

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

PRINTED: 05/01/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/17/2014
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NAME OF PROVIDER OR SUPPLIER  BAPTIST CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 MAIN STREET NEWPORT, KY 41071
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F 000	INITIAL COMMENTS  A Recertification Survey was initiated on 04/15/14 and concluded on 04/17/14. Deficiencies were cited with the highest Scope and Severity of an "F".	F 000	Preparation or execution of this Plan of Correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This Plan of Correction is prepared and executed, as required by the provision of federal and state law.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES  The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.  This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of the facility's policy, it was determined the facility failed to ensure all residents food preferences were honored for one (1) of twenty-four (24) sampled residents (Resident #1). Resident #1 had a food preference of two (2) percent milk; however, received whole milk with his/her meals.  The findings include:  Review of the facility's policy titled, "Resident Nutrition", dated February 2011, revealed once a new resident was admitted to the facility the Dietary Manager or employee would interview the resident within forty-eight (48) hours. The policy revealed during the interview the resident would discuss his/her likes and dislikes.  Review of Resident #1's "Resident Nutrition	F 242	F 242 Self determination Right to make choices  Resident #1 was discharged to a Personal Care Unit on 4/25/2014. Facility observations 4/16/2014 through the end of her stay revealed she received 2% at each meal per her preference. During the survey, resident #1 was being treated for a UTI with increase in confusion (as noted in the rehab records) causing her planned discharge to be delayed 11 days. Earlier in her stay, her primary caregiver states she requested whole milk in the morning for her cereal, and it was provided per her right. Resident #1 suffered no ill effects from receiving the whole milk, and was provided with the preferred 2% milk for the remainder of her stay. The resident had no allergies to milk or contraindications of any kind toward any milk.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Annmarie Hodge* TITLE *LNHA* (X6) DATE *5/22/14*

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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F 242 Continued From page 1

History/Preferences" Assessment, undated, revealed it stated in order for the facility to better meet the nutritional needs for all new residents a few questions would be answered regarding the resident's food likes and dislikes. Continued review of the Assessment revealed Resident #1 had checked he/she disliked whole milk, skim milk, and buttermilk.

Review of Resident #1's Menu Card, dated 04/15/14, for breakfast, lunch, and dinner revealed the resident preferred two (2) percent milk as a beverage.

Review of Resident #1's medical record revealed the facility admitted the resident on 03/11/14, with diagnoses which included Gastroesophageal Reflux Disorder (GERD). Review of the Initial Minimum Data Set (MDS) Assessment dated 03/18/14, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated the resident was cognitively intact.

Observation on 04/15/14 at 8:29 AM, revealed Resident #1 eating breakfast in his/her room. Continued observation revealed Resident #1 had whole milk on his/her breakfast tray. Further observation at this time revealed no evidence of two (2) percent milk on the tray.

Interview with Resident #1 on 04/15/14 at 8:30 AM, revealed he/she preferred two (2) percent milk. Resident #1 stated, "they always send me whole milk. I like two (2) percent milk". Resident #1 reported he/she did not like whole milk. According to Resident #1, his/her daughter had informed his/her likes and dislikes to the staff.

F 242 F 242 Self determination Right to make Choices Cont.

- All residents have the potential for their preferences not to be honored.
- All diet preferences, tray cards and physician diet orders have been reviewed by the Unit Manager of each unit to be sure they are correct and up to date. This review was completed on May 9, 2014.
- Inservices were provided to all nursing staff by the Director of Nursing to review meal service and checking tray cards for fluid preferences when serving a residents tray, as well as appropriate diet and consistency. Nursing staff includes registered nurses, licensed practical nurses and certified nurse aids. Staff is also to notify the dietary department when a resident changes preferences so the tray cards can be updated appropriately with all changes. As always, the resident does have the right to change their preferences for a single meal or permanently. Staff education was completed by May 9, 2014.
- The Unit managers will coordinate an audit of 10 residents for breakfast, lunch and dinner to assure they are receiving the preferred beverages as well as not receiving foods listed as disliked. (Attachment F 242 N116) This will occur monthly for 2 months and then every other month.

5/10/14

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F 242 Continued From page 2

Interview with Certified Nursing Assistant (CNA) #9 on 04/15/14 at 12:50 PM, revealed residents did not have preferences or likes on their meal cards, only dislikes were on it. She stated Resident #1 received whole milk for breakfast and lunch. She indicated the resident had received whole milk earlier at breakfast. CNA #9 stated Resident #1 did not request any other milk, so she provided the resident with whole milk. The CNA reported Resident #1 did not get two (2) percent milk with his/her meals.

Interview with the Dietary Manager on 04/15/14 at 11:30 AM and on 04/16/14 at 1:00 PM, revealed food preferences were obtained on resident admission to the facility. He stated he would assess the resident's food and beverage preferences by talking with the resident, as well as, his/her family. The Dietary Manager stated if a resident changed his/her mind regarding a preference on the meal ticket, the ticket would change and the resident would be reassessed or revisited to ensure food preferences were current. According to the Dietary Manager, Resident #1 had completed a nutrition assessment regarding his/her likes and dislikes. He stated Resident #1 indicated he/she preferred to have two (2) percent milk with meals according to the nutrition assessment. The Dietary Manager stated if he were the CNA assisting Resident #1 with his/her meal, he would have offered the resident beverages he/she preferred. He indicated he then would have asked the resident if he/she wanted something different.

