

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

PRINTED: 12/16/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2011
NAME OF PROVIDER OR SUPPLIER SUMMERFIELD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1877 FARNSELY RD. LOUISVILLE, KY 40216	
(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
F 000	INITIAL COMMENTS A standard health survey was conducted 11/29/11 through 12/01/11. A Life Safety Code Survey was conducted on 11/30/11. Deficiencies were cited with the highest scope and severity of an "G" with the facility having the opportunity to correct before remedies would be imposed. An abbreviated survey was initiated on 11/29/11 and concluded on 12/01/11 to investigate KY17237. The Division of Health Care unsubstantiated the allegation due to lack of sufficient evidence; however, unrelated deficiencies were cited.	F 000	FOOO This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Summerfield Health and Rehabilitation agrees with the citations noted on the pages of this Statement of Deficiencies.	
F 241 SS=G	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of activities of daily living (ADL) reports, it was determined the facility failed to provide incontinent care for one (1) of twenty-six (26) sampled residents in a manner that would enhance the resident's dignity. The facility assessed Resident #6 as requiring total assistance for incontinent care every 2 hours or as needed. On 11/19/11, the facility failed to provide Resident #6 incontinent care for over four (4) hours. Facility staff found Resident #6 crying and very upset because the resident was left wet	F 241	F241 #1 Assistant Administrator and Social Service Assistant interviewed resident #6 on 12-2-2011 to determine if resident was satisfied that her concerns related to the incident on 11-19-11 was resolved and if any similar incidents had occurred. Resident #6 voiced no other concerns and simply sated "I am tired of talking about it". Resident #6 Bowel and Bladder assessment reviewed, new 3 day diary will be initiated to establish a definitive plan for managing residents incontinence. This will be initiated on 1-9-12. Resident care plan will be reviewed and updated with the results of the assessment. Staff will be instructed on plan and monitored to ensure plan is implemented. Unit Manager/Charge Nurse will assume responsibility and will sign off on an audit log daily to ensure plan is implemented and effective.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

X. [Signature]

Xadm

X 1-6-11

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.

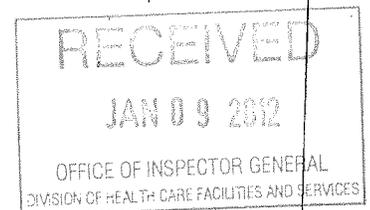
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
If continuation sheet Page 1 of 47

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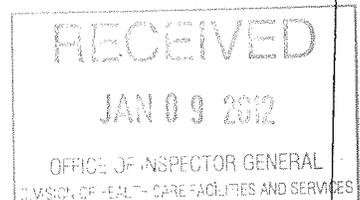
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F 241	Continued From page 1 requiring a complete change of bed linens and clothing. Resident #6 was observed, on 11/30/11 at 6:25 PM, having visible signs of anger. i.e. stiffening of the body, vocal changes and speed changes in speech while explaining the incident of 11/19/11. Refer to F312. The findings include: The facility was unable to provide documented evidence of a specific policy to address dignity. The facility indicated they would follow standards of care. Interview with the Director of Nursing (DON), on 12/01/11 at 4:00 PM, revealed residents are checked for incontinence every two (2) hours when turned and repositioned. Review of the clinical record revealed Resident #6 had resided at the nursing facility since May 2003. Review of the most current diagnoses included: Immobilization Syndrome, Osteoarthritis, and Contractures of hands and legs. The most recent MDS (minimum data set) assessment, dated 09/19/11, revealed the facility assessed the resident as having no cognitive deficit, no behaviors, totally dependent on staff for bathing, dressing, grooming, toileting, bed mobility, and transfers and always incontinent of bowel and bladder requiring assistance from staff for incontinent care. Review of the care plan dated, 09/26/11, revealed the resident was at risk for pressure ulcer formation related to incontinence of bowel and bladder. The interventions detailed staff was to assist with turning and repositioning and would	F 241	F241 Cont. from page 1 This will continue for a minimum of 30 days and may be continued if problems are noted. The DON will monitor the logs to determine the end date and if any additional training or assessment is needed. Social Services to visit the resident weekly to solicit input in regards to timeliness and staff responses to resident needs. #2 Social Services Director will review all grievances for past 3 months to identify any issues related to respect and dignity. These reviews were completed 12-27-11 and any concerns voiced were treated as grievances and follow up completed per policy. Any education, counseling, investigation, re-assessment, care plan review and/or policy reviews were completed. Social services to review all reports of concerns related to being treated with respect and dignity, and timeliness of response of staff with the Assistant Administrator and DON weekly to ensure appropriate actions have been taken and that resident concerns are resolved. All concerns will be forwarded for a second review by the facility QA subcommittee for tracking and trending. Any additional actions needed will be referred to the facility QA Committee to ensure compliance.	



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F 241	<p>Continued From page 2 provide pericare routinely and as needed.</p> <p>Interview, on 12/01/11 at 6:20 PM, with the day shift CNA #3 revealed she had worked on 11/19/11 and left early. CNA #3 revealed she was assigned and responsible for Resident #6's care. She was in Resident #6's room several times; however, documentation in the ADL detail reports revealed she provided care for Resident #6 at 10:22 AM and no other time. Interview, on 11/29/11 at 3:15 PM and 11/30/11 at 6:25 PM, with Resident #6 revealed he/she was changed one time at 10:00 AM and the day shift CNA did not come back and change the resident again before she left for the day. The resident stated he/she was total care and dependent on staff because of the hand contractures. He/she revealed even though he/she used the call light to get assistance staff did not respond timely, he/she had an incontinent episode resulting in the resident having to lie in wet clothing and on wet bed linens. She stated she was very upset and this situation made her cry.</p> <p>Interview, on 11/30/11 at 6:05 PM, with the evening shift CNA #4 revealed she found Resident #6 wet on 11/19/11 when she responded to the resident's call light. She went to the resident's room around 2:30 PM to see what the resident needed and found Resident #6's bed linens and clothing urine soaked which required changing. The resident was crying and was upset. In addition, CNA #4 stated the resident's peri-area was red on observation and she stated according to the resident the peri-area was painful. CNA #4 further stated she provided care to other residents and did not document the care provided on the ADL detail report until 4:44 PM.</p>	F 241	<p>F241 Cont. from page 2</p> <p>DON will review all 24 hour reports for past 30 days to identify any complaints or concerns voiced by residents related to care being provided and issues related to respect and dignity. These reviews will be completed by 12-27-11.</p> <p>#3 This appears to be an isolated incident that occurred due to a change in staff assignments and communication of responsibility. Specific procedures were implemented on 12-23-2011 regarding nursing supervisor communication and documentation of unit assignments when staff re-assignment is necessary. Education provided to licensed and non-licensed staff on respect and ensuring resident dignity, providing ADL care to residents to maintain and enhance their feeling of self-worth and self-esteem and reassignment communication. This was completed on 12-23-11 and was provided by Director of Staff Development, ADON and DON. This education will be repeated quarterly for 2 quarter then annually. Staff education will be tracked by Director of Staff Development to ensure all licensed and non-licensed nursing staff comply with the educational requirements.</p>		



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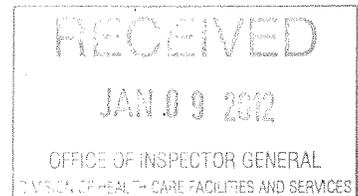
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F 241	Continued From page 3 Review of the ADL detail report for 11/19/11 revealed incontinent care was provided for Resident #6 at 10:22 AM and 4:44 PM. There was no documented evidence incontinent care was provided between those times. Interview, on 11/29/11 at 3:15 PM and 11/30/11 at 6:25 PM, with Resident #6 revealed he/she had concerns regarding being left wet and staff not providing incontinent care as requested. The Resident stated he/she was very upset when this occurred. The resident reported the incident to the Social Worker. Interview, on 12/01/11 at 4:00 PM, with a Social Worker who Resident #6 reported the 11/19/11 incident, revealed the resident was upset during their conversation. The Social Worker stated the resident reported he/she was left wet by the day shift CNA #3. The resident told her that he/she had activated the call light but the CNA had turned off the light and not provided care. The Social Worker indicated the resident gets upset whenever the routine is altered and it sounded to her like the staff missed the 2:00 PM round. Interview, on 11/29/11 at 4:00 PM, with the Director of Nursing (DON) revealed she became aware of the incident on 11/22/11. She stated the Social Worker reported she was in Resident #6's room speaking with the roommate when Resident #6 requested to speak with someone regarding his/her concerns. The resident had reported to the Social Worker he/she had been left wet on 11/19/11. The DON stated she went to speak with the resident on 11/22/11. The resident told the DON that CNA #3 (first shift aide assigned to	F 241	F241 Cont. from page 3 Director of Staff Development/DON/ADON will observe each licensed and non-licensed nursing staff member interact with a resident within the next 3 months to evaluate effectiveness of education. Thereafter each nursing staff member will be observed on an annual basis. All newly hired nursing staff will be observed during orientation, within 3 months and then annually. All newly hired employees will be educated during orientation. Social Services Director will attend the next Resident Council Meeting to discuss with residents their right to be treated with respect and dignity and their right to voice a grievance if they feel this right has been violated or if they feel that they have not received the care that they expect. She will repeat this discussion quarterly for the next year then annually. Social Services Director will also instruct Social Services staff to discuss this right with each resident during their next visit with each resident. All newly admitted resident will have this right explained during the admission assessment. Any concerns voiced will be addressed within 24 hours by Social Service, nursing and the Assistant Administrator.	

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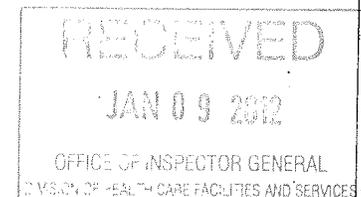
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F 241	Continued From page 4 Resident #6) left early and did not provide incontinent care. In addition, the DON revealed she had not reviewed the ADL detail to determine if facility staff had provided timely incontinent care to this resident. Observation, on 11/29/11 at 11:30 AM, revealed Resident #6 was lying in bed with a splint on his/her right hand and right leg due to contractures. Interview with the resident at this time revealed the resident was totally dependent on staff for all care needs. The resident stated he/she gets upset just talking about the 11/19/11 incident. The resident was observed visibly angry as evidenced by the resident's body stiffening in bed, having a change in the sharpness of the tone of his/her voice and his/her speech becoming rapid while detailing the incident.	F 241	F241 Cont. from page 4 #4 Staff education will be tracked by Director of Staff Development to ensure all licensed and non-licensed nursing staff comply with the educational requirements. Director of Staff Development/DON/ADON will observe each licensed and non-licensed nursing staff member interact with a resident within the next 3 months to evaluate effectiveness of education. Thereafter each nursing staff member will be observed on an annual basis. All newly hired nursing staff will be observed during orientation, within 3 months and then annually. All newly hired employees will be educated during orientation. Social Services Director will attend the next Resident Council Meeting to discuss with residents their right to be treated with respect and dignity and their right to voice a grievance if they feel this right has been violated or if they feel that they have not received the care that they expect. She will repeat this discussion quarterly for the next year then annually. Social Services Director will also instruct Social Services staff to discuss this right with each resident during their next visit with each resident.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to accommodate the individual needs and preference for accessible room lighting for one (1) resident (#5) of the twenty-six (26) sampled residents.	F 246		



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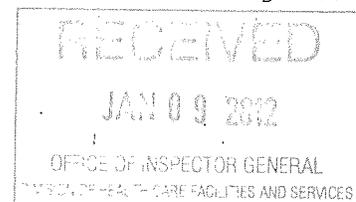
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F 246	Continued From page 5 The findings include: The facility did not provide a policy on room lighting or accommodation of needs. The facility admitted Resident #5 on 12/26/08 with the following diagnoses: Coronary Artery Disease, Diabetes, Hypertension, Atrial Fibrillation (irregular heart beat), Congestive Heart Failure, Dementia, Paranoia, Low Back Pain, and Immobilization Syndrome. Record review revealed the facility assessed Resident #5 on the Minimum Data Set (MDS), dated 09/05/11, as having adequate vision with corrective lenses, cognition as minimal impairment, mood as minimal depression, and behavioral symptoms not directed towards others. The activity portion revealed having books, newspapers, and magazines were very important to the Resident. The MDS indicated the resident had no impairment to the upper extremities and utilized a walker and a wheelchair for mobility. Observation and interview with Resident #5, on 11/29/11 at 11:30 AM, revealed the resident's bed was pushed against the wall with the head of the bed facing the window. The over-bed light was turned off with the light cord string hanging down and tucked behind the foot of the bed. A bedside table was noted next to the bed with a lamp on top. A Christmas tree was observed sitting on the dresser next to the television. Half the Christmas tree lights were out. The Resident was observed to be sitting in a wheelchair watching television. The Resident stated he/she was upset because someone removed the extension cords to the	F 246	F241 Cont. from page 5 All newly admitted resident will have this right explained during the admission assessment. Any concerns voiced will be addressed within 24 hours by Social Service, nursing and the Assistant Administrator. DON will interview a minimum of 10 dependent and inter-viewable residents monthly for 12 months to ensure that their needs have addressed and that they feel they have been treated with respect and dignity. Any noted issues will be submitted to the facility QA Committee for review. All reported concerns or grievances will be logged and the follow up documented for review no less than quarterly by the facility QA Committee. A subcommittee of QA members and other staff as needed will meet no less than monthly to track compliance with the POC and the effectiveness of the POC. If the plan is not effective the subcommittee will recommend changes to the full QA Committee which will continue to meet no less than quarterly. #5 Completion date 1-10-12		



