

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2014
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NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
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F000000	<p>This visit was for the Investigation of Complaints IN00148234 and IN00148316.</p> <p>Complaint IN00148234- Substantiated. Federal/State deficiency related to the allegation is cited at F323.</p> <p>Complaint IN00148316- Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F315, F323, and F505.</p> <p>Survey dates: May 1 & 2, 2014</p> <p>Facility number: 010758 Provider number: 155662 AIM number: 200229550</p> <p>Survey team: Janet Adams, RN-TC Yolanda Love, RN (May 2, 2014)</p> <p>Census bed type: SNF: 93 SNF/NF: 16 Total: 109</p> <p>Census payor type: Medicare: 36</p>	F000000	<p>Preparation and/or execution of the plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement of Nursing Care at Hartsfield Village of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal laws. It is the intention of this facility that this plan of correction serves as the facility's credible allegation of compliance with all regulatory guidelines.</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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F000157 SS=D	<p>Medicaid: 8 Other: 65 Total: 109</p> <p>Sample: 8</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 8, 2014, by Janelyn Kulik, RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal</p>			

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	<p>representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify the resident's family member of a fall for 1 of 4 residents reviewed for falls in the sample of 8. (Resident #G)</p> <p>Findings included:</p> <p>The closed record for Resident #G was reviewed on 5/1/14 at 9:38 a.m. The resident's diagnoses included, but were not limited to, senile dementia, urinary tract infection, chronic kidney disease, depressive disorder, congestive heart failure, and diabetes mellitus. The resident was admitted to the facility on 2/14/14.</p> <p>The 2/20/14 Minimum Data Set (MDS) Admission Assessment indicated the resident's cognitive skills for decision making were moderately impaired. The assessment indicated the resident required extensive assistance of two staff</p>	F000157	<p>1 Corrections for previous timeframes cannot be made. Resident G no longer resides in the facility. 2 A list of residents with falls over the last 30 days was compiled and reviewed and no other residents were affected by this alleged deficient practice.3 Facility policy for Notification of Change in Condition was reviewed along with F157. The LPN responsible for notification of Resident G's responsible party was counseled for failure to follow the facility policy. In-service education was conducted for the nurses 5-13-14 through 5-15-14 and ongoing to review the policy and expectations for family notification following falls and/or change of condition. The form entitled, "Physician/Family Notification Needs" (attachment#1) will be kept hanging on a clipboard near the phones at all nurses stations to alert nurses and/or administration to follow up on messaged left with the physician/family. Nurses will be responsible for documenting each</p>	05/16/2014			

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	<p>members for bed mobility, transfers, dressing, toileting, and personal hygiene.</p> <p>A Fall Risk assessment was completed on 3/14/14. The assessment indicated the resident's score was (18). A score of (18) indicated the resident was at risk for falls. The assessment also indicated the resident had poor safety awareness and a history of falls.</p> <p>A Safety Event note completed on 4/12/14 was reviewed. The note indicated the resident was found face down on the floor and no visible injuries were noted. Neurological checks were completed with the Safety Event note.</p> <p>The 4/12/14 Nursing Progress Notes were reviewed. An entry made at 3:40 p.m. indicated the Nurse was receiving report from another Nurse and was informed by staff Resident #G was found face down on the floor. Upon entering the room three other Nurses were rolling the resident onto her back. The resident was unable to follow commands for active range of motion. The resident did not voice any pain when range of motion was done to her upper and lower extremities. The resident was assisted into bed via a Hoyer lift (a mechanical left device).</p> <p>The next entry was made on 4/12/14 at</p>		<p>attempt to notify the family per policy. 4 The DON/ADON/Designee will log each incident/event on a tool entitled "Event Compliance Tool" (attachment #2). This tool will be used to monitor compliance for timeliness of family notification. The data collected will be brought to DON weekly for review and quarterly to the QAPI committee for review and recommendations for continued monitoring needs.5 DON responsible for compliance 5-16-14</p>				

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	<p>4:20 p.m. This entry indicated the resident's Physician was paged. There was no documentation of any attempt to notify the resident's POA of the resident being found face down on the floor.</p> <p>The next entry was made on 4/12/14 at 4:50 p.m. This entry indicated the resident's POA (Power of Attorney) called and spoke with the Nurse to inquiry about the resident's general condition and was informed of the resident's fall without injury at this time. The entry indicated the POA stated she felt she should have been called immediately following the fall. The entry indicated the writer told the POA "she chose to wait until MD notification was made in case any new orders were received so that POA notification could be made at the same time as fall notification." The entry also indicated the POA stated she would be in facility to check on the resident.</p> <p>An entry made on 4/12/14 at 5:20 p.m. This entry indicated the resident's daughter came to the Nurses' Station and requested that another assessment be done on her mother. The Nurse and another fellow Nurse entered the resident's room and noted the resident had bruises to both sides of her face and an abrasion to the left lower wrist. The</p>			

