holding the resident's legs and talking to the resident during the procedure. LPN #2 indicated she did not observe LPN #1 inserting the Foley catheter but did see there was no return of urine at the time of insertion. LPN #2 indicated the resident's daughter was in the facility later that day around 4:30 p.m., and LPN #2 went into the Resident #D's room with the daughter and informed the daughter the Foley catheter had been changed and no urine			

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	was observed. LPN #2 indicated she then deflated the catheter bulb and removed the Foley catheter and the catheter had feces on it. LPN #2 indicated she then obtained a new Foley catheter insertion kit and inserted the catheter into the resident's meatus and obtained a return of urine at that time. LPN #2 indicated she was not aware that LPN #1 had never inserted a Foley catheter on a person. The employee file for LPN #1 was reviewed on 6/13/12 at 12:30 p.m. The LPN was hired on 4/5/12. The LPN received her Nursing License on 3/15/2012. There were no Competency/Skills Checklist forms in the file. When interviewed on 6/13/12 at 1:50 p.m., the Staff Development Nurse indicated LPN #1 was hired on 4/5/12 and was a new nurse at the time of hire. The Staff Development Nurse indicated there are several competency assessments new staff are to complete and one is for the insertion of urinary catheters. The Staff Development Nurse indicated LPN #1 completed this competency on 5/30/12. The Nurse indicated this was done after LPN #1 inserted the Foley catheter incorrectly on 5/24/12. The Nurse also indicated new staff nurses receive orientation and provide care to residents			

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	under a preceptor nurse. When interviewed on 6/13/12 at 2:30 p.m., the Staff Development Nurse indicated the facility has Competency/Skills Checklists for each new nurse to have completed during orientation and the completed checklist is to be returned to Staff Development. The Staff Development Nurse indicated the preceptor nurses check off areas on the form when they are completed. The Staff Development Nurse indicated she is responsible to get the checklist back and she did not have a completed Competency/Skills Checklist for LPN #1. The Staff Development Nurse indicated the Director of Nursing determines when each new LPN is to be taken off Orientation. A "Competency/Skills Checklist" was reviewed on 6/13/12 at 2:30 p.m. The checklist included a "Performance Area" for the insertion of indwelling Foley catheters. Sections on the checklist for the area above "Performance Area" included, method, evaluation date, performance level, associate initials, comments and supervisors initials. When interviewed on 6/13/12 at 3:00 p.m., the Director of Nursing indicated LPN #1 had been taken off Orientation in			

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	April. The Director of Nursing indicated LPN #1 did not have a Competency/Skills list completed. The "Lippincott's Nursing Center. Com-Better Resources for Better Care" was reviewed on line. The "Best Practices in Urinary Catheter Care" article in the "Home Healthcare Nurse" June 2010 Volume 28 Number 6 article indicated practitioners should train the correct techniques for catheter insertion and care. The Indiana State Board of Nursing Statues for LPN's indicated the following: 848 IAC 2-3-3 Unprofessional Conduct Section 3. Nursing behaviors (acts, knowledge, and practices) failing to meet the minimal standards of acceptable and prevailing licensed practical nursing practices, which could jeopardize the health, safety, and welfare of the public shall constitute unprofessional conduct. These behaviors shall include, but are not limited to, the following: (2) Performing any nursing technique or procedure for which the nurse is unprepared by education or experience. (8) Accepting delegated nursing measures that he or she knows that he or she is not prepared, qualified, or licensed to perform.			

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	This federal tag relates to Complaint IN000109409. 3.1-35(g)(1)			

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F0315 SS=D	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 observation, record review, and interview, the facility failed to ensure an indwelling urinary catheter (Foley) was inserted correctly and failed to monitor for proper functioning of the catheter when no urine was obtained at the time of insertion for 1 of 3 residents reviewed with indwelling Foley catheters in the sample of 8. (Resident #D) (LPN #1 and LPN #2) Findings include: During orientation tour on 6/12/12 at 2:34 p.m., Resident #D was observed in bed. The resident had a Foley catheter in place. The record for Resident #D was reviewed on 6/13/12 at 8:09 a.m. The resident's diagnoses included, but were not limited to, coronary artery disease, dementing	F0315	1.The Director of Nursing notified resident D's physician on June 14, 2012 of improper insertion on May 24, 2012 and no urine output. Orders were received to change as needed. The Director of Nursing also notified Resident D's responsible party of the new physician order on June 14, 2012. Res D had no adverse effects as a result of the improper insertion 2.No other resident that had a foley catheter change had any issue with improper insertion or decrease in urine output. 3.Staff Development Coordinator to complete competency/skills checklist with licensed nurses on Foley catheter insertion by July 6, 2012. 4.A second nurse will verify urine output after insertion of a foley catheter to verify proper placement. An audit will be completed Monday through Friday in Change of Condition by DON/designee of medical records	07/13/2012