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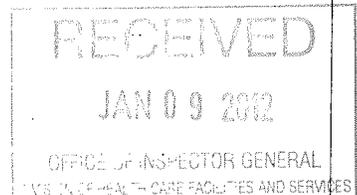
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F 246	<p>Continued From page 6</p> <p>Christmas tree and the bedside lamp and he/she could no longer turn on a light without having to ask for assistance. The Resident stated this concern was expressed to the person who removed the cords, but he/she could not remember who the staff member was they reported to.</p> <p>Observation and interview with Resident #5, on 11/29/11 at 1:35 PM, revealed the resident sitting up in a wheelchair in the resident's room. The Resident stated someone had fixed the Christmas tree lights but the resident could not access the lamp or over-the-bed light. Observation revealed the pull string to the over-the-bed light was not within the resident's reach.</p> <p>On 11/30/11 at 10:15 AM, observation during a skin assessment conducted by the facility staff nurse, revealed the resident reported to the nurse his/her concerns regarding the lamp not working. The nurse looked around the room and stated, "they took your cord?" Observation revealed the nurse left the resident's room without addressing the resident's concern or assuring the resident could access the light.</p> <p>Interview with Resident #5, on 12/01/11 at 2:40 PM, revealed the resident could not reach the over-the-bed pull string; therefore, could not access the light.</p> <p>Interview with LPN #1, on 12/01/11 at 2:55 PM, revealed the maintenance department had removed the extension cord that the resident's Christmas tree and lamp was plugged into. She stated staff should have notified him that the</p>	F 246	<p>F 246</p> <p>#1 On 12-2-2011 with Resident #5's input, the furniture was re-arranged to accommodate access to the lamp, and the over the bed light. This was completed by Housekeeping Director.</p> <p>#2 Facility audit completed on 12-2-2011 by Unit Mangers to ensure all residents capable had access to the over the bed light cords and that all resident personal items (lamps, radios, televisions, etc) were accessible.</p> <p>#3 Staff education will be provided by the Director of Staff Development on addressing all resident concerns timely and with respect and dignity. This education will specifically address the residents right and need to maintain as much independence as possible for as long as possible including being able to access personal items, turn on lights, getting items out of drawers, dressing self, selecting clothes, etc. This will be completed by 12-27-11. This education will be repeated quarterly for 2 quarters then annually will be included in an in-service presentation. All newly hired employees will be educated during orientation.</p>		1-7-12 pd



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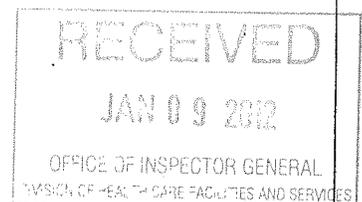
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F 246	Continued From page 7 resident's over-the-bed light cord was not accessible. During an observation and interview with the Activity Director, on 12/01/11 at 3:20 PM, the lamp was now working. The resident was offered books to read and he/she smiled. The Director stated the staff found an electrical outlet behind the resident's bed and plugged the resident's lamp in so she could see. Interview with the Assistant Director of Maintenance, on 12/01/11 at 3:40 PM, revealed the extension cord that the Christmas tree and lamp was plugged into was removed on 11/29/11 related to Life Safety Code issues. He could not say why the lamp was not plugged into another outlet. Interview with the Director of Nursing, on 12/01/11 at 4:05 PM, revealed the light meant something to the resident. She acknowledged the resident would have to use the call light to get staff to turn the over-the-bed light on, making the resident dependent on staff.	F 246	F246 continued from page 7 Social Service assessments (initial and quarterly), and responses to MDS questions related to resident choices, will be used to assess individual resident accommodations and needs. Any special needs, concerns or accommodations will be communicated through the care plan and the nursing assistant assignment sheet. Social service assessment will be reviewed by the corporate consultant on 1-6-12 to ensure it addresses the resident preferences and needs. Social Services Director will instruct Social Services staff to discuss accommodation of resident needs during quarterly review to ensure residents have the means to be as independent as long as possible. Any concerns voiced will be addressed immediately.	
F 253 SS=E	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	F 253	#4 Unit Managers will make rounds weekly for 4 weeks then monthly to ensure room arrangements are appropriate for resident and the maintenance of the residents independence, specifically they will look for location and accessibility of the over the bed light cord,	



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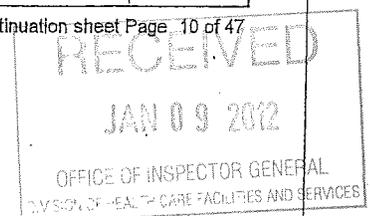
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F 253	Continued From page 8 the routine housekeeping cleaning schedule it was determined the facility failed to provide effective housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior for residents. Ceiling ventilation vents (input and output vents) were soiled on eight (8) out of eight (8) hallways and in the front lobby. Toilets were running in two (2) residents' bathrooms that affected six (6) residents. The caulking around the bases of the toilets in eight (8) residents' bathrooms was stained affecting thirty (32) residents. A toilet was loose in one (1) resident's bathroom affecting four (4) residents. The findings include: Observation on the initial tour of the environment, on 11/29/11 at 2:15 PM, revealed toilets running in residents' shared bathrooms in #201, 402, 404, and a brownish stain in the caulking on the bases of the toilets in shared bathrooms rooms #101, 103, 104, 106, 108, 110, 301, 303, 501, 503, 601, 602, 603, 604, 605, 606, and a loose toilet for the shared bathroom in rooms #802 and 804. Observation, on 11/30/11 at 12:15 PM, revealed a heavy build up of dust and brownish-gray substance on the ceilings of Hall 100, 200, 300, 400, 500, 600, 700, 800 and the lobby entrance. The square output vents on the ceilings on Hall 100, 200, 300, 400, 500, 600, 700, 800 and the entrance lobby were soiled with a black, sooty dust. Observation, on 12/01/11 at 10:00 AM, during the environment tour with the Assistant Maintenance Director (AMD) and the Housekeeping Director	F 253	F246 Cont. from page 8 access to drawers, closets, bathroom and sink areas, accessibility to personal items such as lamps, clocks, radios, televisions, and personal grooming items. Any issues identified will be reported to the ADON for resolution. ADON will report any issues to the facility QA Committee. A subcommittee of QA members and other staff as needed will meet no less than monthly to track compliance with the POC and the effectiveness of the POC. If the plan is not effective the sub-committee will recommend changes to the full QA Committee which will continue to meet no less than quarterly. #5 Completion date 1-7-12.	1-7-12 JG



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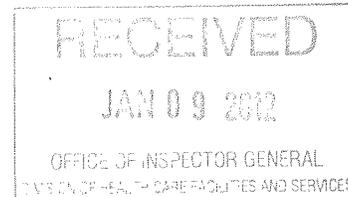
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F 253	<p>Continued From page 9</p> <p>(HD) revealed the large vents in the lobby entrance had less fuzzy dust than the day before but were still soiled. All other vents in Hall 100, 200, 300, 400, 500, 600, 700, and 800 still had a heavy build-up of black sooty dust.</p> <p>Interview, on 12/01/11 at 10:00 AM, with the HD and the AMD revealed the maintenance staff were responsible for cleaning and maintaining the ceiling ventilation vents because of the height of the ceilings and the need for the large vents to be taken down to be cleaned properly. The HD said the vents in the front lobby entrance had been feather dusted yesterday, but needed to be removed from the ceiling to be properly cleaned. The HD stated the vents were still soiled even after the feather dusting yesterday. The AMD was uncertain when the ceiling vents were last cleaned. The AMD revealed the facility did not have a routine schedule in place to clean ceilings vents or light fixtures. The AMD and the HD both revealed the Assistant Director of Nursing (ADON) does a monthly sales tour and forwards any concerns about housekeeping or maintenance to them. The AMD and the HD said they had not received any recent request for cleaning ceiling vents.</p> <p>During interview, on 12/10/11 at 10:15 AM, with the HS (Housekeeping Staff), the HS said I am suppose to clean the low ceiling vents, but I have been too busy, and it is not on my checklist.</p> <p>Review of the daily and weekly housekeeping cleaning schedule revealed the vents were not on the list to be cleaned.</p> <p>Interview with the HD, on 12/01/11 at 10:20 AM,</p>	F 253	<p>F253</p> <p>#1 The ceiling ventilation vents on all eight (8) hallways and in the front lobby were thoroughly cleaned on 12-1-2011 by the Assistant Maintenance Director and Housekeeping Staff. The caulking around the base of the identified toilets was replaced 11-30-2011 by the Assistant Maintenance Director. The running toilets were repaired by the Assistant Maintenance Director on 11-30-2011. The loose toilet was tightened on 11-30-2011 by the Assistant Maintenance Director.</p> <p>#2 The assistant Maintenance Director completed a room to room audit 12-12-2011 to identify any other issues of concern related to housekeeping and maintenance services. Any other identified issues were corrected when identified. ADON will report any issues to the facility QA Committee.</p>	12-31-12 AD	



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F 253	<p>Continued From page 10</p> <p>revealed the caulking on the bases of the toilets are cleaned as needed with a toothbrush. HD commented that the caulking around the bases of the toilets definitely needed cleaning. HD said rounds are conducted monthly on each resident's room and bathrooms and could not say how this got overlooked. The HD stated a loose commode could cause a resident to fall.</p> <p>During interview with the AMD, it was revealed water was most likely leaking at the base of the toilets and the stains on the caulking was a result of rusting. The AMD said the caulking around the bases of the commodes needed to be removed and replaced with new caulking. The AMD said staff are suppose to report any problems using the Work Order Request Board that was on each Unit. The HD said he reviewed the Work Order Board daily and that staff had been instructed to write any requests for Maintenance or Housekeeping needs on the Board or to call if something needed immediate attention. The AMD stated the ADON monthly tour inspection did not mention a need to repair the caulking on the bases of the commodes. The AMD said the running toilets and the loose toilet will be repaired today because it was annoying to the residents.</p> <p>An interview, on 12/01/11 at 3:30 PM, with a family member of an unsampled resident in Room 501 revealed the family member commented the base of the commode was not clean and stated their commode at home does not look like that.</p> <p>During an interview with an unsampled resident in Room 601, on 12/01/11 at 3:40 PM, the resident said, it would be a lot of work to clean out that</p>	F 253	<p>F253 Continued from page 10</p> <p>#3 To maintain ceiling ventilation vents are clean regularly, they will be added to the TELS system for monthly cleaning to be completed by the Maintenance Director or Assistant Maintenance Director.</p> <p>All housekeeping personnel will be in-serviced on reporting caulking that needs to be replaced and/or toilets needing repairs (running or loose) on the maintenance request log. This in-service will be completed by the Housekeeping Director by 12-30-2011. Director of Housekeeping will complete weekly rounds to identify any areas that need repair or additional cleaning. The Assistant Administrator will also be responsible for identifying areas of concern on the monthly sales tour. Any noted concerns will be addressed when identified.</p>	



