

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155156	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/01/2013
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NAME OF PROVIDER OR SUPPLIER ARBORS AT MICHIGAN CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360
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F000000	<p>This visit was for the Investigation of Complaint IN00131446.</p> <p>Complaint IN00131446-Substantiated. Federal/state deficiencies related to the allegations are cited as F315, F323, F465, F469, and F505.</p> <p>Survey date: July 1, 2013</p> <p>Facility number: 000076 Provider number: 155156 AIM number: 100271060</p> <p>Survey team: Janet Adams, RN, TC</p> <p>Census bed type: SNF: 25 SNF/NF: 117 Total: 142</p> <p>Census payor type: Medicare: 25 Medicaid: 94 Other: 23 Total: 142</p> <p>Sample: 8</p> <p>These deficiencies reflect state</p>	F000000	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. We are requesting paper compliance for this survey.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	findings cited in accordance with 410 IAC 16.2. Quality review completed on July 4, 2013, by Janelyn Kulik, RN.			

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>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 record review and interview, the facility failed to ensure treatment for a urinary tract infection was initiated in a timely manner related to not obtaining treatment orders from the Physician when abnormal urine culture results were reported to the facility for 1 of 3 residents reviewed for urinary tract infections. (Resident #J)</p> <p>Findings include:</p> <p>The record for Resident #J was reviewed on 7/1/13 at 3:18 p.m. The resident's diagnoses included, but were not limited to, high blood pressure and a history of malignant neoplasm of the prostate.</p> <p>A Physician Progress Note was completed by the Nurse Practitioner</p>	F000315	<p>F- 315: Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. What corrective actions have been accomplished for those residents found to have been affected by the deficient practice: Resident J was assessed for any signs or symptoms of urinary tract infection on 7/9/13. No signs or symptoms of urinary tract infection were noted. Urine was noted to be clear, yellow without a strong odor. How the facility will identify other residents having the potential to be affected by the same deficient practice: All urine cultures were reviewed on 7/10/13 that were obtained in the last 30 days for active residents, any deficiencies noted were corrected at this</p>	07/15/2013			

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	<p>on 6/19/13. The Progress Note indicated the resident was admitted to the facility after a hospitalization for dehydration. The Review of Systems section indicated the resident had a fever. The Abnormal/Pertinent Findings section indicated the Nurse reported the resident had a temperature of 99 degrees in the evening. The Assessment/Plan was to obtain a urinalysis test to rule out a urinary tract infection.</p> <p>A Physician Progress Note was completed by the Nurse Practitioner on 6/24/13. The Progress Note indicated the urine culture was positive for a urinary tract infection. The Assessment/Plan was to initiate Levaquin (an antibiotic) 250 milligrams once a day for one week.</p> <p>The June 2013 Physician orders were reviewed. An order was written on 6/19/13 for a urinalysis laboratory test to be completed. There was another order written on 6/24/13 for the resident to receive Levaquin 250 milligrams by mouth once a day for one week.</p> <p>The 6/2013 Medication Administration Record was reviewed. The first dose of the Levaquin was administered on 6/24/13.</p>		<p>time. Measures the facility will take to ensure that the problem will be corrected and will not recur: Licensed nurses will be re-inserviced by DHS or designee related to notification of laboratory results by 7/11/13. DHS or designee will audit labs daily using audit tool A. The DHS or designee will report findings to QA&A monthly for 6 months or 100% compliance is obtained.</p> <p>Quality assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: QA&A will monitor monthly for trends and make recommendations to the plan of correction as needed. QA&A will monitor for 6 months or until 100% compliance is met.</p>		

