DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 12/21/20
FORM APPROVE
2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465128	A. BUILDING _____ B. WING _____	C 12/12/2001

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE REHABILITATION CENTER	1216 EAST 1300 SOUTH SALT LAKE CITY, UT 84105

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F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility did not provide the necessary care and services to attain or maintain the highest practicable physical well-being for one resident at the facility (Resident 1). Facility staff failed to perform cardiopulmonary resuscitation (CPR) on resident 1 who expired after a significant change in condition. Resident 1 had a signed medical treatment plan that included wishes for CPR, mouth to mouth resuscitation,and hospitalization. Additionally, the facility failed to send resident 1 to the hospital, as per the medical treatment plan, when resident 1's significant change was assessed by a nurse and the nurse was unable to reach resident 1's attending physician. Findings include: Resident 1 was a 61 year old male that was admitted to the facility on 9/1/78 with diagnoses that included, paranoid schizophrenia, osteoporosis, chronic obstructive pulmonary disease and pain. Review of the history and physical, dated 7/9/2001 revealed that resident 1 had recently been diagnosed with esophageal cancer.	F 309	1/7/02 acceptable in written addum per phone call Adm. approval of Quality Assurance Plan The preparation of the plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions and/or in the statement of deficiency. The plan of correction was prepared solely because the provisions of the state and federal law require F309 It is the policy of the facility to protect the rights of the residents to direct their own care, including advanced directives, as far as they are able. The agency nurse, who was on the shift in question, was aware of the resident's code status and CPR order and acted independent of, and contrary to the facility policy. On 12/24/01 and on 12/26/01there were mandatory inservices held by the facility, to teach to all staff, the facilities responsibility to provide CPR to all those who have a full code status, in the event that their hearts cease functioning. This inservice will be repeated for all those who work in the facility, including agency staff. The code status of each patient is found on the 24-hour report and in each patient's chart as marked with a large green or red card under the Advanced Directive tab. It is the responsibility of the DON to ensure that all nurses follow this rule and that the facility remains in compliance with this tag, by providing direction to all new staff to provide CPR for all those with full code status and auditing inservice sheets on a monthly basis. → a making changes as required. At a minimum yearly, The DON will review all deaths and the information, along with the audit of inservice, will be brought to the QA committee to ensure compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ADMINISTRATOR 1/8/02

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days aft such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	Continued From Page 1 1. RECORD REVIEW Review of resident 1's medical record on 12/6/01, revealed the following: The comprehensive assessment - minimum data set (MDS), dated 3/21/01, documented in the "Identification and Background Information - Responsibility/Legal Guardian" section that resident 1 was responsible for himself. The quarterly assessment, dated 9/6/01, documented in the "Cognitive Patterns - Memory" section that resident 1's short and long term memory was "OK". The "Physical Functioning and Structural Problems - Activities of Daily Living (ADL) Self Performance" section documented that resident 1 was independent with all ADL's including ambulation, dressing, eating, toilet use, personal hygiene, and bathing. The "Nurse's Notes" section revealed a nurse's noted dated 12/5/01 at 3:00 PM, that documented, " Res. [resident] expired [at] approx. [approximately] 1230 [12:30 PM] in bedroom on bed. There was an extensive amount of blood on the floor surrounding bed. It was reported to this nurse that res. was having emesis [at] approx. 0845 [8:45 AM]. Upon assessment noted emesis was blood tinged [with] chunks in it. Held AM meds [medications] and had VS [vital signs] taken...res was cleaned up and physician [name of resident's attending physician] was paged [at] approx 0900 [9:00 AM] when no reply was received physician was re-paged. Res. continued to have blood tinged emesis and was checked on by various members of staff approx. [every] 15 min. [minutes]. When this nurse still received no reply to pages attempted to reach nurse practitioner [name of practitioner] and she was paged via voice mail and numeric page approx. a total of 4 or 5 times. [At]	F 309	The facility alleges compliance as of 1/8/02.	

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F 309	Continued From Page 2 1230 [12:30 PM] it was reported that res. had expired. Listened apically for 5 min. no HR [heart rate] detected so physician notified [name of nurse practitioner] via voicemail and she phoned back [at] approx. 1245 [12:45 PM] and ordered to release body to mortuary ...." The advance directive section revealed a green sheet of paper in the front of this section. This sheet of paper documented in large bold letters "FULL CODE" (cardiopulmonary resuscitation when the resident's breathing and heart stop). This section also contained a "Medical Treatment Plan", dated 10/29/01. This plan documented, "Resident indicates yes to CPR, yes to mouth to mouth resuscitation, yes to hospitalizations yes to IV's [intravenous fluids], yes to antibiotics and no to feeding tubes." This form was signed by resident 1 on 10/29/01. 2. INTERVIEWS In an interview with the facility director of nursing (DON) on 12/6/01 at 4:00 PM, she stated that the nurse on duty the day resident 1 had a change in condition and expired was a "pool" nurse from a temporary staffing agency. The DON stated that the agency nurse had only worked one other time at the facility. The DON stated that she was in a meeting that morning, but the nurse had made her aware of resident 1's change in condition and that she had been unable to reach resident 1's attending physician. The DON stated that at that time she had the facility social worker try to reach the nurse practitioner for resident 1's attending physician. The DON stated that she did not personally assess resident 1's condition. The DON stated that as she was leaving the facility to go to lunch she told the agency nurse to "keep an eye" on the	F 309		

