

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/23/2004
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2004
NAME OF PROVIDER OR SUPPLIER INTERNATIONAL VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 4815 SOUTH WESTERN AVE CHICAGO, IL 60609		
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F 442	<p>Continued From page 47</p> <p>Review of physician's order dated 6/1/04 shows an order for an antibiotic twice a day for 14 days re: positive for MRSA sputum culture. Review of physician's orders dated 6/16/04 show: please obtain sputum samples times 2, re: completion of antibiotic therapy.</p> <p>Review of the final laboratory report dated 6/24/04 show no methicillin staph aureus isolated. Further review did not show that a second sputum culture had been obtained and sent as ordered. R21 was taken off of contact isolation on 6/30/04.</p> <p>During interview on 7/27/04 at 11:15am in the ice cream parlor, R21 stated, "I was on respiratory isolation, me and my room mate. They only did one sputum test on me."</p> <p>On 8/2/04, via telephone, the facility was asked to send their policy and procedure for isolation precautions. Review of the isolation precaution guidelines faxed to the survey team did not address isolation precautions for respiratory isolation.</p> <p>Review of the facility's isolation guidelines show, for MRSA obtain 2 negative cultures in a row starting 48 hrs after antibiotics are completed. Cultures must be at least 24 hours apart.</p> <p>4. On 7/28/04 at 11:00 AM, the surveyor observed E12 (LPN) enter R23 room, which is an isolation room with the 2nd floor portable sphygmometer (blood pressure machine) and a stethoscope. The surveyor then observed E12</p>	F 442			

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F 442	<p>Continued From page 48</p> <p>exiting the same isolation room with the sphygmometer and stethoscope. E12 stated during interview that the 2nd floor only has one sphygmometer, and that isolation resident rooms do not have a sphygmometer or disposable stethoscope. E22 (ADON) of the second floor was informed of the surveyors observation regarding E12. E22 stated each isolation room should have their own equipment, and stated she would show me where the sphygmometer and stethoscope are kept. The surveyor and E22 then checked for the supplies in the following isolation rooms: Rm. 221 and Rm. 223. There was no sphygmometer or stethoscope in either room or in the isolation cart. Review of facility isolation audit provided by E22 revealed there are 13 isolated residents on the 2nd floor with infections consisting of Methicillin Resistant Aurous, Vancomycin Resistant and C-Diff. Review of facility Infection Control Policy dated April 12, 2004, requires "isolation equipment must be kept inside isolated room which includes, disposable thermometers, disposable blood pressure cuff, disposable stethoscope and disposable sphygmometer.</p> <p>On 7/28/04, at 12:10 PM, the surveyor observed E11 (CNA) transferring R22 from bed to a reclining chair. R22 is an contact isolation with MRSA to the wound and respiratory isolation ESBL of the urine and sputum. R22 has a tracheostomy. E11 was not wearing a mask or a disposable gown at the time of the observation. When asked by surveyor why E11 was not wearing a gown or mask while providing care to R22, E11 stated "I washed her up this morning."</p>	F 442			

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F9999 F9999	Continued From page 49 FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1030 b) The facility shall maintain in a suitable location the equipment to be used during these emergencies. This equipment shall include at a minimum the following: a portable oxygen kit, including a face mask and/or cannula, an airway, and bag-valve mask manual ventilating device. 300.1210 a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing needs of the resident. 300.1220 b) The DON shall supervise and oversee the nursing services of the facility, including: 300.1220 b) 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 300.1220 b) 3) Developing an up-to-date care plan for each resident based on the resident's comprehensive assessment, individual needs	F9999 F9999			

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F9999	<p>Continued From page 50</p> <p>and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel representing other services such as nursing, activities, dietary, and other modalities as are ordered by the physician shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.</p> <p>3240a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>Based on observation, staff and resident interviews and record review, the facility failed to provide emergency services to a resident (R12) who is oxygen dependent with a tracheostomy, and who was experiencing acute respiratory distress as observed on 07/26/04 at 2:10pm, and experiencing long periods of apnea (not breathing) as noted on 07/27/04 at 10:50am (approximately 21 hours later). R12 was finally placed on a ventilator (artificial respirator) on 07/27/04 at 11:20 a.m. (approximately 21 hours later). R12 was found unresponsive, without vital signs at 3:30pm. R12 was then transferred to a hospital for further care and management. E2 (Director of Nursing) stated that the resident is still in the hospital</p> <p>The facility did not have evidence that R12 was being assessed or monitored, nor of Z1 (physician of R12) being notified for the first 21 hours after R12 started having respiratory distress. The facility did not provide emergency intervention when R12 started having long</p>	F9999			