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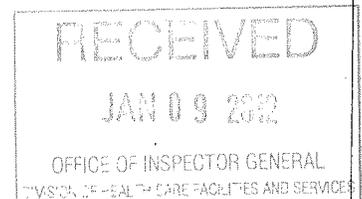
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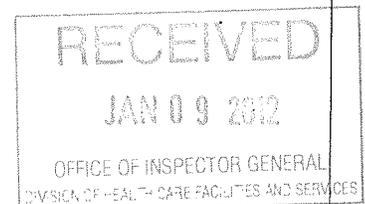
F 253	Continued From page 11 stain, but it sure needs it. Interview, on 12/01/11 at 5:00 PM, with LPN #10 revealed the staff was instructed on how to fill out a request for maintenance or housekeeping services. The staff was to utilize the Work Order Clip Board on each Unit. Interview, on 12/01/11 at 5:05 PM, with CNA #11 revealed staff was suppose to call Housekeeping when toilets are soiled. CNA #11 said if Housekeeping has already gone for the day we are suppose to clean it. Interview on 12/01/11 at 5:10 PM, with an unsampled resident in Room 104-A revealed four residents use the same toilet that was between Room 104 and Room 106. The resident said the toilet required a lot of cleaning because four of them use it and it needed cleaning around the base now.	F 253	F253 Continued from page 11 #4 The Director of Housekeeping will keep a log of any repairs or additional cleaning needed and will provide this log to the Administrator weekly for follow up to ensure the repairs or cleaning were complete. In addition the sales tour will be given to the Administrator when completed monthly for follow up. The Administrator will look for repeat areas of concern and report these to the facility QA committee for review and action. #5 12-31-2011	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279	F 279 #1 The care plans for resident #17 were reviewed by the IDT and revised or developed as indicated. Included but not limited to as indicated monitoring the shunt site, monitoring for complications related to dialysis such as hypotension and abnormal bleeding, monitoring weights, watching diet and dietary intake, etc.	1-12-12 JL



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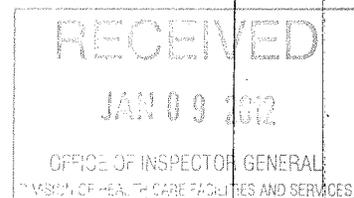
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F 279	Continued From page 12 psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to develop and implement a care plan for dialysis services for one (1) of twenty-six (26) sampled residents. The facility determined Resident #17 required hemodialysis (a treatment that cleans the blood by removing wastes and excess water from the body), via a left arm shunt (vascular access for hemodialysis), at a local hemodialysis provider leaving the facility three (3) times a week. The facility failed to develop a comprehensive care plan for Resident #17 's diagnosis of End Stage Renal Disease, (when the kidneys are no longer able to work at a level needed for day-to-day life), including the care and maintenance of his/her hemodialysis shunt for the resident to maintain the highest, possible well-being. The findings include: The facility did not have a specific policy for developing a comprehensive care plan. However, interview with the Administrator on 12/01/11 at approximately 5:00 PM, it was revealed the facility followed the Resident Assessment Instrument (RAI) process for development of resident care	F 279	F279 Continued from page 12 #2 All comprehensive care plans to be reviewed by IDT by 12-30-11 to ensure that all needs are addressed and that all care plans are current and applicable to the resident. Any updates or revisions will be completed as indicated. #3 Nursing staff including IDT re-educated on the use of the care plan to direct care and the need to include special procedures on the individual care plan. This was completed by the DON on 12-27-2011. IDT reviewed the corporate presentation on care planning on 12-30-2011, this was confirmed by the DON. MDS staff will receive and review all MD orders to ensure any specialized service or change in orders are included in the care plan. The initial care plan will be reviewed by the MDS staff after completion to ensure all specialized services are noted on the care plan.	



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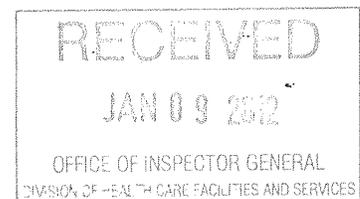
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F 279	Continued From page 13 plans. Review of the medical record for Resident #17 revealed the facility admitted the resident on 11/24/11 with diagnoses of Diabetes Mellitus and End Stage Renal Disease. The resident received hemodialysis via a left upper arm shunt three (3) days a week. Since the resident had only been at the facility for eight (8) days, the facility had not completed the Minimum Data Set (MDS) admission assessment. The clinical record did not indicate if a Brief Interview for Mental Status (BIMS) had been completed. Continued review of the medical record revealed the facility developed an initial care plan on 11/24/11, the day the facility admitted the resident. The initial care plan indicated the resident was alert and orientated to person, place and time. The initial care plan reserved a section labeled devices and treatments for Dialysis, however, this section was blank. Further review of the Medication Administration Record (MAR) indicated a Dialysis Flow Record with the resident's name listed at the top of sheet. The form included handwritten information for two (2) sets of vital signs and one (1) blood glucose level and one (1) facility staff initials. There was no dedicated section on the MAR to observe and monitor the resident's shunt for thrill and bruit Observation, on 12/01/11 at 1:30 PM, revealed Resident #17 lying in the bed with a clean and dry gauze dressing to his/her upper left arm. Interview, on 12/01/11 at 1:30 PM, with Resident #17 revealed the resident could remove the dressing because that was what the hemodialysis center told him/her to do.	F 279	F279 Continued from page 13 #4 DON to review 25% of care plans each week for 8 weeks to ensure all care plans are reviewed a second time within the quarter to ensure that they are accurate and individualized for each resident., DON will then review a minimum of 25% of care plans each month to ensure our procedure for development and review of care plans is implemented. DON will report any issues she finds to the facility QA committee for follow-up. A subcommittee of QA members and other staff as needed will meet no less than monthly to track compliance with the POC and the effectiveness of the POC. If the plan is not effective the sub-committee will recommend changes to the full QA Committee which will continue to meet no less than quarterly. #5 Completion date 1-12-2012	



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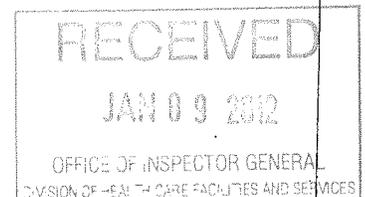
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F 279	Continued From page 14 Interview, on 12/01/11 at 2:55 PM with LPN #16, the nurse assigned and responsible for Resident #17's care he had not reviewed the resident's care plan before he provided care; therefore, did not know if the resident was care planned for hemodialysis treatment or what the expectation of care for the shunt required. Interview, on 12/01/11 at 3:30 PM, with LPN #4 revealed she had admitted Resident #17 to the facility on 11/24/11 and created the initial care plan based on her assessment. She stated the resident had renal failure and required dialysis three (3) days a week. LPN #4 stated the initial care plan did not address the resident's dialysis needs. Interview, on 12/01/11 at 3:40 PM, with LPN #9 (manager of the green unit) revealed care plans were used to identify resident needs and for nursing staff to initiate, develop, change, and review. She stated she was not aware the nurses had not developed a care plan that addressed Resident #17's dialysis or care and assessment of the shunt.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 282	F 282 #1 Heel protectors re-applied to Resident #10 on 11-30-11 by CNA Preceptor. Heel protectors re-evaluated on 12-12-11 by Wound/Skin Nurse for continued need. Care Plan updated to reflect continued use of heel protection.	1-9-12 102



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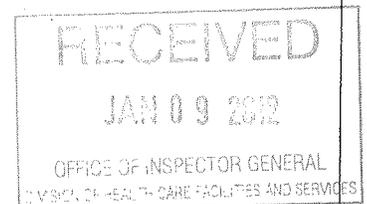
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F 282	<p>Continued From page 15</p> <p>review it was determined the facility failed to implement the care plan for one (1) of twenty-six (26) sampled residents. Resident #10 was care planned to have bilateral heel protectors applied when in bed. However, observation during 2 of 3 days of the survey revealed the heel protectors were not applied as ordered. The facility assessed the resident to be high risk for skin breakdown.</p> <p>The findings include:</p> <p>The facility did not have a specific policy for assistive devices. The administrator stated, on 12/01/11 at approximately 5:00 PM, the facility followed the care plan to deliver care to the residents.</p> <p>Review of Resident #10's clinical record revealed the facility admitted the resident on 10/19/10 with diagnoses of Anoxic Brain Injury, Immobility, and history of a MI (heart attack). Review of the most current MDS (Minimum data set) assessment dated 10/09/11 revealed the facility assessed the resident as dependent on staff for bed mobility, transfers, and all ADL (activities of daily living) care. The assessment revealed the resident was non-verbal and at risk for skin breakdown.</p> <p>Review of the most current care plan dated 10/18/11 revealed the facility identified the resident at risk for skin breakdown related to impaired immobility and incontinence. The facility developed interventions to prevent skin breakdown that included, pressure reduction boots to bilateral feet when in bed as ordered.</p> <p>Observation of Resident #10, on 11/29/11 at</p>	F 282	<p>F282 Continued from page 15</p> <p>#2 Wound/Skin Nurse reviewed all residents utilizing heel protectors to ensure devices available, in use and evaluated continued need of devices on 12-12 and 12-13-11. Any device determined to not be necessary was discontinued with MD order. All care plans reviewed and updated as indicated. All comprehensive care plans will be reviewed and NA Assignment sheets will be reviewed by IDT by 12-30-11 to ensure all needs, including specialized assistive devices are addressed, any needed updates will be made.</p> <p>#3 In-service to be conducted on 12-27-11 for all licensed and non-licensed staff regarding following the resident care plan, ensuring all specialized assistive devices are available, and in use for all appropriate residents. This in-service is to be presented by the Director of Staff development. This in-service will be repeated quarterly for 2 quarters then will be included with annual in-servicing. All newly hired staff will be educated during orientation. All assistive devices that a resident requires will be included on the nursing assistant assignment sheet.</p>		



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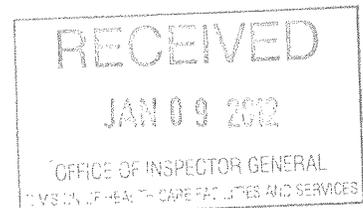
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F 282	<p>Continued From page 16</p> <p>11:30 AM, 1:10 PM, and 3:15 PM, revealed the resident lying in bed with no pressure reduction boots applied. The resident wore regular socks and both feet were position directly on the mattress.</p> <p>On 11/30/11 at 8:15 AM, observation revealed a staff nurse administrating medication per the resident's Gastronomy tube. The resident was lying on his/her back and the pressure reduction boots were not applied.</p> <p>Interview with the staff nurse, at the time of the observation, revealed she had no knowledge of the pressure reduction boots missing. The nurse searched the room but was unable to find the pressure reduction boots. She could not determine how long the boots had been missing.</p> <p>At 10:30 AM, two CNAs were observed to give the resident a bed bath. The resident's feet were observed to be clothed with regular socks and lying on a pillow.</p> <p>Interview with CNA #12, on 11/30/11 at 10:45 AM, revealed she was responsible for Resident #10 and stated the reduction boots were not available for use. The CNA revealed she had provided care for Resident #10 yesterday, 11/29/11, and the pressure reduction boots were not available then. She stated she had not informed the nurse the boots were missing and had not made any attempts to obtain another pair of pressure reduction boots. The facility did not provide the pressure reduction boots until after the surveyor inquired about their location.</p> <p>Interview with Resident #10's sister (POA), on</p>	F 282	<p>F282 Cont. from page 16</p> <p>Unit Managers will use the assign-ment sheet to make rounds on each hallway to check that assistive de-vices are available and in use. Wound Nurse to check weekly dur-ing wound rounds to ensure that all assistive devices related to skin care are available and in use.</p> <p>#4 Unit Managers to make monthly rounds to ensure that the care plans related to specialized assistive devices are followed. They will also ensure that assistive devices are available and in use. Audits will be reported to the DON for review and presentation to the facility QA Committee. A subcom-mittee of QA members and other staff as needed will meet no less than monthly to track compliance with the POC and the effectiveness of the POC. If the plan is not effective the sub-committee will recommend changes to the full QA Committee which will continue to meet no less than quarterly.</p> <p>#5 Completion date 1-9-2012</p>	



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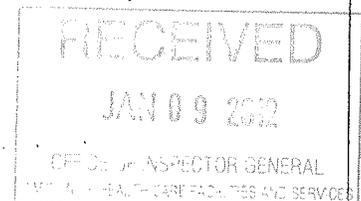
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2011
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F 282	Continued From page 17 11/30/11 at 2:30 PM, revealed the resident had skin breakdown in the past and was at risk for new pressure sore development. She stated the resident went out for home visit during the Thanksgiving holiday; however, the resident was wearing the boots upon return to the facility.	F 282			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and activities of daily living (ADL) records it was determined the facility failed to provide necessary services (incontinent care) for one (1) of twenty-six (26) sampled residents. The facility assessed Resident #6 to require total staff assistance for bathing, dressing, grooming and incontinent care. On 11/19/11, the facility failed to provide ADL assistance for Resident #6 and documentation revealed the resident was not provided incontinent care for over four (4) hours. The resident was found urine soaked, upset and crying. Refer to F 241. The findings include: The facility did not provide a policy specific to provision for ADLs.	F 312	F312 #1 Assistant Administrator and Social Service Director interviewed resident #6 on 12-2-2011 to determine if resident was satisfied that her concerns related to the incident on 11-19-11 was resolved and if any similar incidents had occurred. Resident #6 voiced no other concerns and simply sated "I am tired of talking about it". Resident Bowel and Bladder assessment reviewed, new 3 day diary will be initiated to establish a definitive plan for managing residents incontinence. This will be initiated on 1-9-12. Resident care plan will be reviewed and updated with the results of the assessment. Staff will be instructed on plan and monitored to ensure plan is implemented. Unit Manager/Charge Nurse will assume responsibility and will sign off on an audit log daily to ensure plan is implemented and effective.	1-9-12 109	