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F 309	Continued From Page 3	F 309		

resident. The DON stated that when she returned to the facility after lunch, the facility nurse consultant informed her of resident 1's death. The DON stated that she did not know if the facility had an orientation for agency nurses to the facility's policies. She stated that the facility had a list of pool nurse's responsibilities and a nursing protocol to help make sure that the "pool" nurses were aware of their responsibilities during their shift.

Review of these forms, during this interview, revealed that the "Pool Nurse Responsibilities" and "Nursing Protocol" forms did not include any documentation regarding where to find out the current code status or advance directive information on each resident at the facility. The DON stated that she was unsure if the agency nurses were instructed as to where to find this information.

In an interview with the facility assistant director of nursing (ADON) on 12/5/01 at 4:30 PM, he stated he was also in a meeting the morning of 12/5/01. He stated that he left the meeting at approximately 11:00 AM and spoke with the agency nurse caring for resident 1. He stated that he told the nurse that if the resident continued to vomit bloody emesis and she continued to be unable to reach resident 1's physician or nurse practitioner, she should send the resident to the hospital emergency room for an evaluation.

In a discussion with the facility DON and nurse consultant they showed this surveyor the facility's 24 hour nursing report sheets. They stated these sheets were for the nurse to record any changes in resident condition or orders that had occurred in the last 24 hours. They showed this surveyor that each resident's

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F 309	Continued From Page 4	F 309		

name was listed on this form and below each name was the code status for each resident. Review of this 24 hour report sheet revealed that resident 1 was listed and below resident 1's name were the words, "Full Code".

In a telephone interview with the facility DON on 12/12/01 at 10:00 AM, she stated that she had spoken to the agency nurse that cared for resident 1 on 12/5/01. She stated that she asked the nurse if she knew that resident 1 was a "Full Code" and required CPR. The DON stated that the nurse told her "yes" she knew that resident 1 was a full code. The DON stated that she then asked her why she had not done CPR on resident 1 and she stated that she had not done the CPR because resident 1 appeared to have been expired for some time (this statement by the nurse is inconsistent with the nurse's note dated 12/5/01, by this same nurse, that documented that resident 1 had been checked on by the staff every 15 minutes). The DON stated that the agency nurse further stated that the other staff members present at the time resident 1 was discovered to have expired did not suggest that CPR be performed.

A telephone interview was held with the nurse practitioner (NP) for resident 1's attending physician, on 12/10/01 at 3:30 PM. The NP stated that she had been paged by the facility on 12/5/01 and returned a call to the facility at approximately 10:00 AM. She stated that a nurse from the north station had answered the telephone and attempted to locate the nurse caring for resident 1. She stated that this nurse was unable to find the nurse and told the NP that he knew they had called her regarding resident 1's nausea and vomiting. She stated that this nurse did not tell her that resident 1 was vomiting bloody emesis. She stated that she

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F 309	Continued From Page 5	F 309		

ended the call and returned another call to the facility at approximately 12:00 PM. She stated that she asked for the nurse caring for resident 1. She stated that she was put on hold and remained on hold for approximately 10 minutes and that the nurse never answered the telephone. The NP stated that she returned another call to the facility at approximately 1:00 PM. She stated that she was told at that time that resident 1 had expired. She stated that the issue of resident 1's code status was not discussed at that time. She stated that she was under the impression that resident 1 had stopped his chemotherapy and decided to not have any CPR. She stated that she was not aware that resident 1 was a full code at the time of his death.

The NP stated that she spoke with resident 1's attending physician later that day (12/5/01) and he stated to her that he did not remember receiving any pages from the facility that day.

The NP stated that she spoke with the facility DON on 12/5/01 and explained to the DON that if she and/or resident 1's attending physician were unable to be reached for any physician orders, that the facility should always send the resident to the emergency room for an evaluation.