Interview with the Administrator on 04/16/14 at 1:20 PM, revealed it was her expectation for staff to follow residents' menu cards in regards to their preferences. However, she stated if residents

F 242

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F 242	Continued From page 3 requested something different, then staff should honor the resident's request. The Administrator stated she was informed by staff Resident #1 requested whole milk to drink and/or add to his/her cereal.	F 242			
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy and documents, it was determined the facility failed to ensure provision of housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior to prevent the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Observations revealed resident toothbrushes were unlabeled and uncovered in resident rooms 203, 209, 221 and 411. Additionally, observations revealed a vent cover hanging from the ceiling over the toilet in a community resident bathroom on the 3rd floor.  The findings include:  1. Review of the facility's policy titled, "Resident Safety" dated 10/15/13, revealed residents should store personal care items in a closed area such as a drawer or closet in their room.  Interview with the Director of Nursing (DON) on	F 253	F 253 – Housekeeping and maintenance  1) Toothbrushes: - Toothbrushes were cleaned and/or replaced if necessary, placed in a kidney basin lined with a paper towel, marked with the residents name and placed in the residents' drawer. - There were no adverse effects noted related to the deficient practice. - All residents have the potential to be affected. - Each resident is provided with a kidney basin at the time of their admission. Nursing staff has been instructed to label this basin with the residents name, line it with a clean paper towel and place the residents' toothbrush in it prior to storing in a drawer with like resident personal care items. (See updated Resident Safety Policy – Attachment F253/N134 #1		

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F 253	Continued From page 4 04/17/14 at 3:22 PM, revealed the facility did not have a policy specific for toothbrushes; however her expectation would be for toothbrushes to be labeled and covered for infection control and cross contamination prevention.  Observation on 04/15/14 at 5:10 AM, during the initial tour of the facility in Unsampld Resident G's and Unsampld Resident J's semi-private room 203, revealed two (2) unlabeled, uncovered toothbrushes stored in a wire basket on the bedside table. Continued observation revealed the bristles of the toothbrushes were touching, and also were observed to be touching a hair brush, comb and nail file stored with them. Further observation on 04/15/14 at 5:20 AM, during the initial tour revealed in Unsampld Resident H's and Unsampld Resident I's semi-private room 209, one (1) unlabeled and uncovered toothbrush lying on a bedside table.  Observation on 04/16/14 at 9:08 AM, of resident room 411 revealed an unlabeled, uncovered toothbrush lying on the counter beside the sink under the soap dispenser. Observation of resident room 221 on 04/17/14 at 9:15 AM, revealed three (3) unlabeled and uncovered toothbrushes lying on the sink counter under the soap dispenser.  Interview with Certified Nursing Assistant (CNA) #3, on 04/16/14 at 9:13 AM, revealed toothbrushes should have residents' names on them and should be stored covered to keep them sanitary.  Interview with CNA #7 on 04/17/14 at 2:00 PM, revealed she was taught to label residents' toothbrushes and store them in toothbrush	F 253	Inservice training for all nursing staff the Resident Safety policy was completed by 5/9/2014 by the Director of Nursing and Infection Control Nurse/ADON. Nursing staff includes registered nurses, licensed practical nurses and certified nurse aids. - Each unit manager will coordinate the completion of a toothbrush storage audit monthly x3, then every other month. Toothbrushes found inadequately stored will be corrected/replaced as needed - The results of this audit will be reported at the QA meeting.  2) Vent Cover: - No residents were affected by the broken vent cover - Any resident using that bathroom could have been affected - The vent cover WAS repaired on 4/15/14. (See attached copy of work slip as shown to the surveyors F253/N134 #2) The clips holding the vent cover were bent back into place and the vent cover was firmly in place when signed off by the maintenance department. That repair did not hold - when it was discovered again on 4/16/14, the vent cover was replaced. Work orders are completed by any staff member who discovers the need for a repair. Issues that create a risk to resident safety are called to the maintenance department or on call maintenance worker.		

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F 253	Continued From page 5 holders in the bathroom.  Interview with CNA #4 on 04/17/14 at 2:10 PM, revealed she was taught to residents' toothbrushes were to be rinsed, placed in a plastic bag which was to be labeled with the residents' name and room number.  Interview with Licensed Practical Nurse (LPN) #12 on 04/17/14 at 2:20 PM, revealed it was her expectation for CNA's to rinse residents' toothbrushes, label the toothbrush and place it in a separate holder in the resident's bathroom.  2. Review of the facility's inservice document titled, "Fire/Safety Inservice, undated, revealed damaged equipment could pose a threat of injury risk for residents and staff. Continued review of the policy revealed if staff observed damaged equipment they should fill out a work order to request maintenance.  Observation on 04/15/14 at 5:30 AM, of the community resident bathroom on the 3A West Unit across from Room 314, during initial tour of the facility revealed a loose vent cover hanging from the ceiling over the toilet.  Interview with CNA #5 on 04/15/14 at 5:33 AM, revealed the loose vent cover could cause injury to residents or staff. She stated she was not aware of a work order having been completed to fix the vent. She indicated she would complete a work order, which the Surveyor observed her to complete and submit to the front desk nurse's station.  Additional observation of the same community resident bathroom on 04/16/14 at 9:06 AM,	F 253	F 253 - Housekeeping and maintenance Cont.  Employees will continue to report items in need of repair by the current method. Items not repaired timely will be reported to the maintenance supervisor and/or administrator for follow up.	5/10/14	

