

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

PRINTED: 02/24/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185322	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/12/2010
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NAME OF PROVIDER OR SUPPLIER ROSE MANOR HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40518
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F 000	<p>INITIAL COMMENTS</p> <p>A Recertification Survey and an Abbreviated Survey investigating ARO KY 00014384 was conducted 02/10/10 through 02/12/10, and a Life Safety Code Survey was conducted 02/11/10. Deficiencies were cited with the highest Scope and Severity of a "D". ARO KY 00014364 was substantiated.</p>	F 000		
F 203 SS=D	<p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE</p> <p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</p> <p>Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p>	F 203	<p>F203</p> <p><u>Immediate Corrective Action:</u> memo was posted by Administration on 02/15/10 for review by charge staff (RN/LPN) regarding discharge procedures. The discharge procedure was reviewed by the Asst. Adm. with the charge staff (RN/LPN) at the mandatory meeting on 03/03/10. All RN/LPN staff signed memo to reflect understanding (see addendum).</p> <p><u>Other Residents Potentially Affected:</u> All residents have the potential for negative affects when procedures are not maintained to assure residents right for an orderly discharge process. The S.S. Director will assure a smooth process by making referrals, coordinating and locating outside services, and providing support and assistance to the family as needed on a case by case basis.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Melissa Morris* TITLE *Asst. Administrator* (X6) DATE *3/26/2010*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 203	<p>Continued From page 1</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure the resident or responsible party was notified in writing of the discharge for one (1) of ten (10) sampled residents (Resident #10); The findings include: Review of Resident #10's medical record revealed an admission date of 11/18/09, and diagnoses which included Progressive Dementia, and Parkinson's symptoms. Review of the Admission Minimum Data Set (MDS) dated 12/02/09, revealed the facility-assessed Resident #10 as having both short and long term memory deficits and as being severely impaired with cognitive skills for daily</p>	F 203	<p><u>Systematic Changes:</u> Memorandum was added to facility policy and procedure manual as well as the nursing communication guide. A determination for discharge can be made only by Asst. Adm. /DON as reflected per memo (see addendum). If a discharge determination is made a letter will be posted by the Asst. Adm. (30)days prior to the discharge (unless otherwise warranted due to urgent medical needs) explaining to the family/legal rep. the reason for the discharge determination.</p> <p><u>Monitoring:</u> Will be maintained by the Administrative team and weekly review of facility events and resident changes. Weekly meeting minutes (see addendum) will be maintained to reflect monitoring compliance and will be included in the QA record.</p> <p>Completion Date: 03/04/10</p> <p>N74</p>				

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F 203	<p>Continued From page 2 decision-making. Review of the Resident Assessment Protocol Summary (RAPS) dated 12/02/09, revealed the resident triggered for mood and behaviors, related to resistant and defensive responses to care. Review of the Nurse's Notes revealed the resident experienced aggressive behaviors towards staff at times. Review of the Nurses' Notes, dated 01/02/10, timed 2:30 AM revealed Resident #10 awakened and walked to the nurses station. At 3:00 AM the nurse noted the resident began pacing and yelling incoherently. The nurse documented at 3:05 AM Resident #10 tore a Certified Nursing Assistants (CNA) name badge off. The nurse noted she telephoned the Advanced Registered Nurse Practitioner (ARNP) who gave orders to transfer the resident to the Emergency Room (ER) and an ambulance was called. Continued review of the Nurses' notes dated 01/02/10, revealed the resident "tore off the countertop" to the nurses station at 3:30 AM. The Assistant Administrator was notified by the nurse at 3:40 AM, and the resident's son was notified at 3:55 AM. Resident #10 was transported to the ER by ambulance at 4:30 AM. The nurse documented at 5:10 AM the Assistant Administrator wanted the nurse to call the resident's family and tell them the facility requested Resident #10 be transferred to another facility as his/her needs could not be met. Further review revealed the nurse contacted the family by telephone and informed them they "would need to find a psychiatric hospital/unit in order to adequately treat" the resident's condition. Further review of the record revealed no documented evidence the resident or responsible party was notified in writing to include the</p>	F 203			

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F 203	Continued From page 3 regulatory requirements that the resident was discharged from the facility. Interview on 02/12/10, at 7:10 PM with Registered Nurse (RN) #2 revealed the Assistant Administrator had informed her Resident #10 could not come back to the facility. She stated that's what she told the family when she talked with them on 01/02/10. Interview on 02/12/10, at 6:35 PM with the Assistant Administrator revealed she had not informed RN #2 to tell Resident #10's family that. She stated the facility never discharged the resident, just sent him to the hospital. The Assistant Administrator stated she just wanted to have a plan in place in case the hospital decided to discharge the resident. She stated she understood the family decided not to bring the resident back. In addition, she stated she was not told a letter to discharge the resident was warranted.	F 203			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225	F225 <u>Immediate Corrective Action:</u> The S.S. Director notified the responsible party for resident #5 on 02/12/10. Responsible party was not aware of missing item. Family member was informed that if facility could not locate camera it would be replaced for resident #5. The facility purchased a new camera for resident #5 on 02/26/10. <u>Other Residents Potentially Affected:</u> All residents have the potential to be affected when investigation of potential misappropriation of resident property is not promptly implemented, and reported to other officials in accordance with state law. Resident group meeting was held on 03/11/10 and there were no other reports of missing property.		

