

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2012
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NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
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F0000	<p>This visit was for the Investigation of Complaint number IN00102816.</p> <p>Complaint number IN00102816 unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiencies cited.</p> <p>Survey date: February 15, 2012</p> <p>Facility number: 000510 Provider number: 155507 AIM number: 100285440</p> <p>Survey team: Leslie Parrett RN TC Barbara Gray RN</p> <p>Census bed type: SNF/NF: 34 Total: 34</p> <p>Census payor type: Medicare: 7 Medicaid: 19 Other: 8 Total: 34</p> <p>Sample: 6</p> <p>Sycamore Springs Rehabilitation Center was found to be in compliance with 42</p>	F0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed the plan of correction for the survey ending February 15, 2012. Due to the low scope and severity of the survey finding, please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</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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	<p>CFR part 483 subpart B and 410 IAC 16.2 in regard to the investigation of complaint IN00102816.</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 2/17/12 Cathy Emswiller RN</p>			

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F0315 SS=D	<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 observation, interview, and record review, the facility failed to implement approaches to prevent urinary tract infection, for 2 of 6 resident's sampled for infection control, in the sample of 6. (Resident #A and #B).</p> <p>Findings include:</p> <p>1.) Resident #A's record was reviewed on 2/15/12 at 1:00 P.M. Diagnoses included but were not limited to recurrent urinary tract infection and current urinary tract infection (UTI).</p> <p>Physician's orders for Resident #A indicated the following: 1/18/12 at 4:30 P.M.-Urinalysis and culture and sensitivity for symptoms of mental status change. 1/21/12 at 6:00 P.M. -Discontinue Cipro. Macrodotantin 50 milligram (mg) 2 times day (BID) for UTI. Contact isolation. Urinalysis (UA) and culture and sensitivity (C & S) after</p>	F0315	F315 Requires the facility to 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. The facility will ensure this requirement is met through the following:1. Resident #A and #B were not harmed. Catheters were immediately placed in catheter covers. The radio that was placed on the isolation barrel by family was immediately sanitized and placed on the resident's bedside table. 2. All residents who have a catheter or who are placed on isolation has the potential to be affected. All residents who have catheters were observed to ensure that their catheters were placed on catheter covers. Currently, there are no residents on isolation.	02/20/2012			

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	<p>antibiotic is complete. 1/23/12 at no time-Indwelling foley catheter 18 french (FR) with 30 milliliter (mL) balloon. Change every 30 days and as needed (PRN). Catheter care every shift and PRN. Isolation precautions. Discontinue after 3 negative Vancomycin-resistant Enterococcus (VRE) cultures. 1/25/12 at 9:00 P.M.-Contact precautions in place due to VRE in urine. 2/2/12 at 5:00 P.M. -UA times 3 for VRE. Rectal swab times 3 for VRE. 2/6/12 at 6:00 P.M. Septra DS by mouth BID for 10 days for a diagnosis of UTI. 2/14/12 at no time-Collect another stool swab culture for VRE to verify positive result.</p> <p>During initial tour of the facility on 2/15/12 at 11:45 A.M., a sign was observed posted on Resident #A's bedroom door that stated "Please see nurse before entering residents room". 2 Isolation barrels were observed in Resident #A's bedroom, one barrel was marked trash on the lid and one barrel was marked linen on the lid. A radio/CD player was observed on top of the red barrel marked linen. Resident #A was observed lying in bed with her urinary catheter bag lying on the floor next to her bed uncovered.</p> <p>On 2/15/12 at 12:05 P.M., LPN #1 moved the radio/CD player to Resident #A's</p>		<p>Resident #A was removed from isolation due to having three negative cultures. See below for corrective measures.3. The Foley Catheter Maintenance Procedure as well as the Infection Control Policy and Procedure for Isolation were reviewed with no changes made. (See attachment A and B) The staff was inserviced on the above procedures.4. The DON or her designee will conduct rounds to ensure that all catheters are placed in catheter covers and if someone is on isolation that no items are placed on the isolation barrels. The DON or her designee will use the nursing monitoring tool to help conduct their rounds daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until compliance is maintain.(See attachment C) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly if warranted.5. The above corrective measures will be completed on or before February 20, 2012.</p>				

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	<p>bedside table with her water pitcher. LPN #1 said it was not a good idea to have the radio/CD player on top of the isolation barrel. LPN #1 indicated Resident #A had a UTI.</p> <p>On 2/15/12 at 12:15 P.M., RN #2 indicated Resident #A normally ate in the dining room but would eat lunch in her room that day due to a recent positive rectal swab for VRE . RN #2 indicated the recent urine culture was negative but Resident #A had a UTI.</p> <p>2.) Resident #B's record was reviewed on 2/15/12 at 2:48 P.M. Diagnoses included but were not limited to respiratory failure and perineal necrotizing fasciitis (a progressive rapidly spreading, inflammatory infection, located in the deep fascia).</p> <p>A local hospital note dictated 1/18/12, indicted the following: The resident was found to have cellulitis in the perineal area and was diagnosed with necrotizing fasciitis. She underwent surgical intervention. She continued to have quite a large wound initially difficult to care for as it was close to her rectum and difficult to keep stool out of that area. She underwent a diverting colostomy. She was transferred to a local hospital to care for her extensive wounds.</p>				