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	<p>Review of the 6/2013 laboratory test results indicated a urine specimen was collected on 6/20/13. The final results indicated the culture was positive for enterococcus species (an organism indicating an infection) greater then 100,000 cfu/ml. The laboratory test results indicated the above results were faxed to the facility on 6/22/13.</p> <p>Review of the 6/22/13 and 6/23/13 Nurses' Notes and Skilled Nursing Assessment and Data Collection documentation indicted there was no documentation of the Physician being notified of the urine culture results on 6/22/13 or 6/23/13.</p> <p>When interviewed on 7/1/13 at 3:30 p.m., the Director of Nursing indicated the Physician should have been notified on 6/22/13 when the final results of the positive urine culture were faxed to the facility. The Director of Nursing indicated the results were faxed on the weekend and the Nurse Practitioner was not notified until Monday 6/24/13.</p> <p>This federal tag relates to Complaint IN00131446.</p> <p>3.1-41(a)(2)</p>						

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F000323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure adequate supervision was provided to prevent accidents and hazards related to staff not utilizing the required assistance during a transfer resulting in the resident being sent to the hospital Emergency Room and receiving staples to a laceration on the leg. (Resident #B) (CNA #1) The facility also failed to ensure open spaces in between bars of side rails were no larger than the recommended dimension to prevent possible injury for 1 of 1 resident observed with large openings in the side rails in the sample of 8. (Resident #H) Findings include:</p> <p>1. On 7/1/13 at 1:51 p.m., Resident #B was observed in bed. The resident's bed was in the low position and side rails on each side of the bed were padded with cushions.</p>	F000323	<p>F-323: Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. What corrective actions have been accomplished for those residents found to have been affected by the deficient practice: Bed for resident H was changed out on 7/1/13. Transfer assessment form was updated for resident B on 7/9/13 and no changes to plan of care was needed at this time. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents residing in the facility were assessed on 6/14/13 using a transfer assessment form to ensure all residents were being transferred correctly per their ability. Any deficiencies noted were corrected at that time. All beds in facility were assessed by maintenance director for compliance with side rails by 7/15/13 and any deficiencies noted was corrected at this</p>	07/16/2013			

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	<p>The record for Resident #B was reviewed on 7/1/13 at 1:00 p.m. The resident's diagnoses included, but were not limited to, dementia, high blood pressure, congestive heart failure, and osteoarthritis.</p> <p>An "Incident/Accident Investigation" dated 6/7/13 at 1:10 a.m., indicated the LPN was called to the resident's room by a CNA and the CNA stated the resident had received a skin tear when the resident's left leg hit the side rail during a transfer. A 8.5 cm (centimeter) x 10 cm laceration was noted on the resident's left calf. Steri strips (thin bandage strips) were applied to hold the wound together and to stop the bleeding. The Physician was notified and new orders were obtained to send the resident to the hospital for an evaluation and treatment.</p> <p>The 6/2013 Nurses' Notes were reviewed. An entry made on 6/7/13 at 2:00 a.m. indicated a laceration was noted on the resident's left calf area and steri strips and a dressing were applied to hold the wound together and to control the bleeding. The Physician was notified and orders were received to transfer the resident to the hospital Emergency Room for</p>		<p>time. Certified nursing assistants will be re-inserviced by 7/11/13 by Restorative Nurse. The assesment was initiated after the residents event on 6/7/13 for the safety of all residents. Measures the facility will take to ensure that the problem will be corrected and will not recur: DHS or designee regarding use and reading of C.N.A. care cards and return demonstration on transfers. DHS or designee will use audit tool B to monitor 2 C.N.A.'s 3 times a week on different shifts and will report findings to QA&A monthly for 6 months or until 100% compliance. Maintenance director or designee will audit any new beds brought into facility and will report findings to QA&A monthly for 3 months. Measures the facility will take to ensure that the problem will be corrected and will not recur: QA&A will monitor monthly for trends and make recommendations to the plan of correction as needed. QA&A will monitor for 6 months or until 100% compliance is met.</p> <p>INFORMAL DISPUTE RESOLUTIONF 323- FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVI CESSURVEY DATE: 07/01/2013 The Facility certainly understands and appreciates the Surveyors' and Resident B's family underlying concerns that Resident B sustained a skin tear</p>				