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F 225	<p>Continued From page 4</p> <p>misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure a thorough investigation was completed and state agencies were notified related to misappropriation of property for one (1) of ten (10) sampled residents (Resident #5). The findings include: Interview on 02/11/10, at approximately 10:00 AM, during a group interview, Resident #5 revealed he/she had a missing digital camera. Resident #5 stated he/she reported this to the Social Services (SS) Director. Interview on 02/12/10, at 3:35 PM with the SS Director revealed Resident #5 had reported the missing digital camera to her approximately three</p>	F 225	<p><u>Systematic Changes:</u> Administration implemented a missing item form (see addendum) to be completed by the S.S. Director. This form will be completed for any missing item as reported by the resident. This form allows 48hr to locate the item . Reporting to state agencies is required if not located in (2) days time. The investigation will be completed by the S.S. Director and findings submitted (within 5 working days) to state agencies. <u>Monitoring:</u> Will be maintained by weekly team meetings of administrative staff (see addendum). Review of any missing items report will be done by the team to assure compliance with investigative and reporting procedures. The findings will be documented per the weekly minutes and maintained for reference with the facility QA records. Completion Date: 03/04/10</p> <p>N110</p>	

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F 225	Continued From page 5 (3) weeks earlier. She stated she knew the resident had the digital camera as she had replaced the batteries in it before. The SS Director stated she had reported the missing camera to the Assistant Administrator and nursing staff. In addition, she stated she had not completed her investigation. She further stated she had not reported the missing camera to state agencies. Interview on 02/12/10, at 3:55 PM with the Assistant Administrator revealed the SS Director was investigating Resident #5's missing digital camera. She stated it should have been reported to state agencies as misappropriation of property. She further stated the investigation should have been completed by this time. Review of the facility policy relative to abuse/neglect/misappropriation of property revealed, "if abuse is suspected or confirmed, a report will be made immediately to Adult Protective Services and Licensing and Regulations".	F 225			
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	F 274	F274 <u>Immediate Corrective Action:</u> All resident assessments and care plans were reviewed for accuracy. Accurate coding was reviewed by the MDS computer program by the DON and QA Director 02/15/10 thru 02/26/10. There was no way to correct the timing of the assessment for resident #3 but the current assessment properly reflects residents status.		

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F 274	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure a Significant Change Minimum Data Set (MDS) Assessment was completed for one (1) of ten (10) sampled residents (Resident #3). Resident #3 sustained a Hip Fracture and had a decline in physical functioning related to range of motion, transfers, ambulation and eating; however, there was no evidence a Significant Change MDS was completed within fourteen days (14) following determination that a significant change had occurred. The findings include: Review of the Quarterly Minimum Data Set (MDS) Assessment dated 02/23/09 revealed the facility assessed Resident #3 as being able to transfer independently, requiring limited assistance of one staff member for ambulation, and having no limitations with range of motion. Further review of the MDS revealed the facility assessed the resident as requiring limited assistance with eating. Review of the Annual MDS Assessment dated 05/21/09 revealed the facility assessed the resident as requiring total dependence on staff for transfers, and as ambulation not occurring. Further review of the MDS revealed the facility assessed the resident as having limitations and partial loss of range of motion in both legs, limitations and partial loss of range of motion in one foot, and as requiring total dependence on staff for eating.	F 274	<u>Other Residents Potentially Affected:</u> All residents are affected when staff do not act promptly to assess a decline or improvement in health status. The facility must assure a significant change assessment is done when a major improvement or decline occurs. All resident assessments are currently accurate as assessed per review of DON and QA Director as previously noted. <u>Systematic Changes:</u> Review of significant change assessment requirements was completed by DON and QA Director with input of Asst Adm. on 02/22/10. A plan was implemented for weekly meetings for review of 24hr shift report from previous week by the Adm. team. This reports reflects all resident changes and daily review of facility events per shift. This review will occur weekly by the DON, Asst. Adm., S.S./Act, F.S.S., and the QA Director. This will assure input of all departments related to resident status/changes. <u>Monitoring:</u> Will be maintained by weekly meetings by the Adm. staff. Minutes from meetings (see addendum) will be retained as a quality assurance tool and maintained with the QA records. Completion Date: 03/04/10 N182	