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	<p>Physician was called and orders were obtained to send the resident to the hospital.</p> <p>When interviewed on 5/2/14 at 9:20 a.m., the Director of Nursing indicated no one called the Resident's daughter to inform her of the fall until the daughter called the facility to check on her Mother's status. The Director of Nursing indicated attempts should have been made to notify the resident's daughter before she called in to the facility.</p> <p>The facility policy titled "Notification of Resident Change In Condition Policy" was reviewed on 5/1/14 at 9:10 a.m. The facility Administrator provided the policy and identified the policy as current. There was no date on the policy. The policy indicated the facility was to promptly notify the resident, their legal representatives or family of changes in the resident's health condition and of any accident involving the resident which had the potential for or actual injury.</p> <p>This Federal tag relates to Complaint IN00148316.</p> <p>3.1-5(a)(1)</p>			

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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 urinary tract Infections were treated promptly related to the lack of notifying the Physician of Culture and Sensitivity laboratory test results in a timely manner for 2 of 3 residents reviewed for urinary tract infections in the sample of 14. (Residents #G and #J)</p> <p>Findings include:</p> <p>1. The closed record for Resident #G was reviewed on 5/1/14 at 9:38 a.m. The resident's diagnoses included, but were not limited to, senile dementia, urinary tract infection, chronic kidney disease, depressive disorder, congestive heart failure, and diabetes mellitus. The resident was admitted to the facility from</p>	F000315	<p>1 Corrections for previous timeframes cannot be made for residents G and J. Resident G no longer resides in the facility. Resident J remains a resident of the facility.2 All residents could have been affected by this alleged deficient practice. A list of all residents with order for cultures in the last 30 days was compiled and reviewed to assure that no other residents were affected. No other residents were affected by this alleged deficient practice.3 The Culture policy was reviewed with the Infection Control Nurse and the responsibility was established for daily review and supervision of culture results 5 times per week. An In-Service was conducted for the nurses on 5-13-14 through 5-15-14 and ongoing to review the Culture Policy as well as F315 in relation to timely notification of</p>	05/16/2014

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	<p>the hospital on 2/14/14.</p> <p>The 2/20/14 Minimum Data Set (MDS) Admission Assessment indicated the resident's cognitive skills for decision making were moderately impaired. The assessment indicated the resident required extensive assistance of two staff members for bed mobility, transfers, dressing, toileting, and personal hygiene. The assessment also indicated the resident was occasionally incontinent of bowel and bladder.</p> <p>The 3/2014 Nursing Progress Notes were reviewed. An entry made on 3/3/14 at 10:06 a.m. indicated the CNA and Nurses documentation indicated the resident had an increase in incontinence and was now frequently incontinent of bladder. An entry made on 3/3/14 at 1:33 p.m. indicated the resident's urine was noted to be cloudy when she was toileted during the shift. The resident had no complaints of pain. An entry made on 3/3/14 at 1:40 p.m. indicated the Physician was notified of the cloudy urine and orders were obtained for a UA (Urinalysis) with a reflex Culture to be obtained via straight catheterization.</p> <p>An entry made on 3/4/14 at 6:00 a.m. indicated a clean catch urine specimen was obtained. The resident's urine was</p>		<p>the physician of culture and sensitivity laboratory results. The nurses will be responsible to contact the Physician upon receipt of the culture results. If unable to reach the Physician, the Alternate Physician/Medical Director will be contacted with culture and sensitivity results to assure timely treatment. A review of the Laboratory Care Evolve Computer system was done to assure that the nurses knew the procedure to check daily every shift for results of cultures. A meeting was held with the MCH laboratory representative on 5-8-14 in regard to auto print for the Care Evolve system to discuss Quality Measures to monitor that the culture results would be sent immediately as the results were available. All lab computers were checked and auto print was working properly as of 5-12-14 4</p> <p>The Infection Control Nurse/Designee will review all resident records daily 5 times per week and log all orders for cultures using the Tool entitled, "Diagnostic Services-Quality Data Collection Form" (attachment #3). We will then monitor the Care Evolve Computer system daily to retrieve results. The nurses will be responsible for Physician notification to assure timely resident treatment. The Data collection forms will be brought to the DON weekly for review and Quarterly to the QAPI</p>		

