

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/03/2014
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NAME OF PROVIDER OR SUPPLIER TIMBERVIEW HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
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F000000	<p>This visit was for the Investigation of Complaints IN00140612 and IN00141984.</p> <p>Complaint IN00140612- Substantiated. Federal/state deficiencies related to the allegations are cited at F314 and F441.</p> <p>Complaint IN00141984- Substantiated. Federal/state deficiency related to the allegation is cited at F250.</p> <p>Survey dates: January 2 & 3, 2014</p> <p>Facility number: 008505 Provider number: 155580 AIM number: 20064830</p> <p>Survey team: Janet Adams, RN, TC Yolanda Love, RN</p> <p>Census bed type: SNF: 9 SNF/NF: 116 Total: 125</p> <p>Census payor type: Medicare: 14</p>	F000000		

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

TITLE

(X6) DATE

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

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F000250 SS=D	<p>Medicaid: 104 Other: 7 Total: 126</p> <p>Sample: 12</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 8, 2014, by Janelyn Kulik, RN.</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review, and interview, the facility failed to ensure ongoing behavior management was provided related to the lack of monitoring of resident behaviors and lack of following the facility Behavior management protocols for documentation of all behaviors including assessment of the resident, possible precipitating factors, and evaluating the effectiveness of interventions for 2 of 5 residents reviewed for</p>	F000250	F250 The facility requests paper compliance for this citation. This Plan of Correction is the center's 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. 1)	01/27/2014			

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	<p>behaviors in the sample of 12. (Residents #L and #N)</p> <p>Findings include:</p> <p>1. On 1/2/14 at 10:45 a.m., Resident #L was observed ambulating in her room. The resident's room was on the secured Special Care Unit. The resident did not have a roommate.</p> <p>The record for Resident #L was reviewed on 1/2/14 at 12:00 p.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbances, congestive heart failure, joint pain, peripheral vascular disease, and altered mental status.</p> <p>The 12/9/13 Minimum Data Set (MDS) admission full assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (4). A score of (4) indicated the resident's cognitive patterns were severely impaired.</p> <p>Review of a 12/18/13 Psychiatric Evaluation report indicated the resident was alert, orientated to person, her demeanor was resistant and impulsive, and her thought process was illogical. The report</p>		<p>Immediate actions taken for those residents identified: Resident #L- Unable to correct, resident has been discharged from facility. Resident #N- Unable to correct documentation due to time frame of occurrences. 2) How the facility identified other residents: Behavior documentation will be reviewed from 1-1-14 to present to identify any other residents affected. 3) Measures put into place/ System changes: Licensed nurses and CNA's will be educated regarding behavior reporting and documentation. Behavior documentation will be reviewed at least 3x/week to ensure appropriate documentation was completed with appropriate follow-up and interventions put in place as needed. Social Services Director will be responsible for oversight. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 1/27/14</p>				

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	<p>also indicated staff reported the resident's behavioral issues included, verbal abuse, outbursts, and paranoia.</p> <p>An "Incident Report Form" was completed on 12/26/13. The report indicated an incident occurred on 12/26/13 at approximately 1:36 p.m. The report indicated Resident #L initiated verbal and physical aggression towards Resident #Q (her roommate at the time). A written statement, made by the CNA working on the unit, indicated the residents had "words" in their room and the CNA took Resident #Q to the Dining Room and Resident #L then entered the room and started yelling at Resident #Q, grabbing at Resident #Q, and the residents were kicking at each other.</p> <p>The 12/2013 "Follow Up Question Report" was reviewed. The form was used by CNA's to note any behaviors the resident displayed.</p> <p>An entry was made on 12/27/13 at 1:39 p.m. This entry indicated the resident's Behavior Symptom was recorded as "Abusive Language." A second entry was also made at 1:39 p.m. The resident's Behavioral Symptoms were recorded as</p>						