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	<p>an evaluation and treatment. An entry made on 6/7/13 at 6:00 a.m. indicated the resident returned from the hospital Emergency Room at 4:30 a.m. The entry indicated the resident was assessed with 26 staples noted to the calf.</p> <p>The 4/17/13 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (3). This indicated the resident's cognitive patterns were severely impaired. The MDS assessment also indicated the resident required extensive assistance (resident involved in activity with staff providing weight-bearing support) of two or more persons for transfers. The MDS assessment also indicated the resident's balance in moving from a seated position to a standing position was not steady and the resident was only able to stabilize with the assistance of staff. The MDS assessment also indicated the resident demonstrated impairment in functional range of motion on both lower extremities.</p> <p>The resident's current care plans were reviewed. A care plan initiated on 12/3/12 and last updated with a goal date of 7/30/13 indicated the</p>		<p>during a bed transfer and concerns of Resident H's gap between the mattress and side rail. The Facility asks the ISDH reviewer to examine the facts of both situations and the actual federal regulation in deciding whether the Facility should receive a Tag under F323, and the attached level in scope and severity of 'G'. The Facility asks the ISDH reviewer to keep the following points in mind while deciding this IDR. Resident B's Assessments and necessary tools were in place, as evidence by:</p> <ul style="list-style-type: none"> · All residents residing in the facility had correct transfer assessment to ensure all residents were being transferred correctly per their ability.(exhibit M) · The facility identified hazards and risks, implemented interventions to reduce hazards and risks and monitored effectiveness and modified interventions as necessary. (exhibit L) · MDS and Care Cards were all current and correct, (exhibit K1 and K2) · Systems were in place to effectively communicate information identifying resident specific information. <p>Individualized plans of care were developed to address resident needs and goals were conveyed to the staff. (exhibit J)</p> <p>Furthermore, the Facility provided the orientation and tools to CNA #1 to be able to provide safe resident care as evidenced</p>		

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	<p>resident had a ADL (Activities of Daily Living) self-care deficit. The care plan indicated the resident needed assistance or was dependent for bed mobility and transfers.</p> <p>When interviewed on 7/1/13 at 2:10 p.m., the Unit Manager indicated the resident received a laceration to the leg during a transfer on 6/7/13. The Unit Manager indicated she initiated an investigation of the injury and the CNA (CNA #1) who transferred the resident was interviewed. The CNA indicated she transferred the resident by herself without the assistance of another staff member or the use of a gait belt (a strap secured around the resident waist to assist in transferring a resident). The Unit Manager indicated the resident's transfer status was for the resident to be transferred with the assistance of two staff members. The Unit Manager indicated the CNA Care Card (written document which included information and instructions on the care for each resident) at the time indicated the resident was to be transferred by two staff members. The Unit Manager indicated CNA #1 was terminated after the investigation related to transferring the resident by herself.</p>		<p>by: Ø Staff member had been oriented on:1. March 26, 2013: Job description (EXHIBIT A) 2. March 26, 2013: Guidelines for Gait belt usage (EXHIBITB)3. March 28, 2013: Educated on transferring, repositioning and lifting residents safely (EXHIBIT C)4. May 10, 2013 she had completed job specific competency check (EXHIBIT D)5. June 1, 2013 had counseling (EXHIBIT E) on transfers and following resident care card. This was in accordance with disciplinary action as documented in EXHIBIT F.6. Also CNA #1 was supervised by Charge nurses who are "provide clinical supervision of patient care staff working with residents assigned on your unit to provide direct care." EXHIBITS G and H. The skin tear was not the result of the Facility's action or lack of action. CNA#1 acted in contradiction to all of her training. She furthermore acknowledged that she did not follow the directions provided. The Facility had and continues to have proper systems in place. The facility did not fail to provide adequate supervision nor assistive devices to keep the resident free of accident hazards as possible. Resident H did not incur an injury or was not at risk for entrapment while in bed. As per the State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care</p>		