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	<p>concentrated and cloudy yellow with malodor. An entry made on 3/5/14 at 11:20 a.m. indicated the Physician was notified of the UA results and orders were received to start Cefitin (an antibiotic) 250 milligrams twice a day for one week. There was no documentation related to obtaining the culture & sensitivity results in the Nursing Progress notes from 3/6/14 thru 3/9/14. An entry made on 3/10/14 at 2:00 p.m. indicated the Nurse spoke with the Physician regarding the UA C&S (culture and sensitivity) results and new orders were received to change the resident's antibiotic to Bactrim DS one tablet twice a day for one week.</p> <p>The 2/14/14 Physician orders indicated the resident was admitted with orders to receive Cephalexin (an antibiotic) 250 milligrams every 12 hours for (5) days for the treatment of an UTI (Urinary Tract Infection).</p> <p>The 3/2014 Physician orders were reviewed. An order was written on 3/3/14 for UA (urinalysis) with culture to be obtained. The order also indicated staff may straight cath (catheterize) the resident to obtain the urinalysis specimen. An order was written on 3/5/14 for the resident to receive Cefitin (a Cephalosporin antibiotic) 250</p>		Committee for review and recommendations for continued monitoring needs.5 DON responsible for compliance 5-16-14				

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	<p>milligrams twice a day for one week for a diagnosis of UTI. An order was written on 3/10/14 to discontinue the Ceftin and start Bactrim DS (a Sulfonamide antibiotic) one tablet twice a day for 7 days.</p> <p>The resident's Laboratory tests were reviewed. A urinalysis was collected on 3/4/14 at 10:48 a.m. The specimen was received on 3/4/14 at 11:23 a.m. Results of the urinalysis were positive for 2+ bacteria (normal is negative), and white blood cells greater then 900 (normal is 0-3).</p> <p>Results of the Urine Culture & Sensitivity were completed on 3/6/14 at 9:09 a.m. The culture was positive for greater then 100, 000 cfu of Enterobacter species (an infection). The culture sensitivity noted the above bacterial organism was resistant to Ceftrazidime (a Cephalosporin antibiotic) and Cefrtixone (a Cephalosporin antibiotic). The culture sensitivity noted the above organism was sensitive to Trimethoprim/Sulfa (Bactrim- a Sulfur antibiotic). The above report was printed on 3/10/14 at 2:53 p.m.</p> <p>The 3/2014 MAR (Medication Administration Record) indicated the resident received Ceftin 250 milligram</p>				

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	<p>twice a day from 3/5/14 thru 9:00 a.m. on 3/10/14. The MAR also indicated the resident received the initial dose of Bactrim DS on 3/10/14 at 9:00 p.m.</p> <p>When interviewed on 5/1/14 at 2:55 p.m., the Infection Control Nurse indicated the Unit Mangers audit the laboratory results by reviewing the Physician orders and follow up to ensure the results were obtained. The Infection Control Nurse indicated staff Nurses were also to include any orders for lab tests on each 24 hour shift to shift report until all were completed. The Infection Control Nurse indicated the labs were run at the hospital and result pages get automatically printed at the Nurses' Station. The Infection Control Nurse indicated the "printed" date and time and the bottom of each results time was the time the hospital sends the results page to the facility. The Infection Control Nurse indicated she reviewed the 3/2014 24 hour reports and the tracking of the 3/4/14 UA and C&S appeared on the 24 hour report 3/4/14 and 3/5/14 and did not appear on the 24 hour report after that. The Infection Control Nurse indicated the facility should have called the laboratory themselves to obtain the cultures (listed as completed on 3/6/14) results since they were not received within 1-2 days after the UA results were received.</p>			

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	<p>2. The record for Resident #J was reviewed on 5/1/14 at 3:39 p.m. The resident's diagnoses included, but were not limited to, acute renal failure, congestive heart failure, dementia, and high blood pressure.</p> <p>A Physician's order was written on 2/28/14 to obtain a UA and C&S on 3/4/14 to recheck for a UTI (Urinary Tract infection). Another order was written on 3/7/14 for the resident to receive Amoxicillin (an antibiotic) 500 milligrams twice a day for 10 day to treat a UTI.</p> <p>The Laboratory test results were reviewed. A Urinalysis was collected on 3/4/14 at 5:05 a.m. The urine specimen was received in the lab on 3/4/14 at 7:41 a.m. The results of the Urinalysis were printed on 3/4/14 at 10:59 a.m. The results showed the WBC (white blood cell) count was 107(normal 0-3). The above results were signed by the Physician on 3/4/14 and the Physician wrote "await urine culture." The Culture & Sensitivity results report indicated the test results were completed on 3/6/14 at 7:17 a.m. This report had a printed date of 3/6/14 at 10:59 a.m. There was writing in the bottom of the above report</p>			