In an interview with resident 1's oncology (cancer specialist) physician on 12/10/01 at 4:00 PM, she stated that she was not made aware that resident 1 had expired on 12/5/01. She stated that she had seen resident 1 during an appointment at her office at the end of October 2001. She stated that resident 1 was alert and oriented and ambulatory. She stated that resident 1 had never stopped his chemotherapy and that she had requested that the facility schedule a test to evaluate the progress of the chemotherapy, but the

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F 309	Continued From Page 6 facility had not scheduled the test as of the date of resident 1's death. She further stated that in her opinion, resident 1 was not imminently terminal.	F 309		

Directed Plan of Correction and Directed In-service Training
Hillside Rehabilitation Center

This is the Directed Plan of Correction (DPOC) for the Standard Extended survey ending 11/8/01 with a finding of Sub-Standard Quality of Care for pressure sores (F314). Additional areas of non-compliance to be addressed in this DPOC are Quality Assurance (F521), Administration (F490), Pharmaceutical Services (F426), Infection Control (F441), registered nurse coverage (F354), Laboratory Services (F502), and Professional Standards of Quality (F281).

Hillside Rehabilitation Center is being directed to accomplish the following items as part of an acceptable plan of correction:

1. The facility must obtain and use the services of a registered nurse consultant who has no affiliation with Infinia or Mission Health Services. The registered nurse consultant must be approved by the State Survey Agency. The nurse consultant must perform on-site visits to Hillside Rehabilitation Center, at least 3 times a week, to monitor compliance with each deficiency mentioned in this DPOC. The registered nurse consultant will assist the facility to establish effective systems and efficient monitoring of those systems. The registered nurse consultant must document each visit, what was monitored and the findings of the audits. Copies of all audits must be faxed to the State Survey Agency on a weekly basis.

The registered nurse consultant must provide in-services regarding each deficiency as follows:

Pressure Sores - to include prevention, assessment, staging, treatment, nutrition, current standards of practice, and documentation. The in-service regarding pressure sores must be provided to all nurses and nurse aides who provide care within the facility.

Quality Assurance (QA) - to include how to identify issues that necessitate action of the Quality Assurance committee, such as issues which negatively affect the quality of care and services provided to residents. The in-service must also include how to develop and implement plans of action to correct identified deficiencies (including ALL deficiencies cited in the 2567 dated 11/8/01). The in-service regarding QA must be provided to all members of the facility's QA committee (to include the physician, Administrator, Director of Nurses (DON), and 3 other members of the facility's staff).

Pharmaceutical Services - to include the basics of diabetes, types of insulin and their times of onset, sliding scale doses, medication (to include insulin) administration, and taking off medication orders and transfer to the medication administration record. This in-service must be provided to all nurses who provide care within the facility.

Infection Control - to include the setting up of a system which will monitor and investigate causes of infection (nosocomial and community acquired) and manner of spread. The in-service must address the maintenance of a separate record on infection that identifies each resident with an infection, states the date of infection, the causative agent, the origin or site of infection, and

describes the cautionary measures taken to prevent the spread of the infection within the facility. The system must enable the facility to analyze clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner. The in-service must address all aspects mentioned in the interpretive guidelines of F441 (CFR 483.65 Infection Control). This in-service must be attended by the Administrator, Director of Nurses, Assistant Director of Nurses and the facility's infection control coordinator.

Laboratory Services - to include methods to achieve accurate and timely laboratory services, and establishing a system to monitor that results are obtained for each lab ordered.

Professional Standards of Quality - to include urinary catheter care and gastrointestinal tube (G-tube) care. This in-service must be attended by all nurses and nurse aides who provide care within the facility.

Copies of the in-services, along with current nursing and nurse aide staff rosters and in-service sign-in sheets will also be faxed. The in-services will include the date, the start of the in-service and the time the in-services concluded. Staff attending the in-services will also document their discipline.

Pressure Sores

The facility will establish a skin team to include a registered nurse and at least one other person familiar with skin integrity problems. The skin team will meet at least every 7 days. The skin team will perform a skin check (at least every 7 days) of each resident who has been identified by nursing staff as having skin breakdown. The skin team will assess, measure and evaluate the effectiveness of the treatment of the skin breakdown.

Each resident will be evaluated for his/her risk for developing pressure sores at least every 3 months. Skin risk assessments will be performed by a nurse. The skin team will develop a system to ensure and frequently monitor (at least every 7 days) the application of all appropriate preventive measures as indicated by the skin risk assessment results.

Each resident in the facility will have a complete skin check at least every 7 days. These skin checks will be performed by a nurse. The head of the skin team will develop a monitoring tool to ensure that all skin checks are completed. The head of the skin team will perform at least 5 random observations every 7 days, of residents evaluated as being "at risk" for pressure sores, to ensure that skin checks performed by nursing staff are accurate. The head of the skin team will also ensure that issues of skin breakdown are made known to the physician, and if orders are received, are transcribed to the treatment sheet. The head of the skin team will perform at least 2 random observations (of different nurses) of pressure sore dressing changes as performed by floor nurses. This will be done each week. The nurse who was observed, as well as the resident to whom treatment was provided, will be documented. All dressings (including those for G-tubes) within the facility will be dated. The head of the skin team will perform 3 random

observations, at least every 7 days, to ensure that dressings are being changed as ordered by the physician (intent of this is to check the dates on the dressings). This monitoring must also include observations of G-tube dressings. The head of the skin team will also monitor documentation on the treatment sheet to ensure compliance with physician's orders. The skin team will also be responsible to ensure that the physician is made aware of dietary recommendations which would promote the healing of a pressure sore or skin breakdown.