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	illness, high blood pressure, and insomnia. Review of the 6/2012 Physician Order Statement indicated there was an order for the resident to have a urinary catheter in place and an order indicating the urinary catheter could be changed as needed for leakage or dislocation not to exceed 1x (one time) per month. The order also indicated the Physician was to be called if the above occurred. These above orders were initially written on 10/27/2011. The 4/2012 Nurses' Notes were reviewed. An entry made on 4/12/12 at 3:00 p.m. indicated the resident had no adverse reactions to a Foley catheter change. An entry made on 4/17/12 at 8:30 p.m., indicated the resident's Foley catheter was replaced. The 5/2012 Nurses' Notes were reviewed. An entry made on 5/3/12 at 10:00 a.m., indicated the resident had a Foley catheter change. An entry made on 5/10/12 at 4:00 a.m., indicated the Foley catheter was removed and replaced due to leakage. When interviewed on 6/13/12 at 10:00 a.m., the Director of Nursing indicated when the resident's Foley catheter was changed last a LPN inserted the catheter into the resident's rectum instead of the urinary meatus. The Director of Nursing indicated this occurred on 5/24/12 and		to ensure proper documentation of urine output after insertion of foley catcher. On Mondays, the weekend documentation will be reviewed for the same. This will continue weekly times six weeks, monthly for one quarter, and quarterly thereafter for one year. Audit results will be reviewed in monthly PI meeting. 5.Date Certain is July 13, 2012.	

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	there was no documentation of the above in the Nurses' Notes. The Director of Nursing indicated she was notified of the Foley catheter being inserted incorrectly on the evening it occurred. The Director of Nursing indicated she was informed the Foley catheter was inserted into the resident's rectum. When interviewed on 6/13/12 at 10:20 a.m., LPN #1 indicated she was the nurse assigned to care for the resident on 5/24/12 for the day shift. The LPN indicated she worked the day shift from 6:00 a.m. to 2:30 p.m. The LPN indicated a CNA informed her Resident #D's catheter came out while staff were transferring the resident from the chair into her bed. LPN #1 indicated she gathered the supplies needed to insert a new catheter and went into Resident #D's room and LPN #2 was also with her. LPN #1 indicated she had inserted a Foley catheter in a mannequin in nursing school, but had not done so on a person. LPN #1 indicated she did not inform LPN #2 she had not inserted a Foley catheter on an individual. LPN #1 indicated LPN #2 was present and held the resident's legs during the procedure and after the catheter was inserted no urine flow was noted from the catheter into the tubing. The LPN indicated when she first entered the room the resident's brief was wet just			

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	prior to the inserting the catheter. LPN #1 indicated she found out later that the Foley catheter was inserted into the resident's rectum. The LPN indicated this occurred at the end of the shift and she did not go back to the resident's room to observe the functioning of the device. When interviewed on 6/13/12 at 10:25 a.m., LPN #2 indicated she was working the evening shift on the above date and she and LPN #1 went into Resident #D's room right after getting report at change of shift "close to 3:00 p.m." LPN #2 she assisted LPN #1 by holding the resident's legs and talking to the resident during the procedure. LPN #2 indicated she did not observe LPN #1 inserting the Foley catheter but did see there was no return of urine at the time of insertion. LPN #2 indicated the resident's daughter was in the facility around 4:30 p.m. later that day and LPN #2 went into the Resident #D's room with the daughter and informed the daughter the Foley catheter had been changed and no urine was observed. LPN #2 indicated she then deflated the catheter bulb and removed the Foley catheter and the catheter had feces on it. LPN #2 indicated she then obtained a new Foley catheter insertion kit and inserted the catheter into the resident's meatus and obtained a return of urine at that time. LPN #2 indicated she was not aware that			