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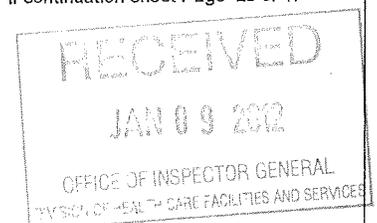
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F 312	Continued From page 18 Review of the clinical record for Resident #6 revealed nursing notes dated 11/19/11 with no documentation of ADL care in the record. Facility staff were unable to provide nursing documentation upon surveyor request. Review of the clinical record revealed the facility admitted Resident #6 to the nursing facility in May 2003. Review of the most current diagnoses included: Immobilization Syndrome, Osteoarthritis, and Contractures of bilateral hands and legs. The most recent MDS (minimum data set) assessment, dated 09/19/11, revealed the facility assessed the resident with no behaviors, totally dependent on staff for bathing, dressing, grooming, and toileting and was cognitively intact. The MDS assessment identified the resident required assistance from staff for incontinent care due to incontinence of bowel and bladder. Review of the care plan dated, 09/26/11, revealed the resident was at risk for pressure ulcer formation related to incontinence of bowel and bladder. The interventions were for peri-care to be provided routinely and as needed and the staff to assist with turning and repositioning. Interview with the Director of Nursing (DON), on 12/01/11 at 4:00 PM revealed residents are turned and repositioned every two (2) hours with incontinence care as needed. Observation of Resident #6, on 11/29/11 at 11:30 AM, revealed the resident to have bilateral hand and leg contractures. Interview with the resident, at the time of the observation, revealed the resident was totally dependent on staff for all care needs.	F 312	F312 Cont. from page 18 This will continue for a minimum of 30 days and may be continued if problems are noted. The DON will monitor the logs to determine the end date and if any additional training or assessment is needed. Social Services to visit the resident weekly to solicit input in regards to timeliness and staff responses to resident needs. #2 Social Service Director to review all grievances to identify any other complaints regarding incontinent care or provision of other ADL care. Any concerns noted will be addressed by DON. These reviews were completed 12-27-11 and any concerns voiced were treated as grievances and follow up completed per policy. Any education, counseling, investigation, re-assessment, care plan review and/or policy reviews were completed. Social services to review all reports of concerns related to being treated with respect and dignity, and timeliness of response of staff with the Assistant Administrator and DON weekly to ensure appropriate actions have been taken and that resident concerns are resolved. All concerns will be forwarded for a second review by the facility QA subcommittee for tracking and trending. Any additional actions needed will be referred to the facility QA Committee to ensure compliance.	



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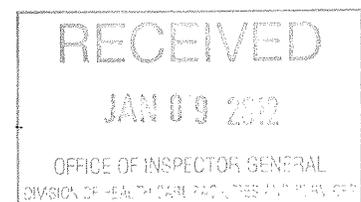
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F 312	Continued From page 19 Interview, on 11/29/11 at 3:15 PM, with Resident #6 revealed an incident occurred a few weeks ago where he/she was left wet and staff did not provide incontinent care as requested. The Resident stated he/she was very upset and it was not right she was left wet by staff. Interview, on 11/29/11 at 4:00 PM, with the Director of Nursing (DON) revealed she was aware of the incident on 11/22/11 and on that date Resident #6 told her CNA #3 left early and did not provide incontinent care. The DON stated she interviewed CNA #3 (first shift aide assigned) who stated she had been in and out the resident's room several times that day. However, the DON revealed she had not interviewed the evening shift staff, the nurse, or any other residents. In addition, the DON revealed she had not reviewed the ADL detail reports to determine if CNA #3 had documented incontinent care to the resident. Review of the ADL detail report for 11/19/11 revealed incontinent care was provided for Resident #6 at 10:22 AM and 4:44 PM. There was no evidence that incontinent care was provided between those times. Interview with evening shift CNA #4, on 11/30/11 at 6:05 PM, who found Resident #6 wet on 11/19/11, revealed around 2:30 PM Resident #6's call light was on and she went to the resident's room to see what the resident needed. She stated she found Resident #6's bed linens and clothing urine soaked and had to be cleaned and changed. CNA #4 stated the resident was upset and crying. In addition, she stated the resident's peri-area was red on observation and further	F 312	F312 Continued from page 19 #3 Unit Managers to review all bowel and bladder assessments by 12-30-2011 to ensure accuracy of assessment for toileting plan or check and change plan. All care plans and NA assignment sheets to be reviewed to ensure the appropriate plan is communicated to staff. Staff to continue to do documentation of any skin issues every shift and licensed staff to continue weekly skin assessments to ensure any skin issues are identified and that treatment begins promptly. Bowel and Bladder assessments will be reviewed quarterly for continued accuracy and to identify any changes in function. All NA assignment sheets will be reviewed by Unit Managers by 12-30-2011 to ensure instructions regarding the provision of all ADL care is identified and appropriate. Staff to be in-serviced on 12-27-11 regarding following the care plan as it relates to the delivery of care to all residents. This in-service will be provided by the Director of Staff Development.	



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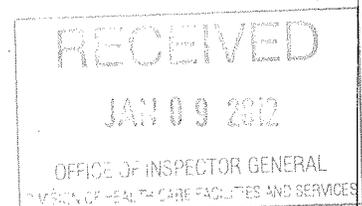
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F 312	Continued From page 20 stated according to the resident the peri-area was painful. Resident #6 was interviewed again, on 11/30/11 at 6:25 PM. The resident stated he/she was changed one time at 10:00 AM and the day shift CNA did not come back and change the resident again before she left for the day. The resident stated he/she was total care and dependent on staff because of the contractures. Resident #6 stated he/she spoke with a Social Worker regarding the incident. Interview with the Social Worker, on 12/01/11 at 4:00 PM, revealed Resident #6 reported the incident to her on 11/19/11, and said he/she was left wet by the day shift CNA #3. The resident told the Social Worker the call light had been activated; however, the CNA had turned off the light, did not provide care and left the room. The Social Worker indicated the resident had a history of getting upset whenever the routine was changed and it sounded to her like the staff missed the 2:00 PM round. Interview with the day shift CNA #3, on 12/01/11 at 6:20 PM, revealed she had worked on 11/19/11 and left early. CNA #3 stated she was assigned and responsible for Resident #6's care. She stated she was in Resident #6's room several times; however, review of the ADL detail reports revealed CNA #3 provided care for Resident #6 at 10:22 AM and no other times were documented.	F 312	F312 Continued from page 20 #4 Unit Managers to make monthly rounds to ensure that the care plans related to incontinent care and ADL's are followed. Audits will be reported to the DON for review and presentation to the facility QA Committee. A sub-committee of QA members and other staff as needed will meet no less than monthly to track compliance with the POC and the effectiveness of the POC. If the plan is not effective the sub-committee will recommend changes to the full QA Committee which will continue to meet no less than quarterly. #5 Completion date 1-9-2012.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		



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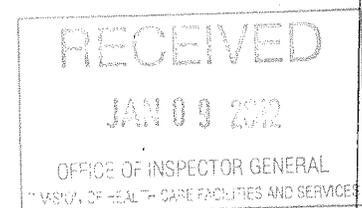
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F 314	Continued From page 21 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure one (1) of twenty-six (26) sampled residents that was identified on the comprehensive assessment as at risk to develop pressure sores, received the necessary preventative measures to prevent new pressure sores. The facility identified Resident #10 was a high risk for pressure sore development. The physician ordered bilateral heel protectors to be applied when the resident was in bed. However, observation and staff interview revealed the heel protectors were not available and applied as ordered. The findings include: The facility did not provide a pressure ulcer prevention policy as requested. On 12/01/11 at approximately 5:00 PM, the administrator stated the facility followed the standards of practice for delivery of care for all residents. The Lippincott, fifth edition, was a reference guide for nursing. Record review revealed the facility admitted Resident #10 with diagnoses of Anoxic Brain Injury, Immobility, and a history of a MI (heart	F 314	F 314 #1 Heel protectors reapplied to Resident #10 on 11-30-11 by CNA Preceptor. Heel protectors re-evaluated on 12-12-11 by Wound/Skin Nurse for continued need. Care Plan updated to reflect continued use of heel protection. #2 Wound/Skin Nurse will review all residents identified as at risk for skin breakdown to ensure all assistive devices and interventions are in place, this will be completed by 12-28-11. All care plans will be reviewed and updated as indicated. Wound/Skin Nurse will review all Pressure Ulcer Risk Screens to ensure that they are current. This will be completed by 12-28-11 All comprehensive care plans will be reviewed and NA Assignment sheets will be reviewed by IDT by 12-30-11 to ensure all needs, including specialized assistive devices and interventions are addressed, any needed updates will be made. #3 In-service to be conducted on 12-27-11 for all licensed and non-licensed staff regarding following the resident care plan, ensuring all specialized assistive devices are available, and in use for all appropriate residents.	1-9-12 02



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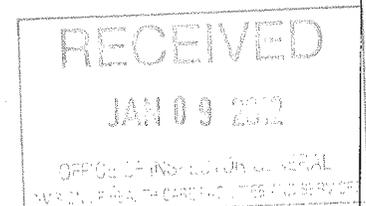
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F 314	<p>Continued From page 22</p> <p>attack) on 10/19/10. Review of the most current MDS (Minimum data set) assessment dated 10/09/11 revealed the facility assessed the resident as dependent on staff for bed mobility, transfers, and all ADL (activities of daily living) care. The assessment revealed the resident was non-verbal and at risk for skin breakdown.</p> <p>Review of the most current care plan dated 10/18/11 revealed the facility identified the resident at risk for skin breakdown related to impaired immobility and incontinence. Preventive measures were developed to prevent skin breakdown that included: pressure reduction boots to bilateral feet when in bed as ordered.</p> <p>Observation of Resident #10, on 11/29/11 at 11:30 AM, 1:10 PM, and 3:15 PM, revealed the resident lying in bed without the pressure reduction boots. Observation revealed the resident's feet were placed directly on the mattress.</p> <p>On 11/30/11 at 8:15 AM, observation revealed the resident lying on his/her back with no pressure reduction boots applied. Interview with the staff nurse, who was present at the time of the observation, revealed she was unaware the pressure reduction boots were not on the resident. Search of the resident's room revealed the reduction boots were not available. The nurse stated the CNA (certified nursing assistant) who was assigned to the resident had not reported to her the pressure reduction boots were missing. She could not determine how long the boots had been missing.</p> <p>At 10:30 AM, two CNAs were observed giving the</p>	F 314	<p>F314 Cont.. from page 22</p> <p>This in-service is to be presented by the Director of Staff development. This in-service will be repeated quarterly for 2 quarters then will be included with annual in-servicing. All newly hired staff will be educated during orientation. Wound Nurse to check weekly during wound rounds to ensure that all assistive devices related to skin care are available and in use.</p> <p>#4 Unit Managers to make weekly rounds for 6 weeks then monthly for 3 months to ensure that the care plans related to specialized assistive devices are followed. They will also ensure that assistive devices are available and in use. Audits will be reported to the DON for review and presentation to the facility QA Committee. A subcommittee of QA members and other staff as needed will meet no less than monthly to track compliance with the POC and the effectiveness of the POC. If the plan is not effective the sub-committee will recommend changes to the full QA Committee which will continue to meet no less than quarterly.</p> <p>#5 Completion date 1-9-12.</p>	



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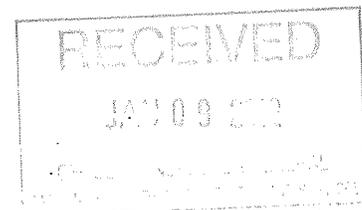
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F 314	Continued From page 23 resident a bed bath. The resident's feet were observed to be clothed with regular socks and lying on a pillow. Interview with CNA #12, on 11/30/11 at 10:45 AM, revealed she was responsible for Resident #10 and did not know where the reduction boots were. The CNA revealed she had provided care for Resident #10 yesterday, 11/29/11, and the pressure reduction boots were not available for use then. The CNA stated she had not informed the nurse that the boots were missing and had not attempted to obtain another set of pressure reduction boots. The facility did not provide the pressure reduction boots until surveyor inquired about their location. Interview with Resident #10's sister (POA), on 11/30/11 at 2:30 PM, revealed the resident had a history of skin breakdown and was a high risk for new pressure sore formation due to the resident's inability to turn and reposition self. The sister revealed Resident #10 went out for a home visit during the Thanksgiving holiday and the resident was wearing the pressure reduction boots upon return to the nursing facility.	F 314		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to	F 365	F365 #1 Resident #25 received a replacement tray with the correct diet on 11-30-11 #2 No other residents voiced concerns over their diet during the afternoon and evening meal on 11-30-11.	1-9-12 JS