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	<p>which indicated the results were faxed to the Physician at 10:40 p.m.</p> <p>The 3/2014 Nursing Progress Notes were reviewed. An entry made on 3/7/14 at 10:22 p.m. indicated the Physician called in and gave orders for the resident to receive Amoxicillin (an antibiotic) 500 milligrams twice a day for 10 days. There was no documentation the Physician was contacted with the Culture and Sensitivity results between 3/6/14 at 10:59 a.m. and 3/7/14 at 10:22 p.m.</p> <p>When interviewed on 5/2/14 at 8:55 a.m., the Infection Control Nurse indicated the staff documented on the 3/7/14 24 hour shift report that they called the Physician twice on the day shift to inform her of the results and no return calls were obtained. The Infection Control Nurse also indicated the results were available on 3/6/14 and should have been called to or faxed to the Physician before 10:40 p.m. on 3/6/14. The Infection Control Nurse indicated the orders for the antibiotic were not obtained until 6:50 p.m. on 3/7/14.</p> <p>This Federal tag relates to Complaint IN00148316.</p> <p>3.1-41(a)(2)</p>				

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000323 SS=D	<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 an assessment was completed after a resident developed facial bruising after a fall for 1 of 4 residents reviewed for falls in the sample of 8. (Resident #G) The facility also failed to provide adequate supervision related to floor mats not in place and chair alarms not attached for 2 of 4 residents reviewed for falls in the sample of 8. (Residents #D and #F)</p> <p>Findings include:</p> <p>1. The closed record for Resident #G was reviewed on 5/1/14 at 9:38 a.m. The resident's diagnoses included, but were not limited to, senile dementia, urinary tract infection, chronic kidney disease, depressive disorder, congestive heart failure, and diabetes mellitus. The resident was admitted to the facility on</p>	F000323	<p>1 Corrections for previous timeframes cannot be made Resident G was sent to the hospital following the nurses assessment per family request on 4/12/14. Resident was admitted with a diagnosis of Hypokalemia. Upon notification of the concern with the placement of the floor mat the Unit Manager replaced the mat at bedside for Resident #F and continued to monitor to assure the mats were in place. Upon notification of the concern that the Personal safety alarm was unclipped for Resident #D, the Unit Manager replaced the alarm as ordered and continued to monitor to assure the alarm was in place. Both residents #F and #D remain residents of the facility. 2 All residents could have potentially been affected by this alleged deficient practice A 100% audit of the events with head injury in the last 30 days was conducted and no other residents were affected. 3 A 100% audit was conducted of the</p>	05/16/2014			

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	<p>2/14/14.</p> <p>The 2/20/14 Minimum Data Set (MDS) Admission Assessment indicated the resident's cognitive skills for decision making were moderately impaired. The assessment indicated the resident required extensive assistance of two staff members for bed mobility, transfers, dressing, toileting, and personal hygiene.</p> <p>A Fall Risk assessment was completed on 3/14/14. The assessment indicated the resident's score was (18). A score of (18) indicated the resident was at risk for falls. The assessment also indicated the resident had poor safety awareness and a history of falls.</p> <p>A Safety Event note completed on 4/12/14 was reviewed. The note indicated the resident was found face down on the floor and no visible injuries were noted. Neurological checks were completed once at the time the Safety Event note completed when the resident was first found on the floor at 3:40 p.m..</p> <p>The 4/12/14 Nursing Progress Notes were reviewed. An entry made at 3:40 p.m. indicated the Nurse was receiving report from another Nurse and was informed by another staff member that Resident #G was found face down on the</p>		<p>resident records for ordered safety devices and the C.N.A. assignment sheets and Nursing Report sheets were updated to reflect the plan of care. The policy for Accident/Incident and Neurological Assessment was reviewed. In-Service education has been provided to all nurses from 5-13-14 through 5-15-14 and ongoing to ensure understanding of the policy for assessment post injury and the supervision required related to safety devices ordered to help prevent injuries from falls. The LPN responsible for the 2nd assessment requested by the family was re-educated for in regard to further neurological assessment post new injury identification. The C.N.A.'s were re-educated regarding safety devices in place to prevent injuries in meetings held from 5-13-14 through 5-15-14 and ongoing. 4 All resident records will be reviewed daily 5 times per week by DON/ADON/Designee to ensure that a proper assessment is completed following an injury. All incidents/events will be logged on a tool entitled, "Event Compliance Tool." This audit tool will be used to review the compliance with our policy Accident/Incident in regard to resident assessment post injury. All resident records will be reviewed daily 5 times per week and new safety devices will be added to the</p>				