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	<p>"Pinching/Scratching/Spitting."</p> <p>Three entries were made on 12/30/13. The first was made at 9:35 a.m. This entry indicated the resident's Behavior Symptom was recorded as "Grabbing" The second entry was also made at 9:35 a.m. This entry indicated the resident's Behavior Symptom was "Abusive Language". The third entry was made at 2:59 p.m. This entry indicated the resident's Behavior Symptom was "Abusive Language."</p> <p>The 12/2013 Clinical Assessment Report-Behavior Sheets were reviewed. There were no Behavior Sheets completed by Nursing staff for the above behaviors the resident displayed on 12/27/13. There were no Behavior Sheets completed by Nursing staff for the above (3) behaviors the resident displayed on 12/30/13.</p> <p>A Clinical Assessment Report-Behavior Sheet form was reviewed. The form consisted of (4) pages. The form include areas where staff were to check the behavior symptom the resident displayed and note the intensity of the behavior, precipitating factors, frequency of the behavior,</p>				

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	<p>interventions attempted, and the outcome of the interventions.</p> <p>The 12/27/13 Nursing Progress Notes were reviewed. An entry made on 12/27/13 at 2:06 p.m. indicated the resident had "verbally threatening behaviors." There was no further description of behavior, other residents or staff involved, precipitating factors, or interventions attempted before or during the behaviors. An entry made at 1:20 p.m. indicated the staff assisted the resident to use the toilet and the resident became angry and used profanity towards the staff. There was no documented pinching, scratching, or spitting in the 12/27/13 Nursing Progress Notes.</p> <p>The 12/30/13 Nursing Progress Notes were reviewed. Only one entry was made on 12/30/13. The entry was made at 7:39 a.m. The entry indicated the resident had no new behaviors and had slept all of the shift.</p> <p>When interviewed on 1/2/14 at 12:55 p.m. the facility Administrator indicated the 12/26/13 interaction between the two above residents occurred in the Special Care Unit. The resident's were roommates at</p>				

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	<p>the time and they were separated after the above incident.</p> <p>When interviewed on 1/3/14 at 8:05 a.m., the facility Nurse Consultant indicated the CNA's were required to document resident behaviors on the wall Kiosk and this then creates an alert on the Nurse's computer notifying the Nurse of the behavior. The Nurse Consultant indicated the Nurses are then required to assess the resident and complete a Clinical Assessment Report-Behavior Sheet. This sheet consisted of an assessment of the behavior and precipitating factors, and interventions attempted. The Nurse Consultant also indicated the Nurses chart in the Nursing Progress Notes. The Nurse Consultant also indicated no Clinical Assessment Report-Behavior Sheets were completed by Nursing related to resident's behaviors on 12/27/13 and 12/30/13.</p> <p>2. On 1/2/14 at 10:44 a.m., Resident #N was observed lying in bed in his room on the secured Special Care Unit.</p> <p>The record for Resident #N was reviewed on 1/2/14 at 11:50 a.m. The resident's diagnoses included,</p>				

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	<p>but were not limited to, high blood pressure, altered mental status, dementia, and chronic kidney disease. The 10/21/13 Minimum Data Set (MDS) annual full assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (5). A score of (5) indicated the resident's cognitive patterns were severely impaired.</p> <p>The resident's current care plans were reviewed. A Behavior care plan initiated on 12/6/13 indicated the resident yelled out and would scream and curse at staff. The care plan also indicated the resident would also hit staff and other residents. Care plan interventions included for staff to allow the resident to calm down and then re-approach the resident, redirect the resident, and offer activities or snacks.</p> <p>An "Incident Report Form" was completed on 12/18/13. The report indicated Resident #N's roommate reported Resident #N told him not to go into the bathroom and verbally threatened him. The roommate indicated Resident #N stated "I will beat your (profanity)". The report indicated no physical contact had been made and resident room</p>			