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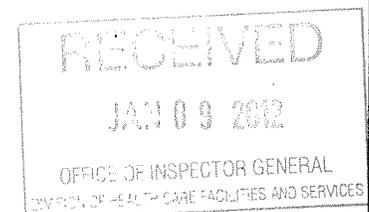
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F 365	<p>Continued From page 24</p> <p>ensure the therapeutic diet ordered by the physician was provided for one (1) of twenty-six (26) sampled residents.</p> <p>The findings include:</p> <p>Review of the physician orders dated 12/01-31/11 and the dietary food card revealed Resident #25 was to receive a carbohydrate controlled mechanical soft diet with ground meat and gravy; no raw fruit, vegetables, nuts, seeds, or corn, hulls. The food card was dated 11/18/11. The dietary food card revealed feed instructions to set up tray. The resident's name and room number was identified on the dietary food card. Review of the clinical record revealed diagnoses of Oropharyngeal Dysphagia, Diabetes Mellitis Type II and Diverticulitis.</p> <p>Observations, on 11/30/11 at 1:00 PM, revealed Resident #25 was sitting up in bed when CNA #7 brought a lunch food tray that contained beef stew with large pieces of beef and vegetables, salad, biscuit and a cookie. CNA #7 provided set up assistance and removed the salad bowl. The resident was observed to take several bites of beef stew and spit out several large pieces of meat. CNA #10 brought another tray into the room stating it was for Resident #25. CNA #7 told CNA #10 the resident already had a meal tray. CNA #10 stood holding the tray and said Resident #25 must have the wrong tray. CNA #7 took the dietary food card from the food tray that had been served to Resident #25 and exchanged the dietary slip with the new tray brought in the resident's room by CNA #10. CNA #7 told CNA #10 to give the tray to [him/her], meaning give the tray to an unsampled resident in room 410 B.</p>	F 365	<p>F365 Cont. from page 24</p> <p>This appears to be an isolated incident related to CNA#7 and the aide was re-educated on tray pass prior to the end of the shift on 11-30-11. Unit Manager/Charge Nurse will observe tray pass daily beginning 1-6-12 to ensure that residents are given the appropriate tray. Dietary staff reviews each tray card and tray as they are prepared to ensure the tray card and tray match, nursing staff are responsible to check tray card with tray and resident identification at time of service. Dietary Director is responsible to see that tray cards and dietary order match.</p> <p>#3 Director of Staff Development re-educated staff on tray pass procedures on 12-12 and 12-13-11. This education will be repeated quarterly for 2 quarters then the information will be included in an annual in-service. All newly hired employees will be educated during orientation.</p>		



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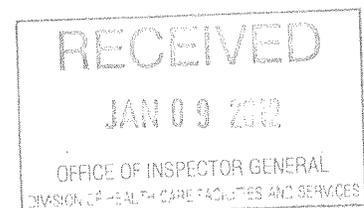
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F 365	<p>Continued From page 25</p> <p>CNA #7 stated they were both regular diets. CNA #10 stood there and did not respond to CNA#7, as they were being observed by surveyor. Resident #25 continued to eat the food initially served by CNA #7. Resident #25 began to ask for her tray of food.</p> <p>Continued review of the dietary food card revealed Resident #25 received a food tray prepared for another resident. Review of the dietary food card for the unsampled resident in room 410 B revealed the diet consistency was regular with a regular diet order, no likes or dislikes were identified and the feeding instructions were for set up tray and assist as needed. The resident should have received a mechanical soft/ground meat with gravy, carbohydrate controlled diet with no raw vegetables, raw fruit, no nuts, seeds, hulls, or corn.</p> <p>Observation, on 11/30/11 at 1:15 PM, revealed a new food tray was provided for Resident #25 by CNA #7. Resident #25 refused to eat the food stating the beef stew had made her sick. Observation of the new tray revealed bite size pieces of soft cooked vegetables with chopped/shredded pieces of beef as ordered by the physician.</p> <p>Interview, on 11/30/11 at 1:05 PM, with CNA #7 revealed the nurse manager had handed her the tray of food to deliver to the resident. She stated she did not read the dietary food card and knew both residents received regular diets. CNA #7 did</p>	F 365	<p>F365 Cont. from page 25</p> <p>DON/ADON/Charge Nurse will observe a minimum of 1 CNA during meal pass daily until all CNA's routinely scheduled at meal times have been observed at minimum of 2 times to ensure that they are checking tray card to tray and to resident, and to observe resident/ staff interaction. This will begin on 1-9-12. Kitchen Manager will audit tray line no less than weekly to ensure the tray card matches the tray and the Dietary Director will audit all tray cards to the diet quarterly.</p> <p>#4 DON/ADON/Charge Nurse will observe a minimum of 1 CNA during meal pass daily until all CNA's routinely scheduled at meal times have been observed at minimum of 2 times to ensure that they are checking tray card to tray and to resident, and to observe resident/ staff interaction.</p>	



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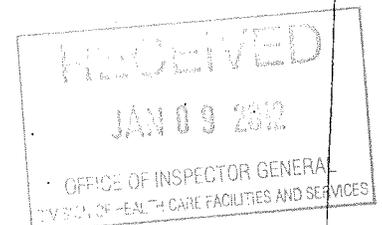
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2011
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F 365	Continued From page 26 not explain why she did not want to exchange the dietary food card and allowed the resident to continue to eat the food that was not prepared as ordered. CNA #7 would not answer when asked what effect the incorrect diet consistency could have on the resident. Interview, on 11/30/11 at 1:10 PM, with CNA #10 revealed Resident #25 had been given the wrong lunch tray and CNA #7 had tried to exchange the dietary food cards. CNA #10 confirmed CNA #7 had told her to give the lunch food tray prepared for Resident #25 to the unsampled resident in Room #410. Interview, on 11/30/11 at 3:50 PM, with LPN #11 and at 6:20 PM with LPN #5, revealed staff were responsible to verify the food delivered was the correct diet for each resident. The nurses stated staff were to verify the diet orders, consistency of liquids, and ensure ordered adaptive equipment were provided at each meal. Staff could find that information on the dietary food cards placed on each resident's tray. The nurses stated trying to switch off the dietary food cards was an unacceptable practice and was not to be done.	F 365	F365 Cont. from page 26 This will begin on 1-9-12. Kitchen Manager will audit tray line no less than weekly to ensure the tray card matches the tray and the Dietary Director will audit all tray cards to the diet quarterly. These observations will be recorded and presented to the facility QA for review no less than quarterly. A subcommittee of QA members and other staff as needed will meet no less than monthly to track compliance with the POC and the effectiveness of the POC. If the plan is not effective the subcommittee will recommend changes to the full QA Committee which will continue to meet no less than quarterly. #5 Date of correction 1-9-12	
F 372 SS=F	483.35(I)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, in-service	F 372	F372 #1 All facility dumpsters were checked by the ADON on 12-2-2011 and the doors were all working properly and the doors were closed.	1-4-12 OL



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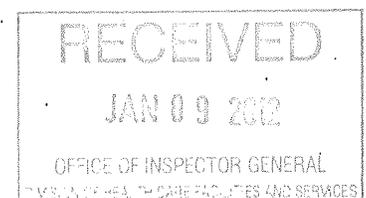
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F 372	<p>Continued From page 27</p> <p>records, dietary cleaning schedule, and review of the 2010 Plan of Correction (POC), it was determined the facility failed to monitor three (3) of the three (3) dumpsters to ensure doors were closed and proper disposal of garbage to prevent harborage of pests and rodents.</p> <p>The findings include:</p> <p>The facility did not provide a policy on the disposal of garbage.</p> <p>Review of the 2010 Plan of Correction (POC) revealed the kitchen staff were educated on how to transport garbage to the dumpster and place into the dumpster, garbage that had been removed from the facility. The POC stated training was completed on 12/07/10. In addition, the dumpster area was to be checked two (2) times daily and placed on a regular cleaning schedule.</p> <p>Review of the cleaning schedule revealed the dumpsters had not been placed on a routine cleaning schedule and monitoring of the dumpsters were not done.</p> <p>Review of the in-service records revealed training on proper disposal of garbage was not completed for all staff until 03/15/11.</p> <p>Observation of the two dumpsters on the side of building by the kitchen exit, on 11/29/11 at 5:30 PM, revealed the dumpster nearest the kitchen door had the front door of the dumpster opened, exposing internal garbage.</p> <p>Observation of the two side dumpsters, on</p>	F 372	<p>F372 Cont. from page 27</p> <p>The dumpster area was cleaned on 12-2-2011 by the ADON.</p> <p>#2 The dumpster area has been checked daily by the Housekeeping Supervisor to ensure the doors are closed and the area around the dumpsters are clean.</p> <p>#3 All staff will be reeducated on proper garbage disposal and maintaining a clean facility environment by Staff Development before 12-30-2011. Education on proper garbage disposal will be included in all new staff orientation effective 12-23-2011. Responsibility to observe the dumpster area and report any problems is that of any staff that take out garbage.</p> <p>#4 The facility has three (3) dumpsters on the property that will be checked daily for 4 weeks,</p>		



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F 372	<p>Continued From page 28</p> <p>11/30/11 at 1:30 PM, revealed both of the dumpster doors were open.</p> <p>Observation of the back dumpster by the parking lot, on 11/30/11 at 3:10 PM, revealed the front door to the dumpster was open, with rolled up soiled gloves lying on the ground in front of the dumpster and two (2) mattress lying on the ground next to the dumpster.</p> <p>Observation of the two (2) side dumpsters, on 12/01/11 at 8:01 AM, revealed the second dumpster had the front door open.</p> <p>Observation of the two (2) side dumpsters, on 12/01/11 at 8:45 AM, revealed both dumpsters with the front doors opened. The first dumpster had rolled up gloves and food debris lying on the ground.</p> <p>Interview with the Assistant Kitchen Manager, on 12/01/11 at 8:35 AM, revealed the dumpster doors should be closed at all times to prevent rodents and insects. She further revealed the area around the kitchen dumpster (dumpster #1 on the side of the building) was to be swept daily. She stated all new employees were trained on proper disposal of garbage. She further revealed the nursing department used the garbage dumpster as well.</p> <p>Interview with the Dietary Manager (DM), on 12/01/11 at 8:45 AM, revealed neither the manager or the assistant manager checked the garbage dumpster several times a day. The DM revealed there had been training on the dumpster.</p>	F 372	<p>F372 Cont. from page 28</p> <p>then weekly for 4 weeks by the Housekeeping Director, Maintenance Director or House Supervisor, they will observe the dumpster areas for cleanliness, that all trash is disposed of properly, and the dumpster doors remain closed. Observation of the dumpsters and dumpster area will also be added to the monthly sales tour that is conducted by the Assistant Administrator. Results of these reports will be given to the Administrator monthly and the compiled data will be reported to the QA Committee quarterly for further review and to ensure ongoing compliance.</p> <p>#5 Completion date 1-4-12</p>	