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F 253	Continued From page 6 revealed the vent cover continued to be hanging from the ceiling over the toilet.  Interview with LPN #2 on 04/16/14 at 9:10 AM, revealed work orders were completed for issues which might not directly affect residents, such as, a blown light bulb. LPN #2 stated with other issues, such as, toilets overflowing the maintenance department was notified immediately for repairs. According to LPN #2, work orders were for less immediate requests and one would be completed for a vent repair.  Observation of the community resident bathroom on 04/16/14, with LPN #2 revealed the unrepaired vent cover. Observation revealed LPN #2 located a work order slip on a shelf in the bathroom which had been completed by CNA #5 on 04/15/14. Continued interview with LPN #2 revealed the vent should have been repaired by maintenance on 04/15/14. She stated she considered the hanging vent cover a safety issue as it could fall from the ceiling and hit a resident or an employee in the head.	F 253		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure Physician's Orders were followed for one (1) unsampled resident (Unsampled Resident F).			

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F 281	<p>Continued From page 7</p> <p>Observation during a medication pass revealed Unsampld Resident F's ten (10) milliequivalent (mEq) Potassium (an electrolyte replenisher) medication was not available to administer as ordered. Review of Unsampld Resident F's Medication Administration Record (MAR) revealed on 04/12/14, 04/13/14 and 04/15/14, staff had documented the medication as administered. The Director of Nursing (DON) indicated the nurse had "borrowed" one (1) dose of the medication on 04/12/14 from another resident, and not given the medication on 04/13/14 and 04/15/14. However, documented the medication as administered on the MAR.</p> <p>The findings include:</p> <p>Review of Unsampld Resident F's medical record revealed the facility admitted the resident on 08/10/2013, with diagnoses which included Congestive Heart Failure (CHF) and Bilateral Lower Leg Edema. Review of the Physician's Orders revealed Unsampld Resident F had orders for Potassium twenty (20) mEq to be given on Monday, Wednesday, and Friday daily in the AM; and Potassium ten (10) mEq on Tuesday, Thursday, Saturday, and Sunday daily in the AM.</p> <p>Observation on 04/16/14 at 8:30 AM, during a medication pass revealed Unsampld Resident F's Potassium twenty (20) mEq was present; however there was no Potassium ten (10) mEq present.</p> <p>Review of Unsampld Resident F's MAR revealed the resident's Potassium ten (10) mEq had been initialed as administered on: Saturday, 04/12/14; Sunday, 04/13/14; and on Tuesday, 04/15/14.</p>	F 281	<p>F 281 Services provided meet professional Standards</p> <ul style="list-style-type: none"> <li>- The physician for Resident F was notified immediately upon discovery that the medication had not been given. A potassium level was checked that day. (drawn 4/16 at 11:21 AM, Resulted 4/16 at 1:36 within normal limits).</li> <li>- BCC staff administers all the Medications for residents. Periodic med pass audits done by MedCare pharmacy reinforce the protocol for missing drugs.</li> <li>- The nurse involved with this incident was terminated for failure to follow established facility policies and falsification of a resident record.</li> <li>- MedCare pharmacy provided an inservice in March 2014 covering procedures for missing medications (Checking e-box, calling the pharmacy for delivery if needed.) Mandatory inservices were again held the week of 5/5/14 through 5/9/14 to review/reinforce these same items.</li> <li>- The procedures will be reviewed quarterly with scheduled nurses meetings.</li> <li>- The facility will continue to discipline employees who do not follow the established protocol and terminate any employee who willfully falsifies a resident record.</li> </ul>	5/10/14

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F 281 Continued From page 8

F 281

Interview with Pharmacy Technician (Tech) #7 on 04/16/14 at 9:30 AM, revealed the pharmacy had sent Potassium ten (10) mEq, eighteen (18) tablets for Unsampled Resident #F on 04/09/14. The Pharmacy Tech stated Unsampled Resident F's box of Potassium ten (10) mEq was returned to the pharmacy the next day, on 04/10/14.

Review of the documentation of medications obtained from the facility's emergency box revealed no documented evidence Potassium ten (10) mEq had been obtained for Unsampled Resident # F, and charged to his/her account.

Interview with the Director of Nursing (DON) on 04/16/14 at 2:10 PM, revealed she had spoken with Licensed Practical Nurse (LPN) #7, who had worked on Saturday, 04/12/13, Sunday, 04/13/14, and Tuesday, 04/15/14. The DON stated LPN #7 had told her on Saturday, 04/12/14 she administered Potassium ten (10) mEq to Unsampled Resident F which she had borrowed from another resident's medication. According to the DON, LPN #7 informed her however, on Sunday, 04/13/14 and Tuesday, 04/15/14, she had not administered the Potassium ten (10) mEq as ordered. Continued interview with the DON revealed LPN #7 told her she had documented the Potassium ten (10) mEq on the MAR even though she had not administered the medication. The DON indicated LPN # 7 gave her no reason for having falsified the Unsampled Resident #F's MAR. The DON stated it was her expectation for all nurses to ensure medication is reordered promptly from the pharmacy to ensure it was available for administration as ordered. She stated she expected the nurses to use the facility's emergency medication box as needed

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F 281 Continued From page 9  
when a resident's medication was not available to ensure the correct dosage was provided as ordered. The DON indicated it was her expectation for all nurses to ensure Physician's Orders were followed and to document truthfully in residents' medical records as they were a legal document.

