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F 441	Continued From page 16 "What is that smell"? This was verified with E18 on 4/21/08 who stated that this had occurred approximately 2 weeks ago and that she had opened the window to let it air out a little.	F 441		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010h) 300.1210a) 300.1210b)2) 300.1220b)3) 300.3220f) 300.3240a) 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 300.1210 General Requirements for Nursing and Personal Care 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 and	F9999		

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F9999	Continued From page 17 personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel representing other services such as nursing, activities, dietary, and such 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. 300.3220 Medical and Personal Care Program f) All medical treatment and procedures shall be adminstered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)	F9999		

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F9999	Continued From page 18 These requirements are not met as evidenced by: Based on record review, observation and interview, the facility failed to provide care to the central line for one of three sampled residents (R1). The facility failed to follow the doctor's orders and facility policies for changing the needle access to the central line. The needle access to the site was to be changed weekly, however facility staff did not change the needle for over 3 months. R1 was admitted to the hospital with MRSE (Methicillin Resistant Staphylococcus Epidermidis) in the port. Findings include: R1 was admitted to the facility on 10/1/07 according to the admission face sheet. R1's MDS (Minimum Data Set) dated 10/26/07 states that R1 has no long term or short term memory loss and that she is alert to season, room, staff names and faces and that she is currently residing in the nursing home. The Minimum Data Set further assesses R1 as having Diabetes, Autoimmune Hepatitis, Hypothyroidism, Hypertension, anxiety disorder, depression, and MRSA (Methicillin Resistant Staphylococcus Aureus) infection and Septicemia. E3, LPN (Licensed Practical Nurse) stated on 4/10/08 at 9:00 a.m. that R1 was admitted in October 2007, with a PICC (Peripherally Inserted Central Catheter) line for the purpose of I.V. (intravenous) Vancomycin infusion. R1's Care Plan dated 1/22/08 does not include the type of central line and/or specific care to the Infusion port inserted in December of 2007 or to the	F9999		

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F9999	Continued From page 19 previous PICC line that was being used with the original admission in October 2007. The Manual "Clinical Nursing Skills-Basic to Advanced Skills- Sixth Edition" states: "Implanted venous access ports, ...are usually placed in a subcutaneous pocket on the chest wall, ...and may be used for months to years before the maximum 2000 punctures are achieved. Ports are best utilized for cyclic therapies like chemotherapy or antibiotic therapy." "Volume II Modules for Basic Nursing Skills, Sixth Edition" states on 553 Paragraph 1, last sentence: "Because of the direct access to the central circulation, the special dynamics of blood flow in the large central veins, and the difficulty in replacing central IV catheters, specialized care techniques are required.....Nursing Diagnosis. Risk for Infection is a major nursing diagnosis for patients with central lines. First, the solution is flowing directly into the central circulation. Any bacteria introduced with the fluid circulate freely, and generalized septicemia may result. Second, the catheter (in this case, a Huber needle with an extension containing a rubber port for the infusions, which was inserted into the port thru R1's skin) enters through the skin and provides a direct path that microbes may follow from the surface, along the outside of the catheter into the central circulation." The facility policy provided per their consulting pharmacy states these implants "are used for extended term therapy (1-5 years or longer). The reservoir is attached to either an open-ended catheter or to a blunt-tip catheter that terminates in the Vena Cava (large blood vessel leading directly to the heart)." Part III. Policy stated	F9999		

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F9999	Continued From page 20 under #3: "Non-coring needles are changed every 7 days and prn (as needed)." Both the manual quoted above, and the facility policy state that the access needle (Huber needle which is bent at a 90 degree angle) must be used with the port and must be changed every 7 days. According to Nurses Notes dated 12/1/07, R1 was readmitted to the local hospital with a possible TIA (transient ischemic attack) and then returned to the facility with a "Mediport (central line) to Right chest" on 12/11/07. Readmission orders included care for the port: "Contact Isolation for MRSA Left knee; Needle change on infusion port every 7 days-change 12/13/07; Saline and Heparin flushes per protocol; change cap and dressing on infusion port per protocol, dressing change every 3 days and cap change every 3 days and after blood draws." Physician Order sheet dated 3/1/08 to 3/31/08 does not list any care or changes to the needle which goes directly into the central line port. Only the following orders were transcribed from the transfer Physician Order Sheet: "Change dressing on the infusion port Q (every) 3 days and PRN (As needed); Change caps when dressing is changed." January to March 2008 Treatment Records do not include any Physician ordered changes in the needle going directly into the central line port, only the dressings and the cap changes are documented. E1, Administrator verified on 4/18/07 at 3:00 p.m., that there was no other place where this documentation could be found.	F9999		