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	<p>changes were initiated.</p> <p>The 12/2013 "Follow Up Question Report" was reviewed. The form was used by CNA's to note any behaviors the resident displayed. An entry made on 12/17/13 at 10:59 p.m. indicated the resident's Behavior Symptoms were documented as "Pinching/Scratching/Spitting." An entry made on 12/21/13 at 8:43 p.m. indicated the resident's Behavior Symptom was documented as "Threatening Behavior."</p> <p>The 12/2013 Clinical Assessment Report-Behavior Sheets were reviewed. There were no Behavior Sheets completed by Nursing staff for the above behaviors the resident displayed on 12/17/13 and 12/21/13</p> <p>The 2/2013 Nursing Notes were reviewed. There was only one entry made on 12/17/13. This entry was made at 7:22 a.m. and indicated the resident had been asleep on the shift. There was no documentation of the resident having any behaviors on 12/17/13. There were three entries made on 12/21/13. The first entry was made at 12:52 a.m. This entry indicated the resident remained on the locked unit and had</p>				

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	<p>no negative or aggressive behaviors. The second entry was made at 2:16 p.m. This entry indicated the resident was resting in bed and no behavior problems were noted. The third entry was made at 9:00 p.m. This entry indicated the resident had no abnormal behavior noted.</p> <p>The 12/2013 Social Service Progress Notes were reviewed. There was no documentation of any behaviors on 12/17/13 or 12/21/13.</p> <p>When interviewed on 1/3/14 at 8:05 a.m., the facility Nurse Consultant indicated the CNA's were required to document resident behaviors on the wall Kiosk and this then creates an alert on the Nurse's computer notifying the Nurse of the behavior. The Nurse Consultant indicated the Nurses then were to assess the resident and complete a Clinical Assessment Report-Behavior Sheet which consists of an assessment of the behavior and precipitating factors, and interventions attempted. The Nurse Consultant also indicated the Nurses also chart in the Nursing Progress Notes. The Nurse Consultant also indicated no Clinical Assessment Report-Behavior Sheets were completed by Nursing related to resident's behaviors on</p>						

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F000314 SS=D	<p>12/17/13 and 12/21/13.</p> <p>The facility policy titled "Behavior Management Plans" was reviewed. There was no date on the policy. The facility administrator provided the policy and indicated the policy was current. The policy indicated Behavior plans were to included preventative measures and management techniques to prevent, reduce, or eliminate or reduce behaviors.</p> <p>This Federal tag relates to Complaint IN00141984.</p> <p>3.1-34(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p>						

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	<p>Based on observation, record review and interview, the facility failed to ensure wound care was provided as ordered by the Physician related a wound treatment and dressing not completed every (3) days as ordered for 1 of 3 residents reviewed for foot ulcers in the sample of 12. (Resident #F)</p> <p>Findings include:</p> <p>During Orientation tour on 1/2/14 at 9:50 a.m., Resident #F was observed in bed. The Day Nursing Supervisor was present at this time. The resident had blue boots in place to both feet. The Nursing Supervisor loosened the strap of the boot on the resident's left foot. There was a dressing wrapped around the resident's ankle area. The dressing was initialed and dated 12/27. The Nursing Supervisor confirmed the date written on the dressing was 12/27.</p> <p>The record for Resident #F was reviewed on 1/2/14 at 3:00 p.m. The resident's diagnoses included, but were not limited to, dementia, anemia, epilepsy, and high blood pressure. The 10/21/13 Minimum Data Set (MDS) significant change full assessment indicated the</p>	F000314	<p>F314 The facility requests paper compliance for this citation. This Plan of Correction is the center's 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. 1) Immediate actions taken for those residents identified: Treatment was completed on Resident #F on 1/2/14. 2) How the facility identified other residents: Residents receiving wound treatment dressings were observed on 1/2/14 and no other residents were affected. 3) Measures put into place/ System changes: Licensed staff will be re-educated regarding completing wound treatments and dressings as ordered by the physician. Will observe at least 5 random residents per week receiving wound treatment dressings to ensure compliance. DON is responsible for oversight. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 1/27/14</p>	01/27/2014	