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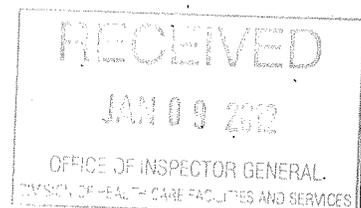
F 372	<p>Continued From page 29</p> <p>Further interview with the DM, on 12/01/11 at 10:45 AM, revealed the Assistant Dietary Manager made out the cleaning schedules. The DM revealed she did not remember what was on the POC regarding the dumpster from the 2010 survey.</p> <p>Interview with the Assistant Dietary Manager, on 12/01/11 at 10:47 AM, revealed she was responsible to assign the tasks currently on the cleaning schedule and monitor to ensure the tasks are completed. She revealed she did not have input regarding the POC and did not develop the cleaning schedule for the dumpsters.</p> <p>Interview with the Maintenance Assistant (MA), on 12/01/11 at 9:10 AM, revealed the dumpster by the back parking lot belonged to housekeeping and maintenance. The MA revealed the mattresses should not be kept on the ground by the dumpster and should be kept in the garage till properly disposed. The MA revealed rodents could get into the mattress and nest. The MA stated the dumpster doors should remain closed to prevent garbage from falling out of the dumpster and to prevent rodents from getting in the dumpster. He stated he did not know what monitoring tool was used for facility rounds. He further revealed the Assistant Administrator performed a monthly facility tour. The MA revealed maintenance and housekeeping were responsible to monitor the back dumpster and the dumpster next to the dietary dumpster.</p> <p>Further interview with the Maintenance Assistant (MA), on 12/01/11 at 10:15 AM, revealed the facility utilized a computer program as an audit tool; however, the program did not include</p>	F 372		
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F 372	Continued From page 30 monitoring of the dumpsters. Interview with the Assistant Administrator, on 12/01/11 at 7:00 PM, revealed monitoring the dumpsters are not on the monthly sale tour. Interview with the Administrator, on 12/01/11 at 1:32 PM, revealed he was not able to find evidence where the education listed in the POC was completed or done by the date of compliance. The Administrator revealed there was no current tool in place to monitor the dumpsters to ensure they were being maintained in a safe sanitary manner.	F 372		
F 441 SS=F	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.	F 441	F441 #1 Resident #14 was placed in Contact isolation on 11-29-11, signage was placed on the door and staff educated on contact isolation precautions by ADON. Resident #3 and #1 have been monitored by ADON to ensure that the practice noted did not present any complications for the resident (infection, deterioration in wound, etc.)	12-30-11



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F 441	Continued From page 31 (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, Center for Disease Control Guidelines, facility policy and procedures review, it was determined the facility failed to have an effective infection control program in regards to isolation, hand washing, and dressing change. This is a repeat deficiency for the last three (3) years. The findings include: Review of the CDC guidelines revealed hand hygiene was necessary after glove removal because hands could become contaminated through small defects in gloves from the outer surface of gloves used during removal. The CDC guidelines stated hand hygiene should be performed immediately after gloves were removed. The CDC recommends changing gloves when going from dirty to clean areas.	F 441	F441 Cont. from page 31 #2 ADON will review all lab reports and wound round reports for past 45 days to ensure that there are no new infections in residents with wounds that may be related to infection control practices. All residents in isolation had signage placed on doors by ADON on 12-28-2011. #3 All licensed and non-licensed nursing staff were in-serviced on isolation precautions per the Lippincott Manual for Nursing Procedures on 12-12-2011 by ADON, DON and Staff Development. This education will be repeated monthly for 3 months then quarterly, all licensed and non-licensed employees must attend a minimum of 4 times within the next year. All newly hired employees will receive their initial education during orientation.	
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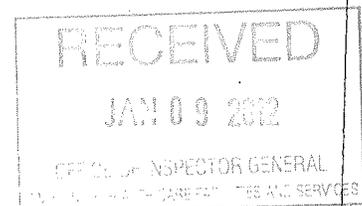
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F 441	Continued From page 32 Review of the facility policy for Infection Control revealed the purpose was to prevent the transmission of infectious or communicable diseases and to control nosocomial infections. The procedure documented to use appropriate barrier precautions to prevent skin and mucous membrane exposure when contact with blood or other body fluids of any resident was anticipated. 1. Wear gloves when expected, contact with blood and body fluids, mucous membranes or non-intact skin. a. Change gloves after contact with each resident. b. Wash hands. Interview, on 12/01/11 at 2:30 PM, with the Nurse Manager revealed staff were to wash their hands in between glove changes, change their gloves when going from clean to dirty and between different wounds. She stated staff was to gather supplies on a clean station, sanitize the bed side table, arrange supplies, sanitize hands, and apply clean gloves prior to touching the wound. Discard gloves, disinfect hands, and apply new gloves before going to the next wound. She was not aware the facility policy did not follow the CDC guidelines. Interview, on 12/01/11 at 2:30 PM, with LPN #7 revealed the facility policy for washing hands during a dressing change involved washing hands when you begin and again washing hands when the dressing change had been completed. Review of the policy and procedure for Wound Care Dressing Changes and Infection Control Measures; updated: 07/06/04 revealed dressing changes were to be a clean technique unless physician orders for a sterile dressing change.	F 441	F441 Cont. from page 32 All licensed staff providing direct care to residents were in-serviced with return demonstrations on dressing changes, hand washing, and glove changes on 12-12-2011 by ADON and DON. ADON will receive a copy of all labs from the Laboratory, ADON will be responsible to check that Isolation Precautions are implemented for any resident requiring isolation. ADON will check within 24 hours to ensure signage is on the door, PPE is available and staff are aware of the specific precautions. #4 ADON will observe each nurse complete a dressing change within the next 4 weeks or until all nurses have been observed completing a dressing change no less than two times. ADON will provide evidence of return demonstrations to DON for reporting to the facility QA committee.	
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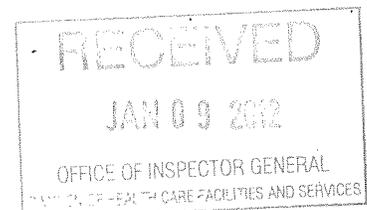
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F 441	Continued From page 33 Contact precautions should be followed for body substance contact. Wear additional barriers-gowns, masks, and goggles if secretions are likely to soil clothing, skin, or splash. For a resident with multiple pressure ulcers, they should be treated in order of most clean (head, hand, foot) to least clean (perinea, sacral areas). Glove changes should be changed between residents. They do not need to be changed between ulcers for a resident with multiple sites. Licensed personnel will adhere to the facility's hand washing protocol before and after each dressing change. Using alcohol based cleanser does not replace good hand washing technique between residents with pressure ulcers. Storage of documented supplies will be kept in a clean, and dry place. Treatment carts will not be taken into the room. Prior to the dressing change, only the supplies necessary for each treatment change will be removed from cart and taken into the room. After caregiver's hands have become soiled no other supplies will be taken until after their gloves have been removed and good hand washing technique preformed. Review of the Lippincott's Nursing Procedures, fifth edition, utilized by the facility for isolation precautions revealed contact precautions prevent the spread of infectious diseases transmitted by contact with body substances containing the infectious agent. Contact precautions apply to patients who were infected or colonized (presence of microorganism without clinical signs and symptoms of infection) with epidemiologically important organisms that can be transmitted by direct or indirect contact. Effective contact precautions require a single room and the use of gloves and gowns by anyone having contact with	F 441	F441 Cont. from page 33 ADON will continue to track and trend infections and communicable diseases and report no less than quarterly to the facility QA Committee. #5 Completion date 12-30-2011	12-30-2011

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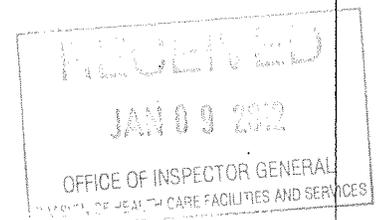
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F 441	<p>Continued From page 34</p> <p>the patient, the patient's support equipment, or items soiled with body substances containing the infectious agent. Thorough hand washing and proper handling and disposal of articles contaminated by the body substance containing the infectious agent are also essential.</p> <p>Review of the facility Methicillin Resistant Staph Aureus (MRSA) policy revealed for new admission with the diagnosis of MRSA, all staff on the unit would be notified when they arrive, in the change of shift report, and verbally to all ancillary staff involved in direct care of the resident. A contact precaution notification sign will be placed in the resident's room to notify any visitors or staff. The licensed nurse was to notify family and visitors to limit direct contact and wash hands appropriately prior to leaving the resident's room. MRSA diagnosed within the resident population that the notification to the attending physician will be made when a laboratory result comes in identifying a resident to have MRSA by lab interpretation. All symptoms will be reported. When residents have been treated with appropriate antibiotic therapy and are asymptomatic for 48 hours after the completion of the antibiotics they may be removed from contact isolation. If a follow up or repeat culture is ordered and the result returns colonized and the resident has been asymptomatic off of antibiotics for 48 hours they may be taken out of contact precautions.</p> <p>Observations, on 11/29/11 at 9:25 AM, 11:44 AM, 1:26 PM, and 3:23 PM, revealed LPN #13 was observed to provide care for Resident #14 when she provided pain medication prior to removing sutures from the resident's right eyebrow. At this</p>	F 441			



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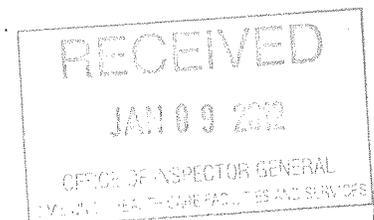
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2011
NAME OF PROVIDER OR SUPPLIER SUMMERFIELD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1877 FARNSELY RD. LOUISVILLE, KY 40216	
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F 441	<p>Continued From page 35</p> <p>time CNA #8 was observed to remove the lunch tray from Resident #14's room. Neither staff was observed to wear personal protective equipment (PPE) identified as a yellow disposable gown, no masks, and no gloves (for entering room and no personal contact). Surveyor was in resident's room at the observation times and no staff notified surveyor of contact precautions for Resident #14.</p> <p>Observations, on 11/30/11 at 8:20 AM, revealed a three drawer cabinet outside of Resident #14's room containing yellow disposable cover gowns, masks, and gloves. A sign on the door said to talk with the nurse prior to entering the room. No sign was observed to identify what precautions were to be implemented.</p> <p>Review of the clinical record for Resident #14 on 11/30/11 revealed an admission date of 07/27/06. Physician telephone orders dated 11/17/11 for a wound culture and an antibiotic Clindamycin 300mg. was to be administered four (4) times a day for ten (10) days. On 11/20/11 at 3:00 PM, staff documented new physician orders were received, discontinue Clindamycin and start Bactrim DS, one tablet two (2) times a day for fourteen (14) days. Review of the laboratory report with an approval date of 11/21/11 revealed the results of the wound culture was positive for MRSA. Nursing documentation, on 11/21/11 at 1:30 PM, revealed the wound care physician was aware of culture and sensitivity results and new orders by the primary physician. Nursing documentation, on 11/23/11 at 3:11 AM, revealed the resident remained on Bactrim DS for MRSA.</p> <p>Interview with LPN #12, on 11/30/11 at 8:20 AM,</p>	F 441		



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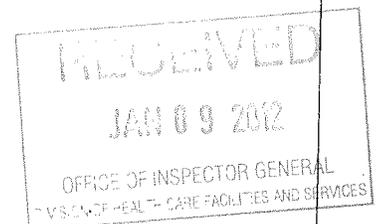
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F 441	<p>Continued From page 36</p> <p>revealed she had not worked on the unit and she was told during shift change Resident #14 had MRSA of the wound. She stated there usually was an orange sign on the door to inform staff of what precautions should be implemented; however, it was not there.</p> <p>Interview, on 11/30/11 at 10:10 AM, with the CNA #8 revealed she provided care for Resident #14 on 11/29/11 and 11/30/11. However, she was not made aware of the contact precautions put in place until the nurse informed her during the morning report on 11/30/11. She stated she was the primary CNA for the group which included Resident #14. She stated there was no PPE set up for use or signage on the door to ensure staff of precautions needed. She stated they used universal precautions; however, if they failed to implement them they could spread infections to other patients.</p> <p>Observations of dressing changes for Resident #14, on 11/30/11 at 10:10 AM, revealed the resident was identified as having MRSA by LPN #12 as she put on PPE. LPN #12 had arranged her supplies on the resident's bedside tray without disinfecting the area. LPN #12 was observed to remove the old dressing from the resident's right shin, obtain clean gauze with her gloved hand and misted the wound with saline as she swabbed the wound with the soiled gloved hand. She removed the gloves and replaced with new ones to dress the wound. She removed the gloves and applied new gloves to remove the old dressing from the toe wound infected with MRSA. She obtained new gauze from the opened stack and swabbed the toes with saline, cross-contaminating the remaining gauze that</p>	F 441			