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F9999	<p>Continued From page 51</p> <p>periods of apnea and failed to have supplies readily accessible in the event of a respiratory emergency.</p> <p>Findings includes:</p> <p>R12's diagnoses includes Insulin Dependent Diabetes mellitus, Bilateral amputee, Tracheostomy, Gastrostomy tube. R12 was admitted to the facility on 07/12/04.</p> <p>During the initial tour with E9 (nurse) on 07/26/04 at approximately 11:25Am, R12 was observed by surveyor in bed with trach (tracheostomy) collar attached to an oxygen cylinder. This cylinder was delivering oxygen to R12 at 35%. R12 was observed to be alert and oriented and able to talk in low voice around his trach. R12 was also observed to have a foley catheter with 200cc dark urine draining in the bag and had evident large amounts of sediment in the tubing. R12 was also observed to be in need suctioning and oral care during this observation. E9 stated, R12 "is total care."</p> <p>R12 was again observed on 07/26/04 at 2:10Pm. R12 was receiving G-tube (Gastrostomy) feeding at 95cc/hour and the head of R12's bed was noted to be less than 45 degrees elevated. When surveyor entered the room, R12 raised his head and moved his edematous hand toward the trach and stated "I'm hot! I'm about to pass out!" R12 appeared ashen/pale in color, anxious, and in evident moderate respiratory distress. Surveyor summoned E13 (nurse) to R12's room at this time. E13 was observed to enter R12's room, suction him and call E18 (respiratory therapist director) at this time.</p>	F9999			

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F9999	<p>Continued From page 52</p> <p>Review of R12's clinical record for 07/26/04 did not reveal evidence that any intervention, including staff monitoring , was ever done for R12 after his complaint, nor was Z1 called, even though R12 was in respiratory distress on that day.</p> <p>Surveyor interviewed E13 on 07/29/04 regarding what was done for R12 when E13 was notified of R12 respiratory distress on 07/26/04 at 2:10Pm? E13 stated, "No, I didn't do any vital signs for R12 when you came and got me , I only suctioned R 12 and called E18 " .</p> <p>Surveyor interviewed E 18 on 07/27/04 regarding what was done for R12 on 07/26/04 at 2:10Pm when R12 went in respiratory distress? E18 stated, " I increased his oxygen".</p> <p>On 07/27/04 at 8:25Am, R12 was observed in bed with trach collar to oxygen and with shallow labored breathing, anxious, edematous. R12 was again observed later that morning at 10:50Am, E18 was observed to be obtaining ABG's (arterial blood gas) from R12 at this time. E18 stated to surveyor "R12's arms are so edematous ." R12 was observed at this time with Cheyne-stokes breathing confirmed by E18 (long periods of apnea).</p> <p>At 11:00Am,(10 minutes later) R12 was again observed in his room with Cheyne-stokes respirations. There was no one present in the room with R12 at this time. Surveyor summoned E3 (assistant director of nurses) to the room. E3 entered R12's room, looked at R12 and immediately left R12's room and saw E18 across</p>	F9999			

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F9999	<p>Continued From page 53</p> <p>the hallway and asked E18 to come and see R12 . E18 stated, "I'm going to put R12 on a vent". E3 turned to surveyor and stated,"E18 is going to put R12 on a vent"</p> <p>It was noted by surveyor that E18 left R12 in distress alone in room until summoned by surveyor at 11:00Am, even though R12 was having Cheyne stokes respiration when E18 was with him at 10:50Am.</p> <p>It was also noted by surveyor that E3 did not initiate emergency nursing interventions (including suctioning and ambu'ing R12) when summoned to room by surveyor, E3 left R12's room after noting Cheyne-stokes respirations when she observed him at 11:00Am.</p> <p>At 11:10am, E18 was noted to enter R12's room, ambu and suction him. E18 was unable to locate yanker suction to suction R12's mouth and requested respiratory staff to go and retrieve one. E18 was also requesting other necessary supplies to use before putting R12 on the vent which was not available/accessible in R12's room . Staff had to retrieve the needed supplies from other locations. At one point, E18 who became tired of waiting for the requested supplies, stopped ambu'ing R12, left room to retrieve them herself. No one ambu'ed R12 during the time E 18 left the room to get supplies. E18 soon returned to R12's room and continued to ask for the ventilator that had been requested earlier. The ventilator was finally delivered to R12's room by another respiratory therapist. It was discovered that the ventilator had been taken to the wrong room in error prior to bringing it to R12</p>	F9999			