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	<p>resident rarely or never understood and her cognitive skills were not assessed. The assessment also indicated the resident required extensive assistance (resident involved in activity with staff providing weight bearing support) of (2) or more persons for bed mobility and transfers. The assessment also indicated the resident was totally dependent on staff for hygiene and dressing.</p> <p>Review of the current Physician orders indicated there was an order to cleanse the left heel wound with wound wash, pat dry, apply a Sure-Prep 70% Alcohol pad topically to the resident's left heel, and then cover the wound with a dry dressing every (3) days on the day shift. The order was initiated on 12/13/2013.</p> <p>The 12/2013 and 1/2014 Pressure Ulcer Progress Reports for the left heel wound were reviewed and assessed as follows: 12/12/13 Left heel -Suspected Deep Tissue (a purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and shear) ulcer to the left heel. The area measured 1.3 cm (centimeters) x 1.0</p>						

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	<p>cm.</p> <p>12/18/13 Left heel -Suspected Deep Tissue wound measuring 1.3 cm x 1.0 cm</p> <p>12/26/13 Left heel -Suspected Deep Tissue wound measuring 1.3 cm x 1.0 cm</p> <p>1/2/14 Left heel -Suspected Deep Tissue wound measuring 1.3 cm x 1.0 cm</p> <p>When interviewed on 1/2/14 at 4:40 p.m., Wound Nurse #2 indicated she changed the dressing to the resident's left heel earlier in the day. The Wound Nurse indicated the treatment was to be completed every three days. The Wound Nurse indicated she removed the left foot dressing at that time and completed the treatment. Wound Nurse #2 indicated the dressing she had removed was dated and initialed by herself on 12/27/13.</p> <p>This Federal tag relates to Complaint IN00140162.</p> <p>3.1-40(a)(2)</p>						

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to</p>	F000441	F441 The facility requests paper compliance for this citation. This	01/27/2014	

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	<p>ensure infection control policies and standards were maintained related to properly assessing, documenting, and tracking active infections for 1 of 3 residents reviewed for infections in the sample of 12. (Resident #J)</p> <p>Findings include:</p> <p>On 1/2/14 at 10:44 a.m., Resident #J was observed in bed. An isolation kit was noted to be hanging on the outside of the resident's room door.</p> <p>The record for Resident #J was reviewed on 1/2/14 at 11:00 a.m. The resident's diagnoses included, but were not limited to, persistent vegetative state, acute and chronic respiratory failure, and tracheostomy (surgical opening in the trachea).</p> <p>Review of the Hospital Medical Progress Notes dated 11/20/13, indicated the resident's diagnoses included, but were not limited to, decubitis wounds, chronic hypoxemia (low blood oxygen), tracheobronchitis (respiratory infection), C-diff (Clostridium difficile-an intestinal infection), and encephalopathy (brain disease).</p>		<p>Plan of Correction is the center's 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. 1) Immediate actions taken for those residents identified: Physician for Resident #J was notified, and physician consulted with Infectious Disease Specialist. Copy of cultures were obtained from hospital stay. 2) How the facility identified other residents: Reviewed infection report for the last 30 days to identify any other residents affected. 3) Measures put into place/ System changes: Licensed staff will be educated regarding assessment, documentation and tracking of infections. Residents currently receiving antibiotics will be reviewed at least 3x/week to ensure appropriate documentation and assessments are completed including reason for antibiotic use. Infection Log will be reviewed weekly to ensure required information, including culture results and reason for antibiotics are present. 4) How the corrective actions will be monitored: The results of these</p>				

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	<p>Review of the Hospital Medical Progress Notes dated 11/22/13, indicated the resident's sputum laboratory test results revealed few gram negative rods (bacteria that is resistant to most antibiotics). Multiple decubitus ulcers, leukocytosis (above normal range white blood cell count), CDAD (Clostridium difficile-associated diarrhea), and tracheitis (inflammation of the trachea) were also noted. Further review also indicated the resident was to continue taking Vancomycin (an antibiotic) and also to begin Zosyn (an antibiotic).</p> <p>Review of the Nursing Notes dated 11/22/13, indicated the resident was admitted to the facility from the hospital. There was no evidence of documentation related to the above documented diagnoses.</p> <p>Review of Nursing Notes dated 11/23/13, indicated the resident was to continue on Zosyn and Vancomycin for infections in the trach and urine. Further review of Nursing Notes dated 11/23/13 indicated the resident was in isolation due to ESBL (bacteria) in the urine and Pseudomonas (bacteria) to the trach. There was</p>		audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 1/27/14				