F 281

F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

F 323

F 323 Free of Accidents/Hazards/Devices

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

- No residents were adversely affected by this practice.
- All wandering/confused residents have the potential to be affected
- Bleach wipes were removed from the patient only bathroom.
- Doors to the medication/storage areas in the A building have been closed and locked (until a locking system can be installed on the supply cabinet) a key is accessible to all staff.
- The lockable cabinets behind the nurses station in the C-Building are now kept locked, and all potentially hazardous chemicals/materials have been moved to these locked areas

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, and review of the facility's policies, it was determined the facility failed to ensure the resident environment remained as free from accident hazards as was possible. Observations revealed unlocked storage areas that contained items to include razors, PDI Sani-Cloth Bleach Germicidal Wipes, bottles of mouth wash, syringes with needles and disposable razors.

The findings include:  
Review of the facility's policy titled "Resident Safety", dated 10/15/13, revealed all chemicals or hazardous materials were to be kept in a secure area when not in use.

All Nursing staff, which includes registered nurses, licensed practical nurses and certified nurse aids, were educated by the DON and ADON on the need to keep these doors/cabinets locked. Inservice was completed by 5/9/2014.

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NAME OF PROVIDER OR SUPPLIER  BAPTIST CONVALESCENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 120 MAIN STREET NEWPORT, KY 41071	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 323 | Continued From page 10

Review of the facility's policy titled "Medication Storage in the Facility", undated, revealed medication supplies were to be locked or attended by persons with authorized access.

Review of the Material Safety Data Sheet (MSDS) for the PDI Sani-Cloth Bleach Germicidal Wipes, revealed the product was considered a Hazardous Chemical, as defined by the OSHA (Occupational Safety and Health Administration) Hazard Communication Standard, 29 CFR 1910.1200. Further review revealed the product was labeled to be kept out of reach of children. Review of the MSDS for PDI "Sani Hands" instant hand sanitizing wipes revealed the product was flammable and labeled to be kept out of reach of children.

1. Observations of the "Patient Only" 3A West bathroom, across from Room 314, while touring the facility on 04/15/14 at 5:30 AM and again on 04/16/14 at 9:06 AM, revealed Sani-Cloths with Bleach on the bathroom shelf behind the toilet.

An interview with Certified Nursing Assistant (CNA) #5, on 04/15/14 at 5:33 AM, revealed the bleach would be considered hazardous to the resident.

An interview with Licensed Practical Nurse (LPN) #2, on 04/16/14 at 9:10 AM, with regard to the "Patient Only" bathroom, revealed the bleach wipes should not be in the bathroom and she removed them.

2. Observation of the medication/storage room on the third floor, on 04/15/14 at 7:30 AM, revealed the door to the medication/storage room was unlocked, with no staff within visible sight of

F 323 | F 323 Free of Accidents/Hazards/Devices Cont

- Management staff, unit managers and charge nurses are responsible for monitoring the doors/cabinets during rounds and to immediately lock any area found unlocked. Offenders will be reeducated/disciplined by their department head.
- Formal rounds/audits will be completed at least 3 times a week (Attachment F323N219), and reeducation/disciplinary action taken as necessary.

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F 323	Continued From page 11 the door. Further observation revealed six (6) disposable razors, nineteen (19) medication syringes with needles, four (4) boxes of two hundred (200) count alcohol prep pads, two (2) boxes of one hundred (100) count nail polish remover pads and one (1) pill splitter with razor blade attached. Subsequent observation, on 04/15/14 at 9:00 AM, revealed the door to the medication/storage room was unlocked, with no staff observed to be in sight of the unlocked door.  Interview with LPN #2, on 04/15/14 at 12:15 PM, revealed the door to the storage room was not normally locked. Further interview revealed items such as the syringes with needles, disposable razors and cleaning cloths could be hazardous to a resident that was cognitively impaired.  3. Observation of the 3rd Floor Nurse's Station storage area on 04/17/14 at 2:55 PM revealed the nurse's station was vacant and the storage area door was unlocked. The surveyor was able to walk into the room, walk around and walk out. Several residents were in wheelchairs in the area. The surveyor stood at the nurse's station awaiting a nurse. LPN #2 arrived at 3:03 PM from the elevator. LPN #2 stated she did not know who was responsible for the area, but the door should have been shut and locked.  4. Observation of the C Unit Nurses station, behind the desk, on 04/16/14 8:40 AM, revealed no one was sitting at the desk. Behind the nurses station, unlocked cabinets contained multiple unpackaged syringes with attached needles. Further observation revealed four (4) bottles of sanitized wipes, two (2) bottles of sani-cloth bleach wipes, one (1) container of Ativa Screen Cleaning Wipes, which displayed "keep out of	F 323			

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F 323 Continued From page 12

reach of children", and one (1) Sani-cloth Bleach (orange bottle). In the upper unlocked cabinet, six (6) razors were stored. Observation further revealed the nurse, Licensed Practical Nurse (LPN) #4, returned to the nurses station at 8:46 AM.

Interview with LPN #4, on 04/16/14 at 8:47 AM, revealed there were items in the cabinet that resident's should not have access to. LPN #4 stated there were two wanderers on the floor, Unsampled Residents D and E. She added it was possible those residents could wander through the nurses station and have access to these items. She reported it was important to lock the items due to resident's safety and stated, "you would not want the residents to put the bleach clothes in their mouths and/or cut themselves with the razor or poke themselves with the needles". LPN #4 revealed the facility never kept the cabinet locked, but stated it should be locked.