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F9999	<p>Continued From page 54</p> <p>'s room. R12 was finally placed on ventilator at 11:25Am by E18.</p> <p>On 07/29/04 surveyor interviewed E18 regarding obtaining blood gases and putting R12 on a ventilator. E18 stated, "I called Z5 (physician of R12) and told Z5 that R12 was in respiratory distress and he told me to do a blood gas, but in the process of getting a blood gas, R12 was having several periods of apnea. I called Z5 again and told him that R12 was having long periods of apnea and he told me to go ahead and put R12 on a vent and get a blood gas later. I had to change the trach and then apply the vent. It takes about 15 minutes total to do that".</p> <p>Review of nurses notes dated 07/27/04 3:30 Pm reveals, "Upon rounds resident noted unresponsive, unable to obtain v/s (vital signs), CPR initiated per nurse et respiratory, 911 called, staff assisted by doctor on unit with code. Z1 notified with orders to send to nearest hospital." R12's admitting diagnosis was urosepsis, hyperglycemia, and post cardiac arrest.</p> <p>Per interview, record review, and observation, the facility has a 30 bed vent/trach unit located on the 2nd floor of the facility. There were a total of 8 residents who are vent dependent and 9 residents with trach collars noted during this survey.</p> <p>Z1 was interviewed by phone on 07/28/04 at 1:35 Pm and stated, "R12's head was always down when getting his G-tube feeding, he also has a tracheostomy and his head should be kept up. Z1 continued, " I always found R12's head down</p>	F9999			

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F9999	<p>Continued From page 55</p> <p>when I came into the facility, so I wrote an order the last time I was there to keep R12's head up. I think R12 aspirated ! " Surveyor further interviewed Z1 regarding facility notifying him regarding a change in R12's condition on 07/26/04 when R12 developed respiratory distress while getting a G-tube feeding. Z1 stated, "I never got a call regarding a change in R12's condition on 07/26/04. I did not get a call until 07/27/04 when the facility called me and told me R12 was now on a vent."</p> <p>Review of the facility's change in condition policy confirmed that the facility should have notified the resident's physician after noting a significant change.</p> <p>2). Based on observations, record review, and staff interview, the facility failed to provide the necessary care and service for 5 of 29 sampled residents (R7, R14, R17, R22, R23 & R25) and 1 outside the sample (R33) by not:</p> <ul style="list-style-type: none"> -providing care and service for residents with a PICC (Peripherally Inserted Central Catheter) line (R7 & R22). -obtaining dialysis treatment for a resident (R23). -ensuring a resident receive antibiotic as order and informing the physician of changes (R25). -implementing the care and service for a resident on dialysis (R17). -monitoring a resident for the effectiveness of a change in a diuretic (water pill) medication (R14). -developing and implementing a care plan for the use of the diuretic (R14). - not taking out a resident's intravenous catheter after infiltration (R33). <p>Findings include:</p>	F9999			

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F9999	Continued From page 56 1. R17 has a diagnosis of end stage renal failure and receives dialysis three times a week. R17's care plan dated 5/27/2004 and target date of 8/25 /2004 stated, Problem: ...potential for complications secondary to hemodialysis. Goal :....signs and symptoms of complications will be identified immediately and appropriate intervention will be rendered, through staff monitoring and intervention by nest review. Approaches included...monitor pre/post weights and record finding Disc(discipline) nursing. The surveyor did not find any documented pre/post weights for R17. On 7/28/2004 during the daily status meeting with the facility, the surveyor was told by E14 (dietitian) commended she though the weighs were done at dialysis and sent to the facility. On 7/29/2004 the surveyor was given dialysis sheets from an outside facility. The surveyor asked where were the documents at the time of review. E3 told the surveyor the documents were obtained from the out side dialysis center. However, the care plan does not indicated the weighs were to be retrieve from the dialysis center. Next R17 has an order (8/2004) for calcium carbonate for 1300mg to be given three times a day. According to the order the medication is given 9am, 1pm and 5pm daily. On 7/28/2004 the surveyor observed R17 in her room from 10:50 am thru 12:20pm and then again at 1:10pm. At 1 :10pm the surveyor questioned R17 about receiving any medication before or right after meal time. R17 told the surveyor she did not receive any medication as of yet. The surveyor checked the medication administration record for	F9999			