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	<p>floor. Upon entering the room three other Nurses were rolling the resident to her back. The resident was unable to follow commands for active range of motion. The resident did not voice any pain when range of motion was done to her upper and lower extremities. The resident was assisted into bed via a Hoyer lift(a mechanical left device).</p> <p>The next entry was made on 4/12/14 at 4:20 p.m. This entry indicated the resident's Physician was paged. There was no assessment of the resident's physical or neurological status in this entry.</p> <p>The next entry was made on 4/12/14 at 4:50 p.m. This entry indicated the resident's POA (Power of Attorney) called and spoke with the Nurse to inquiry about the resident's general condition and was informed of the resident's fall without injury at this time. The entry indicated the POA stated she felt she should have been called immediately following the fall. The entry indicated the writer told the POA "she chose to wait until MD notification was made in case any new orders were received so that POA notification could be made at the same time as fall notification." The entry also indicated the POA stated she would be in facility to</p>		<p>assignment sheets and report sheets for the front line staff to monitor throughout their shifts. DON/ADON/Designee will conduct random rounds 3 times per week for 4 weeks, then weekly for 6 months using the tool entitled "Resident Safety Devices-Quality Review Data Collection Form" (attachent # 4) to ensure that the safety devices are in place as ordered. The safety devices are monitored on all shifts. Results of these audits will be brought to DON weekly for review and to the QAPI committee quarterly for review and recommendations for continued monitoring needs. When we reach a threshold of 90% compliance with safety devices, ongoing monitoring will then remain with the nurses and aides with their routine rounds. 5 DON responsible for compliance 5-16-14</p>				

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	<p>check on the resident. There was no physical or neurological assessment of the resident documented in this entry.</p> <p>The next entry was made on 4/12/14 at 4:55 p.m. This entry indicated the Nurse found the resident with both legs hanging over the right side of the bed and the resident was tearing at her brief and was able to be redirected when observed during (2) hour rounds. The resident was repositioned, her brief was checked, and the resident's bed was in the lowest position. There was no other physical assessment or neurological assessment in this entry.</p> <p>The next entry was made on 4/12/14 at 4:58 p.m. This entry indicated the Physician was made aware of the resident's fall without "visible injury." No new orders were received. There was no physical assessment or neurological assessment in this entry.</p> <p>The next entry was made on 4/12/14 at 5:20 p.m. This entry indicated the resident's daughter came to the Nurses' Station and requested that another assessment be done on her mother. The Nurse and another fellow Nurse entered the resident's room and noted the resident had bruises to both sides of her face and an abrasion to the left lower wrist. The</p>			

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	<p>Physician was called and orders were obtained to send the resident to the hospital. There was no documentation of any assessment of the resident's neurological status or any Neurological checks being completed at this time.</p> <p>The next entries were made on 4/12/14 at 6:00 p.m. and 6:05 p.m. There were no physical or neurological assessment of the resident in these entries. There was no documentation of any Neurological checks being completed at these times.</p> <p>The next entry was made on 4/12/14 at 6:48 p.m. This entry indicated the report was give to the hospital Emergency Room Nurse at this time. There was no physical or neurological assessment of the resident noted in this entry. There was no documentation of any Neurological checks being completed at this time.</p> <p>The next entry was made on 4/12/14 at 7:00 p.m. This entry indicated the resident exited the facility on a stretcher for transport to the hospital Emergency Room. There was no physical or neurological assessment of the resident noted in this entry. There was no documentation of any Neurological checks being completed at this time.</p>						