Interview with the Director of Nursing (DON), on 04/17/14 at 3:32 PM, revealed she had been employed at the facility for two (2) years and the doors to the storage room had not been locked. Continued interview revealed, to the DON's knowledge, the facility had received no negative reports due to the unlocked door. Further interview revealed it could potentially be dangerous for a cognitively impaired resident to obtain a hazardous item from the unlocked room.

Interview with the Administrator, on 04/16/14 at 2:24 PM, revealed she had been at the facility for eight (8) years and the storage rooms had never been locked. Further interview revealed the facility did have residents that wandered.

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F 323  F 431 SS=F	<p>Continued From page 13</p> <p>Continued interview revealed the facility's plans were to install locks on the doors for safety.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>	F 323  F 431	<p>F 431 Drug Records, Label/Store drugs and biologicals</p> <ul style="list-style-type: none"> <li>- No residents were assessed to be affected by this practice.</li> <li>- Any resident receiving a refrigerated medication had the potential to be affected.</li> <li>- An addendum was made to the MedCare Pharmacy Manual (Attach 341/N143 #1) that instructs the staff to record the refrigerator temperature nightly on 10 to 6 shift. If reading is outside of recommended setting adjust the temperature control and recheck in 4 hours. If the temperature is still out of range, move all medications to a working refrigerator and complete a maintenance request to have the refrigerator and/or thermometer checked/repaired. Medications can be returned to the refrigerator when it is functioning properly</li> </ul>	

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F 431 Continued From page 14

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure all drugs and biologicals were stored in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys, in accordance with State and Federal laws. Observation of the medication refrigerators on the second and third floors revealed they were unlocked. Additionally, the facility failed to ensure the temperature control policy was implemented related to monitoring the temperature of the medication refrigerators throughout the facility.

The findings include:

Review of the facility's policy, titled "Medication Storage in the Facility" undated, revealed medication rooms, carts, and medication supplies were to be locked or attended by persons with authorized access. Further review revealed only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medication (such as medication aides) are allowed access to medications. Continued review revealed medications requiring refrigeration should be stored between thirty-six (36) degrees Fahrenheit and forty-six (46) degrees Fahrenheit.

1. Observation of the medication/storage room on the third floor, on 04/15/14 at 7:30 AM, revealed the door to the medication/storage room to be unlocked with no staff within visible sight of the door. Further observation revealed the medication refrigerator inside the medication/storage room to have a lock on the

F 431 431 Drug Records, Label/Store drugs and Biologicals Cont

- The refrigerator temp log was revised, the log now reads - Refrigerator range 36-46 degrees, freezer range below 30 degrees. The log also contains the following instructions - to check temperature daily on the 10-6 shift, adjust if outside the range and recheck in 4 hours. If still out of range, notify the maintenance department.
- The policy/new form were inserviced and initiated on 4/17/2014. The Director of Nursing and Assistant Director of Nursing inserviced all registered nurses, licensed practical nurses and certified nurse aids.
- The Unit managers, ADON and clinical coordinator observe the refrigerators daily for appropriate temperature recording and to assure they are kept locked. Omissions in temperature recording or locking procedures are corrected immediately.
- Employees who fail to follow the policy will be reeducated/disciplined as needed.
- Compliance with the procedures will be monitored through the monthly QA meetings.

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F 431	<p>Continued From page 15</p> <p>refrigerator; however the lock was not in the locked position. Additional observation on 04/15/14 at 9:00 AM revealed the door to the medication/storage room to be unlocked with the refrigerator unlocked and no staff were observed to be insight of the unlocked door.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 04/15/14 at 12:15 PM, revealed the medication refrigerator should be kept locked. Further interview revealed the medication refrigerator stored insulins, antibiotics and other medications that could be harmful to residents.</p> <p>Interview with Pharmacists #1, on 04/15/14 at 12:25 PM, revealed the medication refrigerator should be kept locked at all times for safety.</p> <p>Interview with the Director of Nursing (DON), on 04/17/14 at 3:32 PM, revealed the medication refrigerator door should be locked per the facility's policy for safety of the residents.</p> <p>2. Review of the facility's forms, located at five (5) of five (5) of the facility's medication refrigerators, for recording medication refrigerator temperatures, titled "Record Temps Nightly on 10-6", revealed the refrigerator must be at or below forty-one (41) degrees (Farenheit). Further review revealed "if needed, adjust temp and recheck in 4 hours".</p> <p>Interview with Pharmacist #2, on 04/17/14 at 12:50 PM, via phone, revealed the medication refrigerator temperatures should be between thirty-six (36) degrees Farenheit and forty-six (46) degrees Farenheit.</p> <p>Review of the Medication Refrigerator logs for the</p>	F 431		
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F 431	<p>Continued From page 16</p> <p>second floor (2A), dated April 2014, revealed April 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16 and 17 to be below optimal temperature range, between twenty-four (24) and thirty-four (34) degrees Farenheit, with no documented evidence found of manual adjustments made to correct the temperature.</p> <p>Review of the Medication Refrigerator logs for "North Hall", on third floor, dated April 2014, revealed April 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16 and 17 to be below optimal temperature range, between twenty (20) and thirty-four (34) degrees Farenheit, with no documented evidence found of manual adjustments made to correct the temperature.</p> <p>Interview with LPN #2, on 04/15/14 at 12:15 PM, revealed the night shift nursing staff was responsible for checking and documenting the medication refrigerator temperatures. Further interview revealed it was not reported to her by the night shift that the medication refrigerator was not within the optimal temperature range. Further interview revealed the reference temperature she utilized for the refrigerator temperatures was on the refrigerator log sheet which stated below forty-one (41) degrees Farenheit.</p> <p>Interview with the DON, on 04/17/14 at 3:32 PM, revealed the temperatures of the medication refrigerators should be checked on the night shift and documented. Further interview revealed, should a temperature be out of range, adjustments to the temperatures should be made and reported to the oncoming shift to monitor. Further interview revealed she was not certain what the optimal temperatures should have been. She did state in reviewing the refrigerator</p>	F 431		