The Administrator will designate, in writing, a person responsible to perform random observations of residents to ensure that incontinence cares and repositioning are provided at least every 2 hours. These random observations will be performed at least 2 times a week and will be documented as to which residents were observed and the results of the monitoring.

Skin integrity/wound care policies will be reviewed by the RN consultant as well as the skin team to ensure current standards of practice. Review and acceptance of these policies will be documented.

Results of monitoring will be kept and will be faxed weekly to the State Survey Agency.

Quality Assurance (QA)

The facility will establish a QA committee to consist of at least the DON, a physician, and three other members of the facility's staff. The QA committee will meet at least weekly for two months or until substantial compliance is achieved. The physician need only attend the QA meetings monthly for the first two months or until substantial compliance is achieved. The RN consultant will attend the weekly QA meeting to guide the QA committee toward compliance with all issues identified in the Statement of Deficiencies, dated 11/8/01, and ANY OTHER issues the RN consultant feels are non-compliant with federal long term care regulations. The QA committee will be responsible to ensure that effective systems and monitoring of those systems are in place which will help the facility achieve and maintain compliance. Documentation of the QA minutes and progress toward compliance must be kept and faxed to the State Survey Agency weekly.

Administration

The corporate administrator will make at least two on-site visits to the facility every 7 days. The corporate administrator will work with the facility administrator to ensure that the facility is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The dates and time spent within the facility by the corporate administrator must documented. Copies of this documentation must be faxed weekly to the State Survey Agency.

Infection Control

The facility will establish an infection control committee, with the assistance of the RN consultant, to consist of at least one registered nurse and another individual familiar with infection control practices. The committee will meet at least every 14 days until substantial compliance is achieved. The infection control committee will be responsible for setting up and implementing a system which will monitor and investigate causes of infection (nosocomial and community acquired) and manner of spread. The infection control committee will maintain a separate record on infection that identifies each resident with an infection, states the date of infection, the causative agent, the origin or site of infection, and describes the cautionary measures taken to prevent the spread of the infection within the facility. The system must enable the facility to analyze clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner. The committee may refer to the interpretive guidelines for assistance.

Facility infection control policies will be reviewed by the RN consultant and the infection control committee to ensure current standards of practice. Review and acceptance of these policies will be documented.

Pharmaceutical Services

The administration of insulin by direct care nurses will be monitored at least once a day, 7 days a week for a month. Three of the observations will be performed by the RN consultant. The remaining 4 observations will be performed by the DON. During the first week of observation, 3 of the 7 observations will be performed by BOTH the RN consultant and the DON. Observations must be random and must include observations of all shifts during which insulin is administered. These observations will continue until substantial compliance is achieved.

All nurses who provide care within the facility will be required to successfully return demonstrate the proper and accurate administration of insulin to the RN consultant. The monitoring and return demonstration must be documented and also faxed with the weekly reports. A record must be kept of all nurses who perform services in the facility and whether they are a registered nurse or a licensed practical nurse.

The Administrator will designate, in writing, a nurse who will be responsible to monitor the medication administration record of each resident on a daily basis until substantial compliance is achieved to ensure that medications are administered as ordered by the physician. This nurse will document the results of his/her monitoring.

Professional Standards of Quality

The Administrator will designate, in writing, a nurse who will be responsible to monitor urinary catheter care within the facility. The nurse will be responsible to ensure that current professional

standards of quality are maintained when caring for residents with urinary catheters. Daily random observations will be performed to ensure that neither catheter bags or tubing are on the floor and that catheter bags are emptied as necessary. Results of the observations will be documented and included in the weekly reports faxed to the State Survey Agency.

Laboratory Services

The Administrator will designate, in writing, a staff member to monitor and ensure that timely results are obtained for labs which are ordered by the physician. Results of monitoring will be documented and included in the weekly reports faxed to the State Survey Agency.

RN Coverage

The RN consultant will monitor the use of nurses within the facility at least 3 times a week to ensure that the services of a registered nurse are used for 8 consecutive hours a day, 7 days a week. Results of monitoring will be kept and faxed to the State Survey Agency weekly.

Agency (Pool) Staff

The facility will establish a method to ensure that ALL nurses and nurse aides who perform services within the facility are in-serviced regarding the issues contained within this DPOC. A facility staff member will be designated, in writing, to monitor and ensure that all pool staff are in-serviced.