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	LPN #1 had never inserted a Foley catheter on a person. The facility policy titled "Catheterization-Female Resident" was received form the Director of Nursing on 6/14/12 at 7:55 a.m. The Director of Nursing indicated the policy was current. There was no date on the policy. The policy indicated the catheter was to be inserted gently "into the meatus approximately 2-3 inches or until urine begins to flow." This federal tag relates to Complaint IN00109409. 3.1-41(a)(20			

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F0441 SS=E	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 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 the	F0441	1.Resident #E, #F have been discharged home, resident	07/13/2012

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	glucometer (device to check the resident's blood sugar level) was disinfected according to accepted practices and the facility policy for 2 of 4 observations of resident's receiving glucometer checks. This deficient practice had the potential to affect 12 of 12 residents receiving blood glucose testing on the North Unit. The facility also failed to ensure hand washing was completed after the use of the glucometer and before administering medication to another resident. This deficient practice had the potential to affect 40 of 40 residents on the North Unit. (Residents #E, #F, and #J) (RN #1) Findings include: On 6/12/12 at 4:05 p.m., RN #1 was observed walking down a hall on the North Unit. The RN had glucometer device and a lancet in her hand. The RN entered Resident #F's room. The resident was sitting in chair in the room next to his bed. RN #1 pricked the resident's finger with a lancet to obtain a blood sample. The blood sample was applied onto the testing strip in the glucometer device. The RN was not wearing gloves. RN #1 then proceeded to walk out of the resident's room to the Nurse's Station and placed the glucometer on the Medication		J has had no signs and symptoms of infection noted. Physician of resident J was contacted and made aware of the deficient practice and no new orders were received. 2.RN # 1 was immediately stopped from proceeding further by Senior RN #2. RN #1 was verbally educated at time of issue by RN #2. No other resident has been affected. RN #1 received written education by the Director of Nursing on June 14, 2012 on proper cleansing technique of glucometer, wearing gloves during the glucometer procedure, proper hand washing per facility protocol. 3.Licensed nurses were in-serviced by the Director of Nursing on proper cleansing of glucometer, wearing gloves during procedures, and proper hand washing technique on June 27, 2012. Staff was in-serviced on proper hand washing technique on June 27 & 28, 2012. Audit of hand washing to be completed Monday through Friday by Staff Development Coordinator/designee of at least 10 staff members per week, including staff from three 3 shifts to ensure compliance. Staff Development Coordinator is to monitor at least 10 staff members per week, including staff from three 3 shifts to ensure compliance of proper cleansing technique of glucometer, proper glove use during glucometer, and	

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	Cart at the Nurses' Station. The glucometer was not visibly soiled nor were the RN's hands. The RN did not wash her hands or clean the glucometer device prior to exiting the resident's room or at the Nurses' Station. RN #1 then made an entry in the Medication Book on the cart. The RN then opened the Medication Cart drawer and began removing punch cards of medications for Resident #J. Resident #J was sitting in a wheel chair next to the Medication Cart. The RN punched several oral pills out of the cards into a pill cup without touching the pills. The RN then gave the cup of pills to Resident #J and the resident swallowed the pills from the cup. RN #1 then put on a pair of disposable gloves and told the resident she was taking her to another room to give her eye drops. The RN wheeled the resident into an empty resident room on the unit. The RN then began to open the bottle of the eye drops. The RN and the Surveyor exited the room at this time. When interviewed at this time, RN#1 indicated she had completed a glucometer test on Resident #F without wearing any disposable gloves. The RN indicated she wears gloves when performing blood glucose testing "most of the time." The		proper hand washing after completion. This will continue weekly times six weeks, monthly for one quarter, and quarterly thereafter for one year. Audit results will be reviewed in monthly PI meeting.. 4.Date Certain July 13, 2012.	