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	<p>The next entry was made on 4/12/14 at 11:23 p.m. This entry indicated the hospital Emergency Room Nurse was called and reported the resident was being admitted to the hospital.</p> <p>When interviewed on 5/2/13 at 9:20 a.m. the Director of Nursing indicated Resident #G was found face down on the floor in her room on 4/12/14. The Director of Nursing indicated Event charting done at the time of the fall indicated the resident had no injuries and neurological checks completed at that time were normal. The Director of Nursing indicated the facility protocol related to follow up after a fall with no injury was to assess the resident every shift for 24 hours. The Director of Nursing indicated no Neurological checks were completed at the time staff observed bruising to the resident's face. The Director of Nursing indicated she would have expected Neurological checks for be done when Nursing staff observed the resident with the bruising on the face. The Director of Nursing indicated no Neurological checks were noted in the Nursing Progress notes after the resident was noted with bruises to her face after being found face down on the floor.</p>			

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	<p>2. On 5/1/14 at 10:26 a.m., Resident #F was observed in bed. The resident was awake. There were no staff members or visitors in the resident's room at this time. There was a mat on the floor on the right side of the resident's bed. There was no mat in place on the floor on the left side (side closest to the room door) of the resident's bed. A mat was resting on it's side propped up along the foot board of the bed.</p> <p>On 5/1/14 at 11:10 a.m., the resident's room door was closed completely. Upon entering the resident's room with his permission, the resident was observed in bed. There were no staff members or visitors in the resident's room at this time. The two floor mats remained in the same positions as above. No floor mat was in place on the left side of the resident's bed.</p> <p>The record for Resident #F was reviewed on 5/1/14 at 2:00 p.m. The resident's diagnoses included, but were not limited to, dementia, high blood pressure, depression, and history of a fall.</p> <p>The 2/14/14 Minimum Data Set (MDS) Admission Assessment indicated the resident refused to answer questions for a BIMS (Brief Interview for Mental Status) to be completed. The assessment indicated the resident required extensive</p>			

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	<p>assistance of one staff member for bed mobility and personal hygiene, and had only transferred out of bed 1-2 times during MDS observation assessment period.</p> <p>A Fall Risk Assessment was completed on 2/13/14. This assessment indicates the resident was at high risk for falls as the resident did not ambulate and had poor safety awareness.</p> <p>The resident's current care plans were reviewed. A care plan initiated on 2/14/14 indicated the resident was at risk for falls related to a history of falls and the daily use of an antidepressant medication. Care plan interventions included for the resident's bed to be in lowest position, mats to be at the bedside, and a bolster sheet to be in place on the bed.</p> <p>Review of the 5/2014 Treatment Record indicated bilateral floor mats were to be in place starting 4/17/14 and a Bolster sheet was to be in place to the bed starting 2/14/14.</p> <p>Review of a 4/11/14 Safety Event note indicated the resident had a fall on 4/11/14 at 10:55 p.m. The fall occurred in the resident's room and was not witnessed. The resident had no injuries</p>			

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	<p>from the fall.</p> <p>The 4/11/14 Nursing Progress Notes were reviewed. An entry made at 11:02 p.m. indicated the resident was found on the floor. The resident stated he was trying to get up to go the bathroom and he "crawled out of bed."</p> <p>Review of a 4/14/14 Safety Event note indicated the resident was found on the floor in his room on 4/14/14 at 12:30 a.m. The note indicated the resident had been in bed resting just prior to the fall. The note also indicated the resident sustained an abrasion at this time.</p> <p>The 4/14/14 Nursing Progress Notes were reviewed. An entry made at 12:30 a.m. indicated the resident was observed on his buttocks on the floor mat next to his bed. Three pink abrasions were noted. One abrasion was noted to the resident's left knee and two abrasions were noted to his left outer ankle.</p> <p>The 4/17/14 Nursing Progress Notes were reviewed. An entry made at 12:02 p.m. indicated the Fall Committee met related to the resident's 4/11/14 and 4/14/14 falls. The entry indicated the resident had no injury from the 4/11/14 fall and had three abrasions from the 4/14/14 fall. The entry also indicated</p>			

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	<p>both of the above falls were out of the bed and the Bolster sheet was not in place at the time of both of the falls.</p> <p>When interviewed on 5/2/14 at 11:30 a.m., the second floor Unit Manager indicated Resident #F was to have bilateral floor mats in place while in bed.</p> <p>3. On 5/1/14 at 9:20 a.m. and 10:19 a.m., Resident #D was observed sitting in a wheel chair in the hallway. There was an alarm box attached to the back of the resident's wheel chair. There was a cord with a clip at the end of it attached to the box. The cord was hanging down and the clip was not attached to the resident or her clothing.</p> <p>The record for Resident #D was reviewed on 5/1/14 at 11:26 a.m. The resident's diagnoses included, but were not limited to, a history of a fall and a hip fracture, dementia, osteoporosis, anemia, and depressive disorder.</p> <p>Review of the 4/10/14 Minimum Data Set (MDS) Annual Assessment indicated the BIMS (Brief Interview for Mental Status) was (4). A score of (4) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required limited assistance of one staff member for bed</p>			