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	<p>A catheter assessment for Resident #B dated 1/18/12, indicated the following: 16 FR with 10 mL balloon. Change every 30 days and PRN. Catheter care every shift due to wound on bottom. Keep area clean on bottom-surgical site.</p> <p>A physician's order for Resident #B on 2/14//12 at no time, indicated the following order: Clarification: Anchored catheter due to wound healing. Catheter care every shift.</p> <p>During initial tour of the facility on 2/15/12 at 11:50 A.M., Resident #B was observed lying in bed with her urinary catheter bag lying on the floor next to her bed uncovered.</p> <p>On 2/15/12 at 12:02 P.M., LPN #1 placed Resident #B's catheter bag in a blue cloth bag.</p> <p>An interview with the Assistant Director of Nursing (ADON) on 2/15/12 at 3:33 P.M., indicated Resident #B had came to the facility with a wound. The ADON indicated Resident #B had part of her right labia removed and part of her buttock, back to her rectum. The ADON indicated Resident #B had the catheter for wound healing.</p>			
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	<p>An interview with the Director of Nursing (DoN) on 1/15/12 at 4:50 P.M., indicated staff were trained to place a resident's catheter bag in a cloth bag and hang the bag from the bed frame. The DoN indicated staff would know not to place a radio/CD player on top of a isolation barrel. The DoN indicated when made aware, housekeeping had cleaned Resident #A's room and disinfected the radio/CD player.</p> <p>The most recent Foley Catheter Maintenance Procedure provided by the ADON on 2/15/12 at 5:15 P.M., indicated the following: "Placement of catheter tubing - 1. When in bed or wheel chair: a.) Position tubing with no tension. b.) Place in a catheter cover bag underneath wheelchair or on side of bed. c.) Ensure bag or tubing is not touching floor".</p> <p>The most recent Infection Control Policy and Procedure for Isolation provided by the ADON on 2/15/12 at 5:15 P.M., indicated the following: The Urinary Tract - "3. Use a closed drainage system. Keep drainage bags off the floor, but below the level of the patient's bladder".</p> <p>3.1-41(a)(2)</p>			

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F0441 SS=D	<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, interview, and record review, the facility failed to keep catheter bags off the floor and an electronic device off of an isolation</p>	F0441	F441 Requires the facility to keep catheter bags off the floor and an electrical device off of isolation barrels to prevent spread of infections. The facility will	02/20/2012

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	<p>barrel, to prevent the potential spread of infection, for 2 of 6 resident's sampled for infection control, in the sample of 6. (Resident #A and #B)</p> <p>Findings include:</p> <p>1.) Resident #A's record was reviewed on 2/15/12 at 1:00 P.M. Diagnoses included but were not limited to recurrent urinary tract infection and current urinary tract infection.</p> <p>During initial tour of the facility on 2/15/12 at 11:45 A.M., a sign was observed posted on Resident #A's bedroom door that stated "Please see nurse before entering residents room". 2 Isolation barrels were observed in Resident #A's bedroom, one barrel was marked trash on the lid and one barrel was marked linen on the lid. A radio/CD player was observed on top of the red barrel marked linen. Resident #A was observed lying in bed with her urinary catheter bag lying on the floor next to her bed uncovered.</p> <p>On 2/15/12 at 12:05 P.M., LPN #1 moved the radio/CD player to Resident #A's bedside table with her water pitcher. LPN #1 said it was not a good idea to have the radio/CD player on top of the isolation barrel. LPN #1 indicated Resident #A</p>		<p>ensure this requirement is met through the following:</p> <ol style="list-style-type: none"> 1. Resident #A and #B were not harmed. Catheters were immediately placed in catheter covers. The radio that was placed on the isolation barrel by family was immediately sanitized and placed on the resident's bedside table. 2. All residents who have a catheter or who are placed on isolation has the potential to be affected. All residents who have catheters were observed to ensure that their catheters were placed on catheter covers. Currently, there are no residents on isolation. Resident #A was removed from isolation due to having three negative cultures. See below for corrective measures. 3. The Foley Catheter Maintenance Procedure as well as the Infection Control Policy and Procedure for Isolation were reviewed with no changes made. (See attachment A and B) The staff was inserviced on the above procedures. 4. The DON or her designee will conduct rounds to ensure that all catheters are placed in catheter covers and if someone is on isolation that no items are placed on the isolation barrels. The DON or her designee will use the nursing monitoring tool to help conduct their rounds daily times four weeks, then weekly times four weeks, and then every two 		

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	<p>had a urinary tract infection.</p> <p>On 2/15/12 at 12:15 P.M., RN #2 indicated Resident #A normally ate in the dining room but would eat lunch in her room that day due to a recent positive rectal swab for Vancomycin-resistant Enterococcus (VRE). RN #2 indicated the recent urine culture was negative but Resident #A had a urinary tract infection.</p> <p>2.) Resident #B's record was reviewed on 2/15/12 at 2:48 P.M. Diagnoses included but were not limited to respiratory failure and perineal necrotizing fasciitis (a progressive rapidly spreading, inflammatory infection, located in the deep fascia).</p> <p>During initial tour of the facility on 2/15/12 at 11:50 A.M., Resident #B was observed lying in bed with her urinary catheter bag lying on the floor next to her bed uncovered.</p> <p>On 2/15/12 at 12:02 P.M., LPN #1 placed Resident #B's catheter bag in a blue cloth bag.</p> <p>An interview with the Assistant Director of Nursing (ADON) on 2/15/12 at 3:33 P.M., indicated Resident #B had the catheter to promote wound healing.</p>		<p>weeks times two months, then quarterly thereafter until compliance is maintained. (See attachment C) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly if warranted.</p> <p>5. The above corrective measures will be completed on or before February 20, 2012.</p>		

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