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F9999	<p>Continued From page 57</p> <p>R17 for 7/28/2004, according to this record the calcium carbonate was signed as given. However, the surveyor did not observe R17 given nor receiving any medication thirty minutes before or after eating her lunch meal on 7/28/2004.</p> <p>The last lab reported in R17's medication record from the outside dialysis indicated phosphorus level at 5.7 high (no normal ranges given). Other labs provided later by the facility indicated high phosphorous levels on 5/3/2004 6.4 high and 3/1/2004 6.8 high. On 7/28/2004 the surveyor informed the facility's administrative staff of the observations involving R17 and receiving her calcium carbonate during a daily status meeting. No additional information or comment followed the surveyor's concerns.</p> <p>The calcium carbonate in use for treatment for a resident with dialysis, is given during meal time to bind phosphorous in food eaten. The review of R 17's care plan showed no evidence to address R 17's high phosphorus level nor the use of a phosphate binder with meal time to prevent high phosphorus level in the blood.</p> <p>2. R14 is a 70 year old resident re-admitted to the facility on 6/15/2004. R14 has diagnosis of Congestive Heart Failure and Chronic Obstructive Pulmonary disease. On 7/27/2004 the surveyor observed R14 in bed at 10am and 1:40 pm with oxygen running thru a nasal cannula. R 14 told the surveyor he was in bed to keep his feet elevated. R14 stated if he was up in a wheelchair, the swelling would not go down. On 7/28/2004 at 10:20am, the surveyor observed R14 up in a wheelchair at the bedside, R14 appeared to have some trouble breathing. R14's legs and</p>	F9999			

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F9999	<p>Continued From page 58</p> <p>left hand was swollen. A nurse surveyor observed R14's extremities and noted R14 to have 1-2 pitting edema. R14 had swelling in the left hand and both feet. R14 told the surveyor he had the feet and leg swelling for over a week. The doctor saw him and increased his water pill but it has not done any good. The nursing staff informed the surveyor R14 was being transfer to the hospital for an evaluation.</p> <p>The surveyor reviewed all the nursing documentation in R14's chart including current care plan. There was no evidence of monitoring for the effectiveness of the change in R14's Lasix (water pill) The physician 's orders dated 7/15/ 2004 indicated R14's Lasix medication was increased to 40 mg twice a day from 40mg once daily. The physician's progress notes dated 7/15/ 2004 indicated R14 had the present of leg edema .</p> <p>R14's weight record indicated the following information: 5/2004 214 pounds 6/2004 206 pounds 7/2004 236 pounds</p> <p>The surveyor reviewed the nutritional documentation for possible assessment of an unplanned significant weight gain and interventions. The nutritional assessment dated 7 /19/2004 revealed: significant weight changes increase 16.2 times 1 month, 15.7 times 3 months, and 20.4 times 6 months.....Lasix increased, per MD(doctor) some weight increased possibly R/T (related to) fluid.... Resident made aware of weight increase times 6 months, Already receiving skim milk-will add no gravy, cheese, sausage for better weight control</p>	F9999			

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OMB NO. 0938-0391

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F9999	<p>Continued From page 59</p> <p>...follow-up PRN(as needed). E14 (dietitian) was interviewed regarding R14's weight gain. The surveyor asked if a resident weight gain is suspected as a fluid weight gain, how could this be determined? E14 indicated, a weekly weighting of the resident could possible determine it. Weekly weights were not done for E14. The surveyor reviewed R14's care plan dated 4/14/2004 and 7/22/04. There is no evidence the facility had a plan of care to address R14's edema or identified fluid retention problem for possible interventions.</p> <p>3. R25 is a 83 year old resident admitted to the facility on 5/10/2004. On 7/15/2004 the physician ordered for R25 antibiotic therapy for an infection. The physician's order stated, "Primaxin 750mg every 12 hours for 10 days. On 7/29/2004 the surveyor observed R25 in the dining room of the 2nd floor. R25 had a IV (intravenous) catheter located in the left hand.</p> <p>R25's nurses notes were reviewed and the following information was discovered: 7/12/2004 8:30am Resident found in room with PICC (peripherally inserted central catheter) line out.....Contacted ...Infusion nurse and nurse states since he is only going to get it for 5 more days have your nursing supervisor insert and peripheral line. 7/24/2004 9am went go to infuse IVPB-ABT (intravenous piggy back- antibiotic) as ordered. No access noted. Will insert heplock 7/24/10am Heplock inserted to Lt(left) inner aspect of Lt arm times one attempt with good tolerance.</p> <p>R25's MAR(medication administration record)</p>	F9999			