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F9999	Continued From page 21 On Thursday, 3/27/08 8:00 p.m., Nurses Notes state "Blood cultures x's 2 (times 2) drawn from Rt. (right) subclavian central line per orders/protocol et (and) sent to (local) hospital....3/30/08 4:30 p.m., Resident upset--had inquired about blood cultures...results advised 2 were positive for MRSA--advised Dr. (doctor) would be advised tomorrow....8:00 p.m. Asymptomatic--'feels o.k.' 97.1-78-20 (temperature Pulse and Respirations) B/P (blood pressure) 144/76. Rt. (right) subclavian line (central line) intact patent. (E15, LPN (Licensed Practical Nurse). 3/31/08 9:30 a.m., Dr (Z1) called with orders to send to (local hospital) R/T (related to) blood cultures....(E15)." On 3/18/08 at approximately 2:00 p.m. E15 stated that she "thought she would wait for the third culture to return and then call the doctor. I didn't think it was that serious since she had been positive for MRSA in the blood on previous tests." E15 did state that the physician was "very upset" and wanted R1 transferred to the local hospital "right away." Local hospital History and Physical documents that on 3/31/08, R1 was admitted to the hospital. This same History and Physical dated 3/31/08 states, "She (R1) had finished her course of three months of IV (intravenous) antibiotics for septic arthritis of her left knee and right ankle. She was getting post treatment blood cultures from her (central line) port and all three of them came back positive over this weekend. I was not informed of this until Monday morning and she was immediately transported to (local hospital)." On 4/1/08, Z2 Surgeon surgically removed the implanted (central line) port. On 4/16/08, at	F9999		

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F9999	Continued From page 22 approximately 2:30 p.m., Z2 stated per phone, that the failure to change the needle on a weekly basis "could have led to serious harm" and that "failure to change the needle as ordered, most likely allowed bacteria to travel up the needle and into the central line port, which could have traveled to other body sites, causing serious infection." On 4/7/08, R1 was in a room with isolation personal protective equipment outside the door. R1 stated at approximately 9:30 a.m. "No one changed the needle that went into the port (central line) until I went back to the hospital on March 31, 2008." On 4/7/08 at approximately 11:00 a.m., R1 again stated that the needle had never been changed from the time she returned to the facility on 12/11/07 until she was admitted to the hospital on 3/31/08. On 4/7/08 at approximately 9:00 a.m., E2, LPN was asked to supply a list of nurses who would have given care to R1's intravenous Port (central line). As a result the following licensed staff were interviewed. E11, LPN stated on 4/7/08 at approximately 11:00 a.m. that she never changed the caps or the dressings and that she never changed the needle. E4, R.N. stated on 4/7/08 at approximately 10:00 a.m. that she was not aware of orders to change the needle on the port for R1. E3, LPN stated on 4/10/08 at 9 a.m. that there were no orders to change the needle. E8, LPN stated on 4/10/08 at approximately	F9999		

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F9999	Continued From page 23 10:30 a.m. that she had only changed the dressing one time and had flushed it, but never changed the needle. E9, LPN stated on 4/10/08 at 11:00 a.m. that she had been told she could change the dressing and the cap, but had done nothing with the needle. She further stated that she had taken the course on IV therapy through the consulting pharmacy. On 4/16/08 at 10:30 a.m. E12, R.N. stated that she only worked part time and never had to administer care of the port. She stated that she never saw any orders to do anything with the needle change. E5, R.N. stated that she had never seen any order to change the needle, but that she had done blood draws on the port. E5 stated that the midnight shift nurses are supposed to check over new orders for accuracy. On 4/10/08, transfer orders dated 12/11/07 were reviewed and discussed with E1, Administrator, E3, LPN and E17, Director of Nurses regarding the failure to properly transcribe the readmission order. On 4/10/08 at approximately 11:30 a.m., E1, E3 and E17 were asked to accompany surveyor to storage location where IV supplies and Huber needles would be stored. There was no supply of Huber needles. Z7, Pharmacist stated on 4/10/08 at approximately 11:00 a.m. that he had not sent any IV care kits containing any Huber needles to the facility or any Huber needles. On 4/18/08 at 4:00 p.m., E1 Administrator was asked to provide documentation that LPN's had	F9999		

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F9999	Continued From page 24 been trained in advanced IV therapy course offered through the consulting pharmacy. As of 4/21/08 this documentation had not been provided. E1 also stated at the 4/18/08 interview that she was not aware that there was a problem with R1's needle changes to the port until the complaint investigation was initiated on 4/7/08. (A)	F9999		