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	<p>mobility and transfers.</p> <p>The 4/10/14 Fall Risk Assessment indicated the resident's score was (17). A score of (17) indicated the resident was at risk for falls.</p> <p>The 4/22/14 Nursing Progress Notes were reviewed. An entry made on 4/22/14 at 4:15 p.m. indicated the resident returned from the hospital via ambulance. The resident had no complaints of pain. An entry made on 4/22/14 at 4:28 p.m. indicated the Physician was paged to notify him of the resident's return to the facility. An entry made on 4/22/14 at 5:35 p.m., indicated the resident was found on the floor. The resident was on her stomach and was attempting to get up. A hematoma was observed to the left side of the resident's head at the hairline. Neurological checks were initiated and the Ambulance was called for transport back to the hospital. An entry made on 4/22/14 at 8:46 p.m. indicated the staff spoke with the hospital Nurse and was informed the resident was being admitted to the hospital with a subdural hematoma (hematoma on the brain).</p> <p>The 4/24/14 Nursing Progress Notes were reviewed. An entry made at 4:36 p.m. indicated the resident returned to the</p>			

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F000505 SS=D	<p>facility via ambulance. The resident was placed in bed with a personal alarm in place.</p> <p>The 4/25/14 Nursing Progress Notes were reviewed. An entry made at 11:02 a.m. indicated the resident had an alarm placed to the wheel chair and the resident's room was changed to a room closer to the Nurses' Station.</p> <p>When interviewed on 5/2/14 at 11:30 a.m., the second floor Unit Manager indicated the resident was to have a personal alarm in place to the wheel chair for safety precautions.</p> <p>This Federal tag relates to Complaints IN00148234 and IN00148316.</p> <p>3.1-45(a)(2)</p> <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 urine culture results in a</p>	F000505	1 Corrections for previous timeframes cannot be made Resident G no longer resides in the facility Resident J remains a	05/16/2014			

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	<p>timely manner for 2 of 3 residents reviewed for UTI's (Urinary Tract Infections) in the sample of 8. (Residents #G and #J)</p> <p>Findings include:</p> <p>1. The closed record for Resident #G was reviewed on 5/1/14 at 9:38 a.m. The resident's diagnoses included, but were not limited to, senile dementia, urinary tract infection, chronic kidney disease, depressive disorder, congestive heart failure, and diabetes mellitus. The resident was admitted to the facility from the hospital on 2/14/14.</p> <p>The resident's Laboratory tests were reviewed. A urinalysis was collected on 3/4/14 at 10:48 a.m. The specimen was received on 3/4/14 at 11:23 a.m. Results of the urinalysis were positive for 2+ bacteria (normal is negative), and white blood cells greater then 900 (normal is 0-3).</p> <p>Results of the Urine Culture & Sensitivity were completed on 3/6/14 at 9:09 a.m. The culture was positive for greater then 100,000 cfu of Enterobacter species (an infection). The culture sensitivity noted the above bacterial organism was resistant to Ceftriaxime (a Cephalosporin antibiotic) and Cefrtixone</p>		<p>resident in the facility² All residents could have been affected by this alleged deficient practice A list of all residents with orders for cultures in the last 30 days was compiled and reviewed and no other residents were affected by this alleged deficient practice³ The Culture policy was reviewed with the Infection Control Nurse and the responsibility was established for daily review and supervision of culture results 5 times per week. An In-Service was conducted for the nurses on 5-13-14 through 5-15-14 and ongoing to review the Culture Policy as well as F505 in relation to timely notification of the physician of culture and sensitivity laboratory results The nurses will be responsible to contact the Physician upon receipt of the culture results. If unable to reach the Physician, the Alternate Physician/Medical Director will be contacted with culture and sensitivity results to assure timely treatment. A review of the Laboratory Care Evolve Computer system was done to assure that the nurses knew how to check daily every shift for results of cultures. A meeting was held with the MCH laboratory representative on 5-8-14 in regard to auto print for the Care Evolve system to discuss Quality Measures to monitor that the culture results would be sent immediately as the results were available All lab computers were</p>				