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	<p>no evidence of documentation related to the resident's diagnosis of C-diff.</p> <p>Review of the Nursing Notes dated 11/24/13 through 1/2/14, indicated there was no evidence of documentation related to the resident's diagnosis of C-diff.</p> <p>Review of the Physician Progress Notes dated 11/25/13, indicated the resident was readmitted from LTAC (a long term acute care facility). The entry also indicated a foul odor was noted from the decubitus when entering room. Further review also indicated there was no evidence of documentation related to the resident's diagnosis of C-diff. There was an entry indicating: Plan: Continue ABX (antibiotics) as ordered.</p> <p>Review of the Monthly Infection Log dated November 2013, indicated the resident was receiving Zosyn. There was no evidence of documentation related to the source of infection. There was also no evidence of documentation related to the resident receiving Vancomycin.</p> <p>Review of the Medication Administration Record (MAR) dated</p>				

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	<p>November 2013, indicated an order for Zosyn Solution 3-0.375 grams/50 milliliters to be given , intravenously every 6 hours for infection until 12/7/14, beginning on 11/25/13.</p> <p>There was also an order for Vancomycin HCl capsules 125 milligrams to be given via PEG (Percutaneous Endoscopic Gastrostomy) tube every 6 hours for infection until 2/19/14, beginning on 11/25/13.</p> <p>Review of the Care Plan dated 10/15/12, indicated the resident had a need for isolation precautions related to ESBL of the urine. Further review of the Care Plans indicated there was no evidence of documentation related to the resident's need for isolation related to his diagnosis of C-diff.</p> <p>Review of the resident's hospital urine cultures dated 11/18/13 indicated there was no bacterial growth present.</p> <p>Review of the Policy for Infection Prevention and Control Surveillance, indicated the policy of the facility was to closely monitor all residents who exhibit signs/symptoms of infection. Further review of the policy indicated there should be an</p>						

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	<p>initial Infection Surveillance Form and documentation in the narrative Nurse's Notes every shift related to the presence or absence of symptoms. The documentation was to be continued for 48 hours after the symptoms subsided, or until 48 hours after the last dose of antibiotics.</p> <p>Interview with the Nursing Consultant on 1/2/14 at 2:00 p.m., indicated the resident's last known urine laboratory test results were negative.</p> <p>Interview with LPN #6 on 1/2/14 at 2:30 p.m., indicated the resident was on isolation for ESBL of the urine and Pseudomonas of the wound.</p> <p>Interview with Wound Care Nurses #1 and #2 on 1/3/14 at 10:00 a.m., during a wound care observation, the Nurses indicated the resident was on isolation for Pseudomonas of the trach and KPC (bacteria) of the urine. Also noted during that observation, there were three episodes of diarrhea while the resident was turned on his side. There was also a foul odor noted at that time.</p> <p>Interview with LPN #7 on 1/3/14 at</p>			

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	<p>4:00 p.m., indicated the resident was on isolation for ESBL of the urine and Pseudomonas of the trach.</p> <p>Interview with the DoN and the Nurse Consultant on 1/3/14 at 2:25 p.m., indicated the resident was on isolation for ESBL of the urine and Pseudomonas of the trach. However, after further review of the resident's chart they indicated the resident's diagnoses should have included Pseudomonas of the trach and C-diff. They also indicated the resident's care plan should have been updated to reflect the resident's correct diagnoses.</p> <p>This Federal tag relates to Complaint IN00140612.</p> <p>3.1-18(a)</p>				