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F9999	<p>Continued From page 60</p> <p>was reviewed for the month of July/2004, the surveyor discovered that R25 did not receive the antibiotic medication as ordered. The MAR indicated there were missing doses on 7/16 9pm, 7/21 9am, 7/22 9am & 9pm, and 7/23 9pm. The facility's ADON(assistant director of nursing), E22 was asked to review R25's medical record. E22 on interview 7/29/2004 agreed there was no nursing documentation between 7/21 and 7/24/2004 to indicate R25 received antibiotic therapy as ordered. E22 agreed a physician order should have been obtained before a heplock IV was inserted in R25. In addition, E22 agreed the MAR showed missing doses of the antibiotic medication for R25. 7/29/2004 at 9:50am the surveyor asked E28 (nurse) if R25 was receiving antibiotics. E28 stated the antibiotic had a stop dated of 7/26/2004 and was not getting any antibiotics currently. The surveyor found no evidence and the facility did not offered any evidence, after E22 was informed, that R25's physician was made aware of the lack of antibiotic therapy and obtained an order for an insertion of a heplock IV. The facility failed to ensure that R25 received antibiotic therapy as ordered, obtain appropriate physician order for an IV inserted, and inform the physician in regards to missing doses of antibiotic medication for possible intervention.</p> <p>4. R23's diagnosis includes Acute Respiratory Failure, tracheostomy, End Stage Renal Disease and requires hemo-dialysis 3 days a week. Review of R23's nurses notes dated 7/24/04 that R23 was readmitted back to the facility from the hospital on 6/24/04 at approximately 6:00 PM. Review of nurses notes dated 6/26/04 document</p>	F9999			

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F9999	<p>Continued From page 61</p> <p>that R23 was not set up for in-house dialysis because of lack of consent for dialysis. R23's physician was notified with orders to transfer to hospital if facility could not provide dialysis. Further documentation revealed R23 was transferred to the hospital emergency room for evaluation and hemodialysis. Review of hospital record renal-Hypertension Consult final report dated 7/27/04 reflects that R23 had been last dialyzed 6/25/04 , 1 day prior to discharge and did not receive hemodialysis on Friday due to the fact the nursing home did not have consent for dialysis. Further documentation revealed R23 was hyperkalemic (elevated blood potassium level) and was given Kayexalate.</p> <p>Z6 (LPN -dialysis staff) stated in interview on 7/28/04 that R23 has been on in house dialysis since January 2004. Z6 was able to provide consent for hemodialysis for R23 which was dated 11/21/03.</p> <p>Z6 stated that R23 had been out of the facility for over 60 days at the time of her readmission on 6/24/04. Z6 stated that when a resident is newly admitted or readmitted to the facility the admissions office usually notifies the dialysis unit. Z6 further stated that the Dialysis Unit is usually closed by 4:00 PM., so the Admissions Department would notify the Dialysis Unit the next day. Z6 stated that on 6/25/04 the Dialysis Unit had not been notified of R23's readmission to facility and the need for resuming R23's dialysis schedule for Tuesday, Thursday and Saturday.</p> <p>E31 (LPN) who documented in nurses notes on 6/26/04 regarding R23 not being able to receive in house dialysis, stated that she was not really</p>	F9999			

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F9999	<p>Continued From page 62</p> <p>familiar with R23 needs at that time. E31 stated that the dialysis tech Z7 was on the floor checking to see what residents were in the facility, and saw that R23 was back in the facility but not scheduled for dialysis. E31 stated the reason Z7 gave for R23 not to receive dialysis was that there was no consent available.</p> <p>E20 (Admissions Person) stated that she was notified by hospital on 6/24/04 was given diagnoses that includes acute respiratory failure, End Stage Renal Disease, and Hypotension. E 20 stated she had no medical training, and was not aware that a diagnosis of end stage renal disease usually indicates a residents need for dialysis. Interview with E2 (DON), E22 (ADON), and E3 (ADON) stated that when a resident is transferred from the hospital to the nursing home, the facility rarely - a report from the transferring nurse, and that all transfers and admits are accepted through the Admissions Department.</p> <p>5. On 7/27/04 at approximately 11:00 AM, surveyor requested E5 (LPN) to check the site of R7's Peripherally Inserted Central Catheter Line(PICC). Surveyor observed a dressing dated 7/26/04 to area of PICC site. Upon questioning by surveyor if E5 monitors PICC site for infiltration, and monitors for any migration of PICC line E5 stated she did not. Review of July 2004 MAR reflects R7 receives an IV dressing change, but does not distinguish what site. Further documentation reveals R7 is receiving flushes to PICC line weekly. E5 stated she is Intravenous certified. E5 stated she had not been in-serviced on PICC lines while working in facility.</p> <p>During interview on 7/28/04 with E22 (Assistant</p>	F9999			