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F 274	Continued From page 7 Review of the Resident Assessment Protocol Summary (RAPS) dated 05/21/09 revealed Resident #3 was no longer ambulatory and behaviors caused safety concerns. The RAPS further stated the resident could no longer sit in a straight back chair or a wheelchair and used a Geri-chair for positioning. Further review of the RAPS revealed the resident was no longer able to feed self. Review of the Hospital Discharge Summary dated 04/13/09 revealed the resident fell and sustained a Hip Fracture. The resident was admitted to the hospital on 04/02/09 and underwent an Open Reduction and Internal Fixation (ORIF) on 04/03/09. Interview on 02/12/10 at 4:00 PM with the MDS Coordinator/Licensed Practical Nurse (LPN) #2 revealed Resident #3 sustained a fall on 04/01/10 and was admitted to the hospital on 04/02/09 related to a hip fracture. She further stated she completed the MDS with the assistance of the Director of Nursing (DON), the Activities Director, and the Dietary Manager. Continued interview revealed Resident #3 should have had a Significant Change MDS completed after sustaining the hip fracture and declining in areas including transfers, ambulation, range of motion, and eating. She stated, although the Annual MDS was completed 05/21/09, the Significant Change Assessment should have been completed prior to that date, when it was determined by the facility the resident was showing no improvement in these areas.	F 274			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279			

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F 279	<p>Continued From page 8</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and 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).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed ensure the development of a Comprehensive Plan of Care for one (1) of ten (10) sampled residents (Resident #10), related to the use of psychotropic medications. The findings include: Review of Resident #10's medical record revealed diagnoses which included Anxiety, Depression, and Dementia. Review of the Admission Minimum Data Set (MDS) dated 12/02/09, revealed the facility assessed Resident #10 as having both short and long term memory deficits and severely impaired cognitive skills for daily decision-making.</p>	F 279	<p>F279</p> <p><u>Immediate Corrective action:</u> Corrections were added to the care plan of resident#10. A review of all resident care plans was completed by the DON and QA Director 02/15/10 thru 02/26/10 to assure all entries were complete and accurately developed based on the comprehensive assessment. <u>Other Residents Potentially Affected:</u> All residents have the potential to be affected when systems are not maintained to assure that the care plans describe the services to be furnished to attain/maintain the highest practicable physical, mental and psychological well being. <u>Systemic Changes:</u> A system for review of all resident care plans will be completed by the DON (see addendum). Corrections will be made at the time of review by the DON or designee(LPN). The review will co-inside with the MDS schedule to assure that all entries are accurate and timely. Review and training of care plan development process was given to the LPN responsible on 02/26/10 by the DON.</p>		

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F 279	Continued From page 9 Review of the Resident Assessment Protocol Summary (RAPS) dated 12/02/09, revealed the resident triggered for Psychotropic Drug Use. Review of the Psychotropic Drug Use RAP revealed Resident #10 had routine use of Seroquel (an antipsychotic) and PRN (as necessary) use of Xanax (an antianxiety). Further review of the RAP revealed "proceed to CP (care plan) #7". Review of the Comprehensive Care Plan dated 12/02/09, revealed no documented evidence of a care plan (#7) to address the resident's use of psychotropic drugs. Interview on 02/12/10, at 4:30 PM with Licensed Practical Nurse (LPN) #2 revealed she completed the RAPS and care plans. She stated she "rapped" Resident #10's use of psychotropic drug use with the intention of developing a care plan. The LPN stated there should have been a psychotropic drug use care plan developed, however it was an oversight on her part.	F 279	<u>Monitoring:</u> Will be maintained by the Quality Assurance team. Reports/reviews will be submitted for oversight and input per the QA disciplines at the monthly meetings. Completion Date: 03/04/10 N189	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280	F280 <u>Immediate Corrective Action:</u> Revision for care plans of resident #1 and #3 were entered by the LPN/MDS nurse on 02/12/10. Restorative approach was added on resident #1, and the use of an alarm for resident #3 was removed. <u>Other Residents Potentially Affected:</u> All residents are affected when efforts are not consistent to assure timely review and revision of the care plan. A review of all residents care plans was completed on 02/15/10 thru 02/26/10 by the DON and QA Director to assure revision needs were assessed.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185322	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2010
NAME OF PROVIDER OR SUPPLIER ROSE MANOR HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516		
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F 280	<p>Continued From page 10</p> <p>the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the Comprehensive Plan of Care was revised for two (2) of ten (10) sampled residents (Residents #1, and #3).</p> <p>The findings include:</p> <p>1. Review of Resident #1's medical record revealed diagnoses including Cerebral Vascular Disease (CVA) with Right Side Hemiparesis. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 12/29/09 revealed the facility assessed the resident as having both short and long term memory loss, required extensive assistance with transfers and ambulation. The facility also assessed the resident as having limitations in range of motion (ROM) of the arm, hand and foot and as receiving Restorative Nursing Program services for active and passive range of motion, and for walking.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 09/29/09 revealed the resident retained full use of the left side and attempted to do self care.</p> <p>Review of the Nursing Restorative Plan and Flow Record dated 02/10 revealed the resident</p>	F 280	<p><u>Systematic Changes:</u> A mandatory meeting/training session was held on 03/03/10 for all charge staff (RN/LPN). A protocol for weekly review of all care plans (see addendum) was presented by the QA Director. Instruction/training was given to all RN/LPN staff by the QA Director. All RN/LPN charge staff are required to do a complete assessment on all residents weekly. This is accomplished by a schedule which is rotated on a weekly cycle (see addendum). Staff were instructed to note changes on the update form posted with every resident care plan (see addendum). Staff should always be aware of resident changes per shift report and 24hr log which can be referenced for review at any time. This protocol will be added to the nursing communication guide for reference and orientation of (RN/LPN) new hires and agency staff.</p> <p><u>Monitoring:</u> Will be maintained by the DON (see addendum) and the QA director who is also the main charge nurse. Use of the 24hr log will assist in assuring staff awareness of resident status changes. Report of review findings will be submitted by the DON at monthly QA team meetings. Completion Date: 03/04/10 N192</p>		