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	<p>(a Cephalosporin antibiotic). The culture sensitivity noted the above organism was sensitive to Trimethoprim/Sulfa (Bactrim-a Sulfur antibiotic). The above report was printed on 3/10/14 at 2:53 p.m.</p> <p>The 3/2014 Nursing Progress Notes were reviewed. An entry made on 3/3/14 at 10:06 a.m. indicated the CNA and Nurses documentation indicated the resident had an increase in incontinence and was now frequently incontinent of bladder. An entry made on 3/3/14 at 1:33 p.m. indicated the resident's urine was noted to be cloudy when she toileted during the shift. The resident had no complaints of pain. An entry made on 3/3/14 at 1:40 p.m. indicated the Physician was notified of the cloudy urine noted and orders were obtained for a UA (Urinalysis) with a reflux Culture to be obtained via straight catheterization.</p> <p>An entry made on 3/5/14 at 11:20 a.m. indicated the Physician was notified of the UA results and orders were receive to start Ceftin (an antibiotic) 250 milligrams twice a day for one week. There was no documentation related to obtaining the culture & sensitivity results in the Nursing Progress Notes from 3/6/14 thru 3/7/14. An entry made on 3/8/14 at 2:00 p.m. indicated the Nurse spoke with the</p>		<p>checked and auto print was working properly as of 5-12-14 4 The Infection Control Nurse/Designee will review all resident records daily 5 times per week and log all orders for cultures using the Tool entitled, "Diagnositc Services-Quality Data Collection Form." She will then monitor the Care Evolve Computer system daily to retrieve results. The nurses will be responsible for Physician notification to assure timely resident treatment. The Data Collection Forms will be brought to the DON weekly for review and Quarterly to the QAPI Committee for review and recommendations for continued monitoring needs.5 DON responsible for compliance 5-16-14</p>				

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	<p>Physician regarding the UA C&S (culture and sensitivity) results.</p> <p>When interviewed on 5/1/14 at 2:55 p.m., the Infection Control Nurse indicated the Unit Manger audit the laboratory results by reviewing the Physician orders and follow up to ensure the results were obtained. The Infection Control Nurse indicated staff Nurses were also to include any orders on each 24 hour shift to shift report until all were received and noted. The Infection Control Nurse indicated the labs were run at the hospital and result pages get automatically printed at the Nurses' Station. The Infection Control Nurse indicated the "printed" date and time and the bottom of each results time was the time the hospital sends the results page to the facility. The Infection Control Nurse indicated she reviewed the 3/2014 24 hour reports and the tracking of the 3/4/14 UA and C&S appeared on the 24 hour report 3/4/14 and 3/5/14 and did not appear on the 24 hour report after that. The Infection Control Nurse indicated the facility should have called the laboratory themselves to obtain the cultures (listed as completed on 3/6/14) results since they were not received within 1-2 days after the UA results were received.</p>			

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	<p>2. The record for Resident #J was reviewed on 5/1/14 at 3:39 p.m. The resident's diagnoses included, but were not limited to, acute renal failure, congestive heart failure, dementia, and high blood pressure.</p> <p>A Physician's order was written on 2/28/14 to obtain a UA and C&S on 3/4/14 to recheck for a UTI (Urinary Tract infection).</p> <p>The Laboratory test results were reviewed. A Urinalysis was collected on 3/4/14 at 5:05 a.m. The urine specimen was received in the lab on 3/4/14 at 7:41 a.m. The results of the Urinalysis were printed on 3/4/14 at 10:59 a.m. The results showed the WBC (white blood cell) count was 107(normal 0-3). The above results were signed by the Physician on 3/4/14 and the Physician wrote "await urine culture." The Culture & Sensitivity results report indicated the test results were completed on 3/6/14 at 7:17 a.m. This report had a printed date of 3/6/14 at 10:59 a.m. There was writing on the bottom of the above report which indicated the results were faxed to the Physician at 10:40 p.m.</p> <p>When interviewed on 5/2/14 at 8:55 a.m., the Infection Control Nurse indicated the</p>			

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	<p>staff documented on the 3/7/14 24 hour shift report that they called the Physician twice on the day shift to inform her of the results and no return calls were obtained. The Infection Control Nurse also indicated the results were available on 3/6/14 and should have been called to or faxed to the Physician before 10:40 p.m. on 3/6/14. The Infection Control Nurse indicated the orders for the antibiotic were not obtained until 6:50 p.m. on 3/7/14.</p> <p>This Federal tag relates to Complaint IN00148316.</p> <p>3.1-49(f)(2)</p>			