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F9999	<p>Continued From page 63</p> <p>Director of Nursing) ADON of the 2nd floor unit, which house residents with tracheostomy, ventilator dependent and with PICC lines, surveyor asked E22 who monitors the PICC lines of residents on the unit. E22 stated the nurses. E22 further stated the nurses should be documented on the Treatment Administration Record and Medication Administration Record on every shift.</p> <p>R22 was readmitted to the facility on 7/23/04 with diagnosis that include acute respiratory failure, ventilator dependent, and returned with a PICC line to right upper arm with an order for dressing change to PICC line every 72 hours. On 7/28/04, surveyor asked E13 (LPN) who was caring for R 22 if the resident had a PICC line. E13 stated she was unaware that R22 had a PICC line. Upon prompting by surveyor, E13 checked R22 for PICC line site. The site was located to R22's right upper arm. There was a transparent dressing in place dated 7/26/04. There was dried blood at the site and the site appeared soiled. E 13 stated she was not aware that she is to check the PICC lines. Review of Physician's Order Sheet dated 7/1/04 through 7/31/04 indicates under I.V. maintenance that R22 has a PICC line. Review of transfer form dated 7/23/04 documents R22's PICC line. Review of nurses notes from 7/24/04 though 7/27/04 do not reflect any nursing assessments of the PICC site, and there is no documentation on the MAR or TAR that the PICC line has been flushed or a dressing change done. There is no documentation that R22's physician was notified for orders for a PICC line flush.</p> <p>On 7/28/04 at approximately 11:30, surveyor asked E12 (LPN) who was assigned to R33, if R</p>	F9999			

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F9999	<p>Continued From page 64</p> <p>33 had a PICC line. E12 stated she was unsure if R33 has a PICC line. Upon prompting of surveyor to check for PICC line, surveyor and E 12 observed a intravenous site to left lower arm. The area above the IV site was hard and swollen. Upon prompting by surveyor if site was infiltrated, E12 stated it looks like it. Review of physician's current order sheet (POS) revealed an order for . 9% sodium chloride. Review of nurses notes dated 7/25/04 document an attempt to notify physician for a stop order for the I.V. There was no further documentation regarding notification of the physician for a stop order until prompting by surveyor. At 12:00 PM, surveyor asked E12 if IV was discontinued, E12 responded not yet. The surveyor then notified E22 of the observation . At 4:00 PM, E12 came to conference room to retrieve R33's medical record. Surveyor asked E 12 when I.V. was discontinued. E12 responded, "I didn't remove I.V., I just stopped it." When asked by surveyor why I.V. was not removed, E 12 stated only registered nurses can do it. During the team conference meeting on 7/28/04, E2 was informed of E12's statement regarding LPN not be able to discontinue I.V. E2 stated that nurses are able to discontinue an IV. line.</p> <p>Review of the initial facility policy "Peripherally Inserted Central Catheter (PICC) Line was provided by facility on 7/28/04. Review of policy under "Guidelines" requires all aspects of care for a PICC line must be done by a R.N. Further documentation under policies and guideline requires an initial measurement of the upper arm and consistently measuring the same location on the upper arm.</p> <p>On 8/3/04 E2 faxed a newer policy dated 4/04 for</p>	F9999			

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F9999	Continued From page 65 care of PICC lines. Review of policy reveals that a licensed nurse may flush PICC lines, if a physician order is obtained and require staff to document date and time of procedure, site assessment, patient response to procedure and or medication. Under PICC dressing change a licensed nurse may provide dressings changes to PICC lines. The procedure requires documentation of date and time of procedure, site assessment length of external catheter, and patient response to procedure and or medication. Interview with staff (E12, E13,E5, E22) were not aware that measurements of the external catheter (length) must be monitored with PICC lines, or that assessments and care of PICC lines are to be documented.	F9999			