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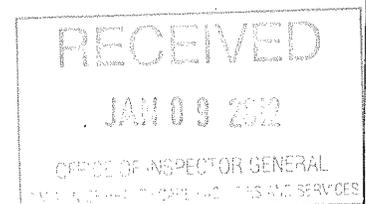
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F 441	<p>Continued From page 37</p> <p>she folded to place between the infected toes. LPN #12 did not disinfect the bedside table after the dressing change and did not disinfect the clip board she had carried into the resident's room. LPN #12 carried the soiled clipboard out of the room and placed it onto the treatment cart and onto the medication cart. The LPN did not change gloves between dirty and clean areas and did not use a disinfectant on her hands between glove changes as recommended by the CDC guidelines.</p> <p>Observation, on 11/30/11 at 11:03 AM, of the dressing changes for Resident #3 revealed LPN #12 gathered her supplies and placed them on the clip board as she carried them to the bedside tray. LPN #12 did not disinfect the tray area prior to setting up her supplies. LPN #12 wore gloves as she removed the old dressings and did not change her gloves to clean the wound. LPN #12 did not disinfect her hands between glove changes and did not change gloves when going from the dirty to clean areas. LPN #12 put the unused supplies on top of the clip board and placed them on top of the medication cart without disinfecting.</p> <p>Interview, on 11/30/11 at 11:41 AM, with LPN #12 revealed protocols for isolation determined what contact precautions were implemented. You were not to bring anything out of a resident's room that was in isolation without disinfecting it. Staff was to disinfect equipment with the bleach wipes. She should have disinfected the clip board prior to and after taking it into the resident's rooms. Additionally she should have changed her gloves when going from dirty to clean areas. She did not know she should have disinfected her hands</p>	F 441			



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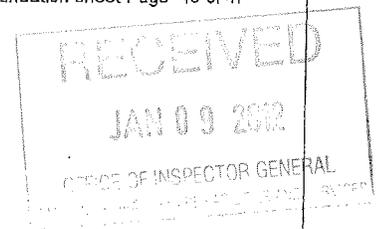
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F 441	<p>Continued From page 38 between each glove change. She guessed she was nervous.</p> <p>2. Observation, on 12/01/11 at 1:45 PM, revealed during the dressing change of Resident #1, Licensed Practical Nurse (LPN) #7 failed to wash her hands between four (4) glove changes as the dressing change proceeded. LPN #7 initially washed her hands prior to the dressing change and put on clean gloves. The resident was incontinent of stool. Incontinent care was provided and then the nurse changed gloves. The decubiti ulcer was cleaned and gloves were changed. Gloves were changed again to place the dressing over the decubiti ulcer and secure it with tape. LPN #7 washed her hands when the dressing change procedure was completed.</p> <p>Interview, on 12/01/11 at 2:25 PM, with LPN #8 revealed hands were to be washed before and after a dressing change.</p> <p>Continued interview, on 12/01/11 at 2:30 PM, with LPN #7 revealed if hands were to become soiled during the dressing change, they would be washed, otherwise, gloves are changed and hands washed when the dressing change is completed.</p> <p>Interview, on 12/01/11 at 2:30 PM, with the Nurse Manager revealed nothing was done from 11/20/11 through 11/29/11 to ensure isolation precautions were put into place once the MRSA</p>	F 441		



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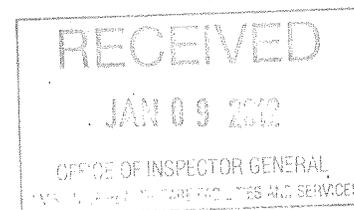
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F 441	Continued From page 39 was diagnosed for Resident #14. She stated precautions were not implemented until after the surveyors had left the unit on 11/29/11 around 5:00 PM. She stated the facility was made aware of the lab results on 11/20/11 and the nursing supervisor or nurse who spoke with the physician should have made notifications. It was an oversight of the nurse managers not to ensure preventative steps were implemented. The facility followed standard precautions; however by not implementing isolation procedures they could have spread infection to other staff and residents. Interview, on 12/01/11 at 3:36 PM, with the Assistant Director of Nursing (ADON) responsible for the infection control program revealed she was responsible to track and trend infections identified. When lab results returned positive she was to receive the lab report in her mail box. Resident #14 had a positive report of active MRSA and she had logged 11/17/11 as the date the culture was obtained and sent to the lab. She documented the antibiotic the resident was started on; however, she had not checked with the staff to verify appropriate precautions were implemented. She didn't write down the date she received the lab results. She trended reports as far as making sure the facility was not spreading the infection from one room to another. She usually followed up with the unit manager to ensure the residents were getting their treatment but had not ensured the facility policies and procedures were implemented. The Unit Manager failed to ensure appropriate PPE and signage was made available. It was an oversight and all of the staff was responsible to ensure the policies were implemented. Additionally, the facility policy for wound care and dressing	F 441		



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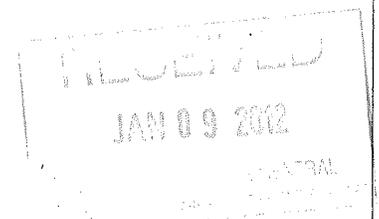
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F 441	Continued From page 40 changes did not meet the CDC guidelines and needed to be updated. Interview, on 12/01/11 at 4:00 PM, with the Staff Development Director revealed infection control in services were held quarterly and staff must attend at least one training a year. He stated CNA's would be notified by the nurse in the shift report of residents identified with an infection. The nurse was to post the signs and set the isolation cart outside the resident's door to alert visitors and staff of precautions to be implemented. If precautions were not implemented when residents were identified with MRSA the infections could go wild throughout the facility.	F 441			
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide a fully functional emergency call light system for all residents. Emergency pull cords in bathrooms were not accessible to three (3) residents on one (1) hall of the eight halls observed. The findings include: Observation, on 12/01/11 at 9:15 AM and at 5:15	F 463	F 463 #1 Emergency pull cords were replaced on 12-01-2011. #2 Assistance Maintenance Director checked the emergency pull cords in every room on 12-02-2011 and replaced any that were not accessible. #3 This facility utilizes a computerized program to assist the Maintenance Department in preventative maintenance and the monitoring of the Emergency Pull Cords has been added to the TELS program to be checked monthly.	12-3-11 199	



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F 463	Continued From page 41 PM, revealed residents' bathrooms located in Rooms 102, 105, and 107 did not have a pull cord attached to the emergency call light switch on the wall next to the toilet. Interview with the Assistant Maintenance Director (AMD), on 12/01/11 at 2:30 PM, revealed all resident bathrooms in the facility are to have a cord attached to the emergency call switch next to the toilet for access in case a resident had a fall and could not reach the emergency switch. Interview with the Licensed Practical Nurse and Assistant Unit Manager (LPN, AUM), on 12/01/11 at 5:15 PM, revealed residents in Rooms 102, 105, and 107 use the bathroom independently and could fall and not be able to reach the emergency switch because the cord was missing. An interview, on 12/01/11 at 5:20 PM, with an unsampled resident revealed both residents in Room 107 use the bathroom independently. The unsampled resident said one of them could fall and not be able to reach the emergency call light switch. Interview, on 12/01/11 at 5:25 PM, with CNA #11 revealed both residents in Room 105 use the bathroom independently. CNA #11 said a resident could fall and not be able to call for help because the call light switch was not within reach.	F 463	F463 Continued from page 41 #4 The Maintenance Director will report the results of the bathroom emergency pull cord audits to the safety committee monthly. The Chairman of the Safety Committee reports on any issues to the facility QA Committee no less than monthly. #5 12-03-2011	
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side.	F 468	F468 #1 The identified handrails were tightened on 11/30/11 by the Assistant Maintenance Director.	12-30-11 DJ



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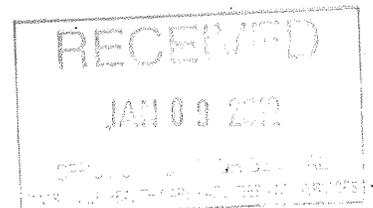
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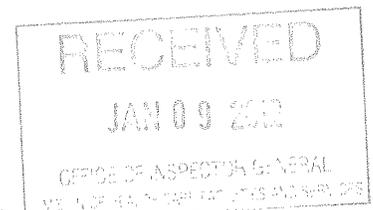
F 468	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure handrails were firmly secured on each side for six (6) of eight (8) hallways. Observation revealed portions of the handrails were loose on Halls 100, 200, 400, 500, 700; and 800. The findings included: Observation on 12/01/11 at 9:00 AM revealed loose handrails on each side of Halls 100, 200, 400, 500, 700 and 800. Interview with the Assistant Maintenance Director (AMD), on 12/01/11 at 9:20 AM, who was present for the environmental tour, revealed handrails are checked daily as the maintenance staff walk down the hallways. The ADM revealed loose handrails was an on-going problem. He revealed there was no set schedule to check the handrails.	F 468	F468 Cont. from page 42 #2 Every handrail was checked and tightened by the Assistant Maintenance Director on 11-30-2011. #3 This facility utilizes a computerized program to assist the Maintenance Department in preventative maintenance and the monitoring of the handrails has been added to the TELS program to be checked monthly. #4 The Maintenance Director will report the results of the bathroom emergency pull cord audits to the safety committee monthly. The Chairman of the Safety Committee reports on any issues to the facility QA Committee no less than monthly.	
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	F 520	#5 12-30-2011	



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F 520	<p>Continued From page 43 action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee 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 record review it was determined the facility failed to have an effective Quality Assurance (QA) committee to ensure ongoing compliance of corrected deficiencies. The facility was cited for problems with their infection control program for three (3) consecutive standard surveys. Review of the plan of correction submitted for the 2010 survey revealed the facility was to monitor noncompliance through the QA committee. However, interview with the Administrator revealed the deficient practice was only monitored for two (2) months. Observation during this standard survey (November 29-December 1, 2011) revealed the facility failed to consistently implement plans of actions to correct identified deficiencies and remain in compliance with state and federal regulations.</p> <p>The findings include: Review of the QA signature sheet revealed the facility conducts QA meetings at least quarterly</p>	F 520	<p>F520</p> <p>#1 Resident #14 was placed in Contact isolation on 11-29-11, signage was placed on the door and staff educated on contact isolation precautions by ADON. Resident #3 and #1 have been monitored by ADON to ensure that the practice noted did not present any complications for the resident (infection, deterioration in wound, etc.)</p> <p>#2 ADON will review all lab reports and wound round reports for past 45 days to ensure that there are no new infections in residents with wounds that may be related to infection control practices. All residents in isolation had signage placed on doors by ADON on 12-28-2011.</p> <p>#3 QA Committee will meet by 12-29-2011 to review the current Statement of Deficiencies and Plan of Correction. Specific sub-committee members will be assigned to monitor and ensure the POC is implemented timely and completely. A subcommittee of QA members and other staff as needed will meet no less than monthly to track compliance with the POC and the effectiveness of the POC.</p>	1-4-12 JG



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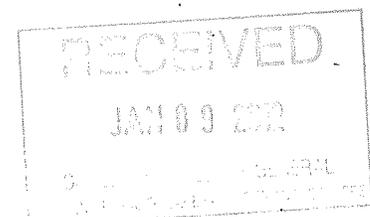
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F 520	<p>Continued From page 44 with the required members.</p> <p>Observation during the course of the survey, 11/29/11 through 12/01/11, revealed deficient practice was found for issues regarding infection control. The facility failed to maintain compliance in areas that would prevent cross-contamination during a wound dressing, isolation precautions, and hand hygiene. Refer to F441.</p> <p>Interview, on 12/01/11 at 2:30 PM, with the Nurse Manager revealed nothing was done from 11/20/11 through 11/29/11 to ensure isolation precautions were put into place once the MRSA was diagnosed for Resident #14. She stated precautions were not implemented until after the surveyors had left the unit on 11/29/11 around 5:00 PM. She stated the facility was made aware of the lab results on 11/20/11 and the nursing supervisor or nurse who spoke with the physician should have made notifications. It was an oversight of the nurse managers not to ensure preventative steps were implemented. The facility followed standard precautions; however by not implementing isolation procedures they could have spread infection to other staff and residents.</p> <p>Interview, on 12/01/11 at 3:36 PM, with the Assistant Director of Nursing (ADON) responsible for the infection control program revealed she was responsible to track and trend infections identified. When lab results returned positive she was to receive the lab report in her mail box. Resident #14 had a positive report of active MRSA and she had logged 11/17/11 as the date the culture was obtained and sent to the lab. She documented the antibiotic the resident was started on; however, she had not checked with</p>	F 520	<p>F520 Cont. from page 44</p> <p>If the plan is not effective the sub-committee will recommend changes to the full QA Committee which will continue to meet no less than quarterly.</p> <p>#4 The facility's Corporate Consultant will monitor the progress and compliance of the sub-committee with the implementation of the POC, and report to the VP of Operations any concerns no less than quarterly.</p> <p>#5 Completion Date 1-4-2012.</p>		