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	<p>2. During Orientation Tour on 7/1/13 at 8:34 a.m., Resident #H was observed in bed. The resident was awake. The side rails on the both side of the upper part of the resident's bed were in the up position. There was no padding or covering on either of the side rails. One of the open gap areas between a section of the bars on the side rails appeared to be approximately 5 inches by 5 inches.</p> <p>On 7/1/13 at 10:50 a.m., the Maintenance Director measured the above area on the bed side rails. The open gap measured 7 inches across and 7 1/2 inches high.</p> <p>The record for Resident #H was reviewed on 7/1/13 at 3:15 p.m. The resident's diagnoses included, but were not limited to, multiple sclerosis, diabetes mellitus, renal failure, and depression. The 6/17/13 Monthly Summary indicated the resident utilized two half bed rails. The Monthly Summary did not indicate if the rails were used as an enablers. The 5/9/13 Minimum Data Set (MDS) quarterly assessment indicated the resident BIMS (Brief Interview for Mental Status) score was (15). This score indicated the resident's cognitive patterns were not impaired. The assessment also indicated the</p>		<p>Facilities, page, 291, "In 1995, the FDA issued a Safety Alert entitled "Entrapment Hazards with Hospital Bed Side Rails."18 Residents most at risk for entrapment Thank you for your consideration in this review. are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc. that may cause them to move about the bed or try to exit from the bed." (Exhibit I) Resident H is Alert and Oriented, with a Brief Interview for Mental Status Score of 15, indicating that Resident H's cognitive patterns were not impaired. (exhibit N) Furthermore, Resident H had limited mobility while in bed without assistance and therefore was not at risk for entrapment. (exhibit O) The surveyor did observe that one of the open gap areas between sections of the bars on the side rail <u>OF ONE BED</u> appeared to be approximately 5 inches by 5 inches. The guideline does recommend that the gap should be less than 4 ¾ inches. Facility does acknowledge that the gap is larger than the recommended measurement. However, it has been confirmed as well that <i>Resident H</i> has been using the same bed for quite a long period of time, a bed that was provided by the state, and there has been no reported incidents of the</p>				

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	<p>resident required extensive assistance (resident involved in activity with staff providing weight-bearing support) of two or more persons for bed mobility and transfers.</p> <p>When interviewed at this time, the Maintenance Director indicated the resident's bed was a specialty bed and not the facility's bed. The Maintenance Director indicated there were no other beds of this type in the building.</p> <p>When interviewed on 7/1/13 at 11:30 a.m. the facility Administrator indicated the open area on the bed side rails was larger then the recommended measurement and the Maintenance Director was now replacing the resident's bed and mattress and the other bed was to be removed from the facility.</p> <p>When interviewed on 7/1/13 at 11:15 a.m., the Director of Nursing indicated the resident had the bed and mattress for a long time. The Director of Nursing indicated there had been no reported incidents of the resident sustaining any injury related to the use of this bed or side rails.</p> <p>The 3/10/2006 FDA (Food and Drug</p>		<p>resident sustaining any injury related to the use of this bed or side rail. Also, resident H had limited mobility in bed without assistance and therefore was not at risk for entrapment. There is no evidence that an actual harm occurred to be cited at a 'G' level. The Facility therefore suggests that no violation of F323 occurred, and that if the ISDH reviewer believes that some level of violation is appropriate, then the scope and severity should be below that of a level G.</p>		

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	<p>Administration) "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" indicated the space between bars of bed side rails were recommended to be less than 4 3/4 inches.</p> <p>The facility policy titled "Guidelines For The Use of Side Rails" was reviewed on 7/1/13 at 10:35 a.m. There was no date on the policy. The Director of Nursing provided the policy and identified the policy as current. The policy indicated "an assessment will be made using the Admission/Monthly or Skilled Nursing Assessment data to determine the resident's symptoms or reason for using the side rails." The policy also indicated "when side rail usage is appropriate, the facility will assess the space between the mattress and the side rails to reduce the risk for entrapment."</p> <p>This federal tag relates to Complaint IN00131446.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>						