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	RN indicated she did not wash her hands after completing the blood glucose testing for Resident #F. The RN indicated hand washing was supposed to be done after using a glucometer. The RN then removed her gloves and washed her hands in the sink in the room Resident #J was taken into. On 6/12/12 at 4:15 p.m., RN #1 was observed washing her hands at the sink in the North Unit Nurses' Station. The RN put on a pair of disposable gloves and took a glucometer and proceeded down the hall to Resident #E's room. The RN entered the room and told the resident she was going to do the glucometer check. The RN and the Surveyor exited the room at this time. When interviewed at this time, RN #1 indicated she had cleaned the glucometer device with alcohol prior to going to Resident E's room. When questioned what the facility's policy was, the RN indicated she thought "we were supposed to use another type of wipe...like a disinfectant." RN #1 then proceeded to the storage room on the unit to look for the correct disinfectant wipes to be used. When interviewed at 4:30 p.m., RN #2 (who was working on the South Unit) was interviewed. RN #2 indicated the facility had disinfectant wipes to be used for the			

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	glucometer machine and RN #1 should have used these wipes. RN #2 indicated she would observe RN #1 to ensure proper procedure was being followed. The Director of Nursing was reached via telephone on 6/12/12 at 4:35 p.m., and informed of the above. When interviewed in the facility on 6/12/12 at 6:30 p.m., the Director of Nursing indicated gloves were to be worn when completing any glucometer test. The Director of Nursing also indicated there are 'Sani Wipes' with disinfectant and bleach that are to be used to clean the glucometer between uses. The Director of Nursing indicated RN #1 should have worn gloves when using the glucometer on Resident #F and then should have washed her hands after completing the glucometer test. The Director of Nursing also indicated the RN should have washed her hands before giving the eye drops to Resident #J. The facility policy titled "Cleaning and Disinfection of the Glucometer" was received from the Business Office Manager on 6/12/12 at 5:42 p.m. The policy had an "Added on" date of 3/10. On 6/12/12 at 7:10 p.m., the Director of Nursing confirmed the policy was current. The policy indicated Super Sani-Cloth of			

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	Sani Cloth Plus wipes or an equivalent product that kills hepatitis B and blood borne pathogens were to be used. This federal tag relates to Complaint IN00108766. 3.1-18(b)(2) 3.1-18(l)			

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.			
	Based on observation, record review, and interview, the facility failed to ensure clinical records were complete related to lack of documentation of a Foley (urinary) catheter inserted incorrectly by a LPN. (Resident #D) (LPN #1) Findings include: During orientation tour on 6/12/12 at 2:34 p.m., Resident #D was observed in bed. The resident had a Foley catheter in place. The record for resident #D was reviewed on 6/13/12 at 8:09 a.m. The resident's diagnoses included, but were not limited to, coronary artery disease, dementing illness, high blood pressure, and insomnia. Review of the 6/2012	F0514	1.The Director of Nursing notified resident D's physician on June 14, 2012 of the numerous foley catheter changes, improper insertion on May 24, 2012 and orders received to change as needed. The Director of Nursing also notified Resident D's responsible party of the new physician order on June 14, 2012. 2.An audit was completed on June 27, 2012 by the Director of Nursing of residents with foley catheters and no issues were noted. 3.Licensed nurses will be in serviced by the Director of Nursing on documentation needed when foley catheter is changed and proper urine output received after insertions to verify placement on June 27, 2012 4.A second nurse will verify urine output after insertion of a foley catheter to verify proper placement. An audit will be	07/13/2012

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	Physician Order Statement indicated there was an order for the resident to have a urinary catheter in place and an order indicating the urinary catheter could be changed as needed for leakage or dislocation not to exceed 1x (one time) per month. The 5/2012 Nurses' Notes were reviewed. There was no documentation of staff inserting the resident's Foley catheter incorrectly. When interviewed on 6/13/12 at 10:00 a.m., the Director of Nursing indicated when the resident's Foley catheter was changed last a LPN inserted the catheter into the resident's rectum instead of the urinary meatus. The Director of Nursing indicated this occurred on 5/24/12 and there was no documentation of the above in the Nurses' Notes. The Director of Nursing indicated she was notified of the Foley catheter being inserted incorrectly on the evening it occurred. The Director of Nursing indicated she was informed the Foley catheter was inserted into the resident's rectum. This federal tag relates to Complaint IN00109409. 3.1-50(a)(1)		completed Monday through Friday in Change of Condition by DON/designee of medical records to ensure proper documentation of urine output after insertion of foley catcher. On Mondays, the weekend documentation will be reviewed for the same. This will continue weekly times six weeks, monthly for one quarter, and quarterly thereafter for one year. Audit results will be reviewed in monthly PI meeting. 5.Date Certain is July 13, 2012..	

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