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F 431	Continued From page 17 temperature log forms, they were not consistent with the facility's policy nor the Pharmacy's recommendations. Continued Interview revealed unsolved issues should be reported to maintenance to follow up on.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  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.  (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.  (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.	F 441	F 441 Infection Control prevent spread, linens  - No residents were assessed to be adversely affected by this practice. - All residents have the potential to be affected by poor infection control. 1) Meal service - Assessment of five residents per unit during lunch and dinner was done by the DON and ADON to assure the proper handling of trays. This observation occurred April 21 - 25. All trays were passed according to policy and without incident. - Inservices regarding proper handwashing and food handling was provided to all nursing staff by 5/9/2014 by the DON and ADON/Infection Control nurse. Nursing staff included registered nurses, licensed practical nurses and certified nurse aids. - Each unit manager (or designee) will conduct a meal audit 3 times a month (once for each meal) on each unit. This will include observations of handwashing and food handling during the meal service (attachment	

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F 441	<p>Continued From page 18</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's policy and inservice education, and the Centers for Disease Control (CDC) guidelines, it was determined the facility failed to ensure an Infection Control Program was maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>Observation during meal service revealed staff scratching their neck and adjusting their clothing without washing or sanitizing their hands afterwards, and staff handling residents' food with their bare hands.</p> <p>In addition, observations during skin assessments and/or perineal care revealed staff not washing hands prior to donning gloves and not washing hands after removing soiled gloves prior to donning clean gloves, when going from a dirty or contaminated area to a clean area.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's policy titled, "Personal Hygiene", dated February 2011, revealed staff were to wash their hands after touching their hair, face, body or clothing.</li> </ol> <p>Review of the CDC guidelines, undated, revealed</p>	F 441	<p>F 441 Infection Control prevent spread, Linens Cont</p> <p>F441/N114 #1) for at least 10 residents. The audits will be brought to the monthly QA meeting and analyzed for trends that may indicate a need for additional training/review.</p> <ul style="list-style-type: none"> <li>- Additionally, the charge nurses are responsible for monitoring the staff routinely during meals to assure appropriate infection control measures are being used.</li> </ul> <p>2) Hand Hygiene</p> <ul style="list-style-type: none"> <li>- Peri care and hand hygiene were observed by the ADON/Infection Control nurse for 5 days during the week of April 21 through April 25. Care was observed on 2 residents on each of five units. All peri care observed was done according to the policy.</li> <li>- Handwashing and hand sanitizer inservices were presented to the registered nurses, licensed practical nurses and certified nurse aids by the DON and ADON/Infection Control nurse and were complete by 5/9/2014. The inservicing places an emphasis on when to wash hands (and/or use sanitizer) during meal service as well as personal care tasks such as skin observations and peri care. A monitoring tool for hand hygiene and skin assessment has been implemented and is consistent with accepted standards</li> </ul>	
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F 441 Continued From page 19  
keeping hands clean was one of the best ways to prevent the spread of infection and illness in all settings.

Observation of the breakfast meal on 04/15/14 at 8:21 AM, revealed Certified Nursing Assistant (CNA) #2 held a resident's toast with her bare hands while putting jelly on it.

Interview with CNA #2 on 04/16/14 at 8:58 AM, revealed she should not use her bare hands to handle food. She stated this was an infection control issue.

2. Observation on 04/15/14 at 8:42 AM, revealed CNA #13 scratched his neck, adjusted his shirt collar and did not sanitize or wash his hands between resident rooms as he passed residents' breakfast trays.

Interview, on 04/17/14 at 5:00 PM, with CNA #7 revealed staff should sanitize their hands between resident tray passes and wash their hands with every third tray passed. She stated the CNA's were in-serviced on tray passing in CNA class.

3. Observation of the breakfast meal on 04/15/14 at 8:49 AM, revealed CNA #11 assisted Unsampled Resident B with his/her meal. CNA #11 was observed to pick up Unsampled Resident B's toast with her bare hands, apply jelly on top of the toast and hand it to Unsampled Resident B to consume.

Interview with CNA #11 on 04/16/14 at 9:30 PM, revealed she had sanitized her hands before picking up the toast to give to the resident. She reported she thought she was handling the food

F 441 F 441 Infection Control prevent spread, Linens Cont

of practice to reduce the spread of infections and prevention of cross contamination. (attachment F441/N114 #3)

Unit managers and charge nurses have been instructed to observe for correct hand hygiene as directed in the policy. All staff is being observed in the proper procedure of food service, peri care and hand hygiene to prevent and control outbreaks and cross contamination using standard precaution.