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NAME OF PROVIDER OR SUPPLIER ARBORS AT MICHIGAN CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360
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F000465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview the facility failed to provide a sanitary and comfortable environment related to wet floor carpeting observed during a brief environmental tour in 1 of 2 resident rooms observed for wet carpeting. (Room 312)</p> <p>Findings include:</p> <p>During an Environmental tour on 7/1/13 at 11:00 a.m. the following was observed: The carpeting under and in front of the wall register was wet in Room #312. The wet area was approximately 3 feet x 2 feet and extended out in front of the register. The carpeting under the window sill and extending under the resident's bed was wet. The area was approximately 4 1/2 feet x 2 feet.</p> <p>When interviewed at this time, the Maintenance Director stated there had been a broken pipe in the vent which caused the leak. The Maintenance Director indicated he had been informed of the area last</p>	F000465	<p>F-465: Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. What corrective actions have been accomplished for those residents found to have been affected by the deficient practice: Room 312 has been thoroughly cleaned and equipment repaired to prevent further leakage by maintenance on 7/2/13. How the facility will identify other residents having the potential to be affected by the same deficient practice: All resident rooms have been checked by maintenance and housekeeping for potential leaks and none have been found. Measures the facility will take to ensure that the problem will be corrected and will not recur: Housekeeping on cleaning a room checks for any potential issues and reports them through maintenance work orders at nurses station or time clocks and they are given to maintenance to handle as soon as possible. Also, Maintenance is available 24/7 for</p>	07/15/2013

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	<p>week and the condensation drain piece was broken and this resulted in the wet carpet. The Maintenance Director stated the residents had been moved out of the room at that time due to this and other concerns with insects on the register and window sill and both residents had since been moved back into their room.</p> <p>When interviewed on 7/1/13 at 11:45 a.m., the Maintenance Director indicated the leaking register was first reported around 6/24/13 and a hose had to be replaced in the register. The Maintainece Director stated he last checked the resident's room on Friday 6/28/13 and did not recall the carpet being wet.</p> <p>When interviewed on 7/1/13 at 12:30 p.m., the Maintenance Director indicated the two residents in Room 312 were again being temporarily moved out of the room for cleaning and repairing.</p> <p>This federal tag relates to Complaint IN00131446.</p> <p>3.1-19(f)</p>		<p>any other issues. Quality assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Maintenance does weekly rounds of rooms to check for potential issues and will report findings in monthly QA report of any trends and potential issues throughout the campus. Completion Date: 7/15/13</p>		

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F000469 SS=D	<p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM</p> <p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>Based on observation and interview the facility failed to ensure the facility remained free of pest related to insects observed on the window sill and long a ledge under the window sill in 1 resident room on 1 of 4 resident units. (The 300 Hall- Room 312)</p> <p>Findings include:</p> <p>On 7/1/13 at 11:00 a.m., there was an accumulation of dead and moving small bug appearing insects noted along the window sill and along the ledge under the window sill in Room #312. The resident's bed was positioned directly parallel along the length of the window sill. The resident was not in the bed at this time. There were no insects observed on the resident's bed linens or on the bed frame. The Maintenance Director and the Housekeeping Director were present at this time.</p> <p>Review of the 6/2013 Resident Concern forms indicated a Concern Form was completed on Sunday</p>	F000469	<p>F-469: Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.</p> <p>What corrective actions have been accomplished for those residents found to have been affected by the deficient practice: Exterminator was called in on 7/1/13 and again came back on 7/5/13 and did room and exterior of building.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice: Any room with pest a report is made to maintenance and a work order is filled out and given to maintenance.</p> <p>Measures the facility will take to ensure that the problem will be corrected and will not recur: Housekeeping and staff look and report any pest issue to maintenance through the maintenance work orders and exterminator is called out if</p>	07/15/2013	

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	<p>6/23/13. The Concern Form indicated concerns were reported related to bugs on the window sill and an air conditioner leaking in Room 312. The Concern Form indicated the two residents were moved to new temporary rooms at this time until the air conditioner could be fixed and pest control called to spray the room. The Concern Form indicated the room was cleaned on 6/24/13 and the Pest Control company was called out to spray the room.</p> <p>When interviewed at this time, the Maintenance Director indicated the Pest Control company had been called and came to the facility on 6/24/13 related to concerns with the insects in this room. The Maintenance Director indicated the company sprayed the exterior for the gnats. The Maintenance Director indicated it was felt the insects were related to the moisture on the floor from the wall register. The Maintenance Director indicated the Pest Control company did not leave an invoice of the work performed.</p> <p>When interviewed on 7/1/13 at 11:45 a.m., the Maintenance Director indicated he was aware of the insects on 6/24/13 and the residents had been moved out of the room at that</p>		<p>necessary.</p> <p>Quality assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Maintenance will report at monthly meeting all findings and corrections made to alleviate any issues for that specific month.</p>		