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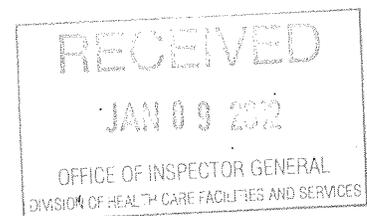
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NAME OF PROVIDER OR SUPPLIER SUMMERFIELD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1877 FARNLEY RD. LOUISVILLE, KY 40216	
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F 520	<p>Continued From page 45</p> <p>the staff to verify appropriate precautions were implemented. She did not write down the date she received the lab results. She trended reports as far as making sure the facility was not spreading the infection from one room to another. She usually followed up with the unit manager to ensure the residents were getting their treatment but had not ensured the facility policies and procedures were implemented. The Unit Manager failed to ensure appropriate PPE and signage was made available. It was an oversight and all of the staff was responsible to ensure the policies were implemented. Additionally, the facility policy for wound care and dressing changes did not meet the CDC guidelines and needed to be updated.</p> <p>Interview, on 12/01/11 at 4:00 PM, with the Staff Development Director revealed infection control in services were held quarterly and staff must attend at least one training a year. If precautions were not implemented when residents were identified with MRSA the infections could go wild throughout the facility.</p> <p>On 12/01/11 at 7:30PM, interview with the Administrator revealed the QA committee reviewed and monitored the plan of correction, for deficiencies cited under infection control for the 2010 standard survey, for only two (2) months. He stated the facility track and trended infections and the QA committee would review those reports quarterly. The Administrator indicated the deficient practice in which the facility was cited for the last two years were different than the issues found with infection control for this survey. He stated the facility had developed a plan of correction to correct the deficient practice cited</p>	F 520		



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F 520	Continued From page 46 under the infection control tag only and did not ensure all aspects of the tag was monitored for compliance.	F 520			



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NAME OF PROVIDER OR SUPPLIER SUMMERFIELD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1877 FARNSLEY RD. LOUISVILLE, KY 40216
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1979, 1998</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V Unprotected -</p> <p>SMOKE COMPARTMENTS: Twelve (12) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator installed in 2001. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 11/30/11. Summerfield Health and Rehab Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred sixty (160) beds and the census was one hundred fifty three (153) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>K000</p> <p>This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Summerfield Health and Rehabilitation agrees with the citations noted on the pages of this Statement of Deficiencies.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Donald D. Irwin by Lisa Gann TITLE: *Administrative by assistant* (X6) DATE: 12/23/2011

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.

DEC 23 2011
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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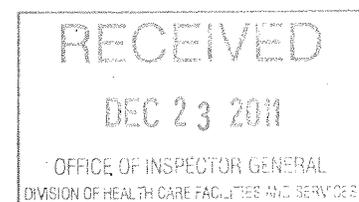
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K 000	Continued From page 1 Fire)	K 000																										
K 050 SS=F	<p>Deficiencies were cited with the highest deficiency identified at F level. CFR: 42 CFR 483.70(a) NFPÁ 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and fire drill review it was determined the facility failed to ensure fire drills were conducted at unexpected times under varied conditions. The deficiency had the potential to affect twelve (12) of twelve (12) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred sixty (160) beds with a census of one hundred fifty three (153) on the day of the survey.</p> <p>The findings include:</p> <p>Fire Drill review, on 11/30/11 at 9:00 AM, with the Assistant Maintenance Director revealed the fire drills were not being conducted at unexpected times under varied conditions. First shift fire drills</p>	K 050	<p>Fire drills will be conducted according to the following schedule for 2012.</p> <table border="0"> <tr><td>Jan</td><td>Between 7:30 and 8:30am</td></tr> <tr><td>Feb</td><td>Between 7:30 and 8:30am</td></tr> <tr><td>Mar</td><td>Between 11:00pm and midnight</td></tr> <tr><td>April</td><td>Between 4:30 and 5:30am</td></tr> <tr><td>May</td><td>Between 2:00 and 3:00pm</td></tr> <tr><td>June</td><td>Between 1:30 and 2:30am</td></tr> <tr><td>July</td><td>Between 10:00 and 11:00am</td></tr> <tr><td>August</td><td>Between 4:30 and 5:30pm</td></tr> <tr><td>Sept.</td><td>Between 1:00 and 2:00pm</td></tr> <tr><td>Oct.</td><td>Between 6:00 and 7:00pm</td></tr> <tr><td>Nov.</td><td>Between 3:30 and 4:30am</td></tr> <tr><td>Dec.</td><td>Between 9:00 and 10:00pm</td></tr> </table> <p>Fire drill tracking will be reported to the QA committee for 4 quarters then a new schedule for 2013 will be developed. Any deviations from the schedule will be reported to the Administrator who will report to the facility QA Committee.</p> <p>Date of Completion 12-27-2011</p>	Jan	Between 7:30 and 8:30am	Feb	Between 7:30 and 8:30am	Mar	Between 11:00pm and midnight	April	Between 4:30 and 5:30am	May	Between 2:00 and 3:00pm	June	Between 1:30 and 2:30am	July	Between 10:00 and 11:00am	August	Between 4:30 and 5:30pm	Sept.	Between 1:00 and 2:00pm	Oct.	Between 6:00 and 7:00pm	Nov.	Between 3:30 and 4:30am	Dec.	Between 9:00 and 10:00pm	12-27-2011
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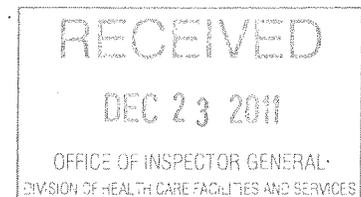
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K 050	Continued From page 2 were consistently being conducted around 9:30 AM each quarter. Interview, on 11/30/11 at 9:00 AM, with the Assistant Maintenance Director revealed he was unaware the fire drills were not being conducted as required. Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency	K 056	Kentuckiana Sprinkler completed an estimate to install the five (5) sprinklers needed on 12-2-2011. Kentuckiana Sprinkler completed an inspection of the facility overhangs on 12-2-2011 and no other areas were identified to need a sprinkler. Work is scheduled to begin on 1-3-2012 and will be completed on 1-7-2012. The additional sprinklers will be added to our preventative maintenance program for testing. Date of completion 1-7-2012.	1-7-2012



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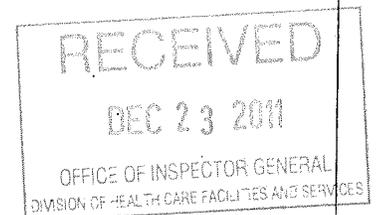
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K 056	Continued From page 3 had the potential to affect seven (7) of twelve (12) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred sixty (160) beds with a census of one hundred fifty three (153) on the day of the survey. The findings include: Observation, on 11/30/11 between 9:00 AM and 4:30 PM, with the Assistant Maintenance Director revealed five (5) porches located outside exit doors throughout the facility to extend out four (4) foot or greater, made of combustible materials, and were not sprinkler protected. The porches are located in the 200, 300, 400, 600, and 800 Halls. Interview, on 11/30/11 between 9:00 AM and 4:30 PM, with the Assistant Maintenance Director revealed he was not aware the porches needed to be sprinkler protected. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056		
K 062 SS=E	Reference: NFPA 13 (1999 Edition) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating	K 062	The escutcheon plates were replaced on the sprinkler heads by the Assistant Maintenance Director on 12-2-2011.	



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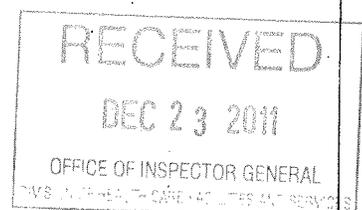
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K 062	<p>Continued From page 4 condition and are inspected and tested periodically: 19.7.6; 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect three (3) of the twelve (12) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred sixty (160) beds and the census was one-hundred fifty three (153) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 11/30/11 between 9:00 AM and 4:30 PM, with the Assistant Maintenance Director revealed two (2) sprinkler heads missing an escutcheon plate (trim piece) at the ceiling line, within the Kitchen bathroom, and room # 210, and 404.</p> <p>Interview, on 11/30/11 between 9:00 AM and 4:30 PM, with the Assistant Maintenance Director revealed he was not aware the escutcheon plate (trim piece) was missing on the sprinkler heads.</p> <p>Reference: NFPA 25 (1998 Edition)</p>	K 062	<p>A facility audit was completed by the Assistant Maintenance Director on 12-2-2011 to ensure that there was a escutcheon plate at the ceiling line for every sprinkler head.</p> <p>To ensure that this does not reoccur a monthly check will be added to the TELS system for monthly audit.</p> <p>Results of the audits for the escutcheon plates will be reported to the quality assurance committee quarterly for review until the committee agrees that the deficient practice is resolved.</p> <p>Completion date 12-27-2011.</p>	12-27-2011



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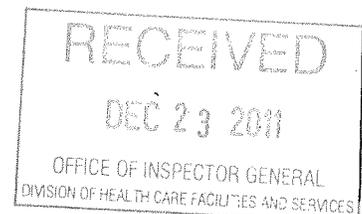
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K 062	Continued From page 5	K 062		
K 130 SS=D	<p>1-11.1 Maintenance shall be performed to keep the system equipment operable or to make repairs. As-built drawings, original acceptance test records, and device manufacturer ' s maintenance bulletins shall be retained to assist in the proper care of the system and its components.</p> <p>NFPA 101 MISCELLANEOUS</p> <p>OTHER LSC DEFICIENCY NOT ON 2786</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress. This deficiency had the potential to affect one (1) of twelve (12) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred sixty (160) beds, with a census of one hundred fifty three (153) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 11/30/11 at 3:29 PM, with the Assistant Maintenance Director revealed an unapproved lock (slide bolt type) was installed on the egress side of the bathroom door in the Kitchen.</p> <p>Interview, on 11/30/11 at 3:29 PM, with the</p>	K 130	<p>The unapproved lock was removed from the egress side of the kitchen bathroom door on 12-2-2011 by the Assistant Maintenance Director.</p> <p>A facility audit was completed by the Assistant Maintenance Director on 12-19-2011 to ensure that there are no other unapproved locks within the facility.</p> <p>The Assistant Administrator, DON, ADON, Office Manager, Receptionist, Activities Director, Therapy Manager, MDS Coordinator, Admissions Director, Medical Records Director were all informed that the slide bolt locks are not approved locks and if they identify an unapproved lock within the facility to inform the Administrator.</p>	



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K 130	Continued From page 6 Assistant Maintenance Director revealed they were unaware of the lock on the bathroom door. Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130	The Assistant Maintenance Director will conduct rounds monthly for 3 months then quarterly to check for any unapproved locks. Any unapproved locks found will be removed immediately and will be reported to the Administrator who will report any issues to the facility QA Committee. Completion date 12-30-2011	12-30-2011
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of twelve (12) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred sixty (160) beds with a census of one hundred fifty three (153) on the day of the survey. The findings include: Observation, on 11/30/11 between 2:00 PM and 4:30 PM, with the Assistant Maintenance Director revealed: 1) Medical Equipment (lift battery charger) was plugged into a power strip located in the Supply Room in the 100 Hall.	K 147	1) On 11-30-2011, the Medical Equipment (lift battery charger) located in the supply Room in the 100 Hall was immediately removed from the power strip and plugged into and appropriate outlet by the ADON. 2) The power strip was removed from room #205 and the oxygen concentrator was plugged into the appropriate outlet on 11-30-2011 by the ADON. 3) The ADON removed the extension cord in the Office Managers Office and the refrigerator was plugged into the appropriate outlet on 11-30-2011. 4).At the time of inspection, on 11-30-2011 the feeding machine, mini-nebulizer, and the resident bed were all removed from the power strip and plugged into an appropriate outlet in room #802.	



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K 147	<p>Continued From page 7</p> <p>2) An oxygen concentrator plugged into a power strip located in room #205.</p> <p>3) A refrigerator was plugged into an extension cord located in the Office Managers Office.</p> <p>4) A feeding machine, mini nebulzer, and a resident bed were plugged into a power strip located in room #802.</p> <p>5) The cord to the resident bed located in room #810, was damaged and wrapped with electrical tape.</p> <p>Interview, on 11/30/11 between 2:00 AM and 4:30 PM, with the Assistant Maintenance Director revealed they were unaware of the extension cords and power strips being misused, and he had not noticed the electrical tape on the cord to the bed.</p> <p>Repeat deficiency from 2009: The facility was cited for wrapping the dryer cords with electrical tape.</p> <p>Reference: NFPA-99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147	<p>5) The bed cord in room #810 was properly repaired by the Assistant Maintenance Director on 11-30-2011</p> <p>The Assistant Maintenance Director completed a facility inspection 12-19-2011 to identify other residents who may be affected by the same deficient practice. No other areas were identified during this tour.</p> <p>All staff will receive in servicing on electrical safety. The Staff Development Director will complete this education by 1-3-2012.</p> <p>Maintenance will complete a monthly check of all areas to ensure compliance is maintained and report the findings to the QA Committee quarterly.</p> <p>Completion Date 1-4-2012.</p> <p style="text-align: right;">1-4-2012</p>