Peri care auditing - The Infection Control nurse will monitor 2 CNAs from each floor and will observe as they provide peri care. This will occur monthly for 3 months and then quarterly. (attachment F441/N114 #2) Results will be reviewed in the QA meeting.

Skin assessments - Registered nurses and licensed practical nurses were reeducated to perform skin assessments from the cleanest to the dirtiest areas of the resident body, and to change gloves/use hand sanitizer if inspecting multiple open or otherwise contaminated areas of the body.

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NAME OF PROVIDER OR SUPPLIER  BAPTIST CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 MAIN STREET NEWPORT, KY 41071
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F 441 Continued From page 20  
in the correct way. Continued interview with CNA #11 revealed she should have used the resident's utensils to apply the jelly and serve it to the resident. She reported this was important due to infection control concerns.

4. Observation of the breakfast meal on 04/15/14 at 8:53 AM, revealed CNA #12 touched the corner ends of Unsampld Resident C's toast with her bare hands and applied jelly to the toast.

Interview with CNA #12 on 04/17/14 at 1:36 PM, revealed staff were not supposed to touch toast, bread, or rolls with their bare hands because of the spread of germs. CNA #12 stated she knew she should not have touched Unsampld Resident C's toast with her bare hands.

Interview with the Director of Nursing (DON) on 04/17/14 at 3:32 PM, revealed staff should not touch a resident's food with their bare hands. The DON stated staff should wash or sanitize their hands after touching their hair or adjusting their clothing. She indicated hand hygiene should be performed to decrease cross contamination.

5. Review of the facility's policy titled, "Proper Glove Use", dated February 2011, revealed hands should be washed thoroughly "before and after" wearing or changing gloves.

Observation of a skin assessment on 04/17/14 at 9:50 AM, revealed Licensed Practical Nurse (LPN) #4 did not wash her hands prior to donning gloves to perform a skin assessment. Continued observation during the skin assessment revealed LPN #4 did not change gloves or wash her hands after assessing the perineal area and buttocks and prior to assessing a clean area of the

F 441 - The Infection Control nurse will audit 2 nurses on each unit for the next three months, then every quarter for accuracy in following this protocol.

- Trends indicating failure to follow these expectations will be reviewed in the monthly QA meetings and the need for reeducation, either by employee or department, will be determined at that time by the Infection Control nurse and QA Coordinator.

5/10/14

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F 441	<p>Continued From page 21 resident's body.</p> <p>Interview with LPN #4 on 04/17/14 at 10:00 AM, revealed she should have washed her hands prior to donning clean gloves for the skin assessment. She stated she also should have removed her soiled gloves and washed her hands after touching the perineal or buttock areas of the resident's body and prior to moving to a clean area of his/her body. Further interview revealed LPN #4 reported by not washing hands and changing gloves staff could cause cross contamination.</p> <p>6. Observation of perineal care on 04/17/14 at 10:30 AM, revealed CNA #6 did not wash or sanitize her hands prior to donning gloves to provide perineal care to a resident. Continued observation revealed CNA #6 completed the perineal care and without removing soiled gloves and washing or sanitizing her hands, adjusted the resident's clothing, linens and bed position.</p> <p>Interview with CNA #6 on 04/17/14 at 10:40 AM, revealed she should have washed her hands prior to donning the gloves for perineal care, and washed her hands after the care was provided prior to touching clean areas. CNA #6 stated hand washing was to decrease germs. She indicated she had contaminated the resident's clean bed linens when she did not remove her soiled gloves and wash her hand after completing the perineal care.</p> <p>7. Observation of a skin assessment on 04/17/14 at 10:50 AM, revealed LPN #6 did not wash her hands after removing her contaminated gloves, when moving from a soiled or contaminated area, and prior to donning clean gloves to move to a</p>	F 441		

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F 441	Continued From page 22 clean area of the resident's body.  Interview with LPN #6 on 04/17/14 at 11:01 AM, revealed she should have removed her contaminated gloves and washed her hands prior to donning the clean gloves to decrease contamination.  Interview with the DON on 04/17/14 at 3:32 PM, revealed hands should be washed prior to donning gloves for a procedure, after taking off contaminated gloves, and prior to donning clean gloves when moving from a soiled or contaminated area to a clean area. Continued interview revealed these areas were infection control issues. She indicated staff should perform hand hygiene to decrease cross contamination.	F 441			
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.  A State or the Secretary may not require disclosure of the records of such committee	F 520	F 520 QAA Committee  None of the residents cited had adverse effects assessed from the described practices. Infection control continues to be a priority focus of the QA team as evidenced by the downward trend in the infection rate. (Currently, there have been 5 UTIs in May, compared to 10 in April.) Charge nurses, unit managers, and the entire management team which includes the DON, ADON and QA Coordinator, is to correct/re educate when poor infection control observations are made. ADON/Infection Control nurse and		