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	<p>time. The Maintenance Director indicated he was in room last on Friday 6/28/13 and had not noticed any insects.</p> <p>This federal tag relates to Complaint IN00131446.</p> <p>3.1-19(f)(4)</p>			

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F000505 SS=D	<p>483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. Based on record review and interview, the facility failed to ensure the Physician was notified of abnormal urine culture laboratory test results in a timely manner for 1 of 3 residents reviewed for urinary tract infections in the sample of 8. (Resident #J)</p> <p>Findings include:</p> <p>The record for Resident #J was reviewed on 7/1/13 at 3:18 p.m. The resident's diagnoses included, but were not limited to, high blood pressure and a history of malignant neoplasm of the prostate.</p> <p>The July 2013 Physician orders were reviewed. An order was written on 6/19/13 for a urinalysis laboratory test to be completed. There was another order written on 6/24/13 for the resident to receive Levaquin (an antibiotic) 350 milligrams by mouth once a day for one week.</p> <p>The 6/2013 Medication Administration Record was reviewed. The first dose of the Levaquin was administered on 6/24/13.</p>	F000505	<p>F-505: Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. What corrective actions have been accomplished for those residents found to have been affected by the deficient practice: 1. Resident J was assessed for any signs or symptoms of urinary tract infection on 7/9/13. No signs or symptoms of urinary tract infection were noted. Urine was noted to be clear, yellow without a strong odor. How the facility will identify other residents having the potential to be affected by the same deficient practice: 2. All urine cultures were reviewed on 7/10/13 that were obtained in the last 30 days for active residents, any deficiencies noted were corrected at this time. Measures the facility will take to ensure that the problem will be corrected and will not recur: 3. Licensed nurses will be re-inserviced by DHS or designee related to notification of laboratory results by 7/11/13. DHS or designee will audit labs daily</p>	07/15/2013	

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	<p>Review of the 6/2013 laboratory test results indicated a urine specimen was collected on 6/20/13. The final results indicated the culture was positive for enterococcus species (organism indicating an infection) greater then 100,000 cfu/ml. The laboratory test results indicated the above results were faxed to the facility on 6/22/13.</p> <p>Review of the 6/22/13 and 6/23/13 Nurses' Notes and Skilled Nursing Assessment and Data Collection documentation indicted there was no documentation of the Physician being notified of the urine culture results on 6/22/13 or 6/23/13.</p> <p>When interviewed on 7/1/13 at 3:30 p.m., the Director of Nursing indicated the Physician should have been notified on 6/22/13 when the final results of the positive urine culture were faxed to the facility. The Director of Nursing indicated the results were faxed on the weekend and the Nurse Practitioner was not notified until Monday 6/24/13.</p> <p>The facility policy titled "Physician Notification Guidelines" was reviewed on 7/1/13 at 10:00 a.m. The policy was dated 12/06/2007. The Director</p>		<p>using audit tool A. The DHS or designee will report findings to QA&A monthly for 6 months or 100% compliance. Quality assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent:</p> <p>4. QA&A will monitor monthly for trends and make recommendations to the plan of correction as needed. QA&A will monitor for 6 months or until 100% compliance is met.</p>				

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	<p>of Nursing indicated the policy was current. The policy indicated the Physician was to be notified of all diagnostic testing results in a timely manner. The policy also indicated the Physician was to be notified of critical lab results by phone as soon as the results are known. The policy indicated other test results could be faxed to the Physician's office during office hours. The policy also indicated during non-office hours the Nurse was to notify the Physician of abnormal results by phone.</p> <p>This federal tag relates to Complainant IN00131446.</p> <p>3.1-49(f)(2)</p>			