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F 520	<p>Continued From page 23</p> <p>except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's Plan of Correction related to the last standard survey completed on 05/10/13, it was determined the facility failed to have an effective Quality Assessment and Assurance committee that developed and implemented appropriate plans of action to correct identified quality deficiencies. Deficient practice related to Infection Control at F-441 was cited on the previous standard survey, and was again identified on the current survey.</p> <p>The findings include:</p> <p>Review of the Statement of Deficiency (SOD) for the standard survey completed on 06/10/13 revealed the facility was cited for deficient practice related to poor infection control technique during the provision of dressing changes and indwelling catheter care, and storage of food items that were not properly sealed.</p> <p>Review of the facility's Plan of Correction (POC), developed in response to the SOD and signed by the Administrator on 06/07/13, revealed the facility maintained an active Infection Prevention</p>	F 520	<p>F 520 QAA Committee (cont)</p> <p>DON will be accountable for educating all registered nurses, licensed practical nurses and certified nurse aids in areas of infection control.</p> <p>Quality Assurance will oversee all monitoring events. Trends indicating a failure in a system will result in additional mandatory education. The Infection Control nurse's role will be to ensure that all monitoring tools are used in a timely and compliant manner. If the Infection Control Nurse and/or the QA Coordinator identifies a trend (even if prior to a QA meeting), monitoring will be increased with immediate education to follow. Formal audits of multiple aspects of infection control protocols will be expanded and continue to be done monthly with alternating focus areas. (Attach F380 N520) These audits will be reviewed in the monthly QA meetings. Trends indicating a failure to follow policy/protocol will result in additional mandatory educational sessions.</p>	5/10/14
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F 520	Continued From page 24 and Control program. Further review revealed educational in-services were mandatory for all staff each year, including but not limited to hand washing, isolation precautions, disease transmission, cleaning protocols, food preparation and Tuberculosis. Continued review revealed monthly audits of infection control practices would be conducted by nursing management, and active surveillance to prevent the onset and spread of infection would be maintained.  Review of the facility's guidelines titled "Serving Meal Trays", undated, revealed hand hygiene should be practiced prior to serving meals.  Review of the facility's educational handout related to meal service, undated, revealed hand hygiene was to be practiced prior to serving meals and between each resident. Further review revealed staff should use hand gel sanitizer after touching the hair, nose, ears or a dirty uniform. Continued review revealed staff should wear gloves if they would be touching the resident's food.  Review of the facility's policy titled "Personal Hygiene", dated February 2011, revealed staff should practice hand washing after touching the hair, face, body, clothing or aprons.  Observation of the breakfast meal, on 04/15/14 at 8:21 AM, revealed Certified Nursing Assistant (CNA) #2 held a resident's toast with her bare hands while putting jelly on it.  Interview with CNA #2, on 04/16/14 at 8:58 AM, revealed she should not have used her bare hands to handle food. Further interview revealed	F 520			

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F 520	Continued From page 25 it was an infection control issue.	F 520		
	Observation, on 04/15/14 at 8:42 AM, revealed State Certified Nursing CNA #13 had passed resident breakfast trays between resident rooms after he scratched his neck and adjusted his shirt collar, and without sanitizing or washing his hands.			
	Interview with CNA #7, on 04/17/14 at 5:00 PM, revealed staff should sanitize their hands between resident tray passes, and wash their hands after every third tray pass. She stated the CNAs were in-serviced on tray passing in CNA class.			
	Observation of the provision of perineal care, on 04/17/14 at 10:30 AM, revealed CNA #6 did not wash or sanitize her hands prior to donning gloves to provide the care to an unsampled resident. Further observation revealed CNA #6 completed the perineal care, and without removing the soiled gloves and washing or sanitizing her hands, she adjusted the resident's clothing, linens and bed.			
	Interview with CNA #6, on 04/17/14 at 10:40 AM, revealed she should have washed her hands prior to donning the gloves, and should have washed her hands after the care was given and prior to touching clean areas on the resident. Further interview revealed hand washing was performed to decrease germs. She stated she had contaminated the resident's clean linen when she didn't remove her soiled gloves and wash her hands after completing perineal care.			
	Observation of a skin assessment, on 04/17/14 at 10:50 AM, revealed Licensed Practical Nurse			

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F 520	<p>Continued From page 26</p> <p>(LPN) #6 donned clean gloves when moving from a soiled or contaminated area to a clean area; however, she did not wash her hands after removing the contaminated gloves and prior to donning the clean gloves.</p> <p>Interview with LPN #6, on 04/17/14 at 11:01 AM, revealed she should have removed the contaminated gloves and washed her hands prior to donning the clean gloves, in order to decrease contamination.</p> <p>Interview with the Director of Nursing, on 04/17/14 at 5:13 PM, revealed she was responsible for the current Infection Control Surveillance program and had identified no issues related to infection rates. Further interview revealed education related to infection control was a continuous process. She stated the facility was no longer conducting formal monthly audits as outlined in the POC, but continued to conduct "spot" audits or checks for infection control practices. Continued interview revealed the facility would "double up" on infection control education and would conduct more audits.</p>	F 520		

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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  Building: 01  Survey under: NFPA 101 (2000 Edition)  Plan approval: 1948, 1967, 1989  Facility type: SNF/NF  Type of structure: Type I fire resistive construction  Smoke Compartment: Twenty-one (21)  Fire Alarm: Complete Fire alarm A Building: Smoke detectors in resident rooms/ Heat detectors in corridors B Building: Smoke detectors in resident rooms/ Heat detectors in corridors C Building: Single station Smoke Detectors in resident rooms/ Smoke detectors in corridors.  Sprinkler System: Complete sprinkler system (wet)  Generator: A Building: Diesel installed 1989 C Building: Diesel installed 1989  A Short Form Life Safety Code Survey was conducted on 04/15/14. The facility was found to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was one hundred and fifty-seven (157). The facility is licensed for one hundred and sixty-seven (167).	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Cand Fitzpatrick, RN* TITLE \_\_\_\_\_ (X6) DATE *5/19/14*

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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