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F 280	<p>Continued From page 11</p> <p>received ambulation with a walker and active and passive ROM due to the diagnosis of CVA and an unsteady gait. The Flow Record was documented as the resident receiving restorative nursing 02/05/10 through 02/10/10.</p> <p>Review of the Comprehensive Plan of Care dated 12/29/09 revealed the resident's Activities of Daily Living self performance was limited due the partial loss of the right side. The goals included; appearance will reflect needs were met, and comfort would be maintained. There were several interventions listed. However, there was no goal or interventions listed related to the Restorative Nursing Program.</p> <p>Interview on 02/12/10 at 11:40 AM with Certified Nursing Assistant (CNA) #4, who was assigned to the resident, revealed the CNAs on the floor provided the restorative nursing. She further stated, the resident received ROM and ambulation during the day shift and was also ambulated to the bathroom.</p> <p>Interview on 02/12/10 at 4:00 PM with Licensed Practical Nurse (LPN) #2/MDS Nurse, revealed she completed the MDSs with the assistance of the DON, Activities Director, and Dietary Manager. She further stated, all nurses were responsible for revising the Plans of Care and the updates were completed on the Care Plan Update Form. LPN #2 indicated she checked the Care Plans quarterly and as she became aware of changes needed. She stated, the the Plan of Care should have been revised to include the Restorative Nursing Program for Resident #1.</p> <p>2. Review of Resident #3's medical record revealed diagnoses which included Alzheimer's</p>	F 280			

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F 280	Continued From page 12 Dementia and a History of a Left Hip Fracture. Review of the Minimum Data Set (MDS) Assessment dated 11/17/09 revealed the facility assessed the resident as having severe impairment in cognitive skills for daily decision making. The MDS revealed the facility assessed the resident to require extensive assistance with all Activities of Daily Living. Review of the Resident Assessment Protocol Summary (RAPS) dated 05/21/09 revealed the resident was no longer ambulatory and was unable to sit in a wheelchair or straight back chair due to the resident sliding hips off the front of the chair in a purposeful manner. The RAPS further stated a Geri-chair was used for positioning. Review of the Plan of Care dated 11/17/09 revealed the resident was at risk for falls related to the lack of safety awareness. There were several interventions listed including a pressure alarm to monitor movement. Observation of the resident on 02/11/10 at 9:00 AM revealed the resident was in the bed and a skin assessment was completed by Licensed Practical Nurse (LPN) #2. No pressure alarm was observed on the bed. Interview on 02/12/10 at 4:00 PM with LPN #2/ MDS Nurse revealed the resident no longer used the alarm in the bed and the Plan of Care should have been revised.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309	F309 <u>Immediate Corrective Action:</u> A mandatory meeting/training session was scheduled and held on 03/03/10 for all charge staff (RN/LPN). The QA Director and the Asst. Adm. reviewed the fall documentation and staff actions for resident #3	

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F 309	<p>Continued From page 13</p> <p>mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well being for one (1) of ten (10) sampled residents (Resident #3).</p> <p>The findings include:</p> <p>Review of Resident #3's medical record revealed diagnoses which included Alzheimer's Dementia, and a History of a Left Hip Fracture.</p> <p>Review of the Nurse's Notes dated 03/14/09 at 8:30 AM revealed Registered Nurse (RN #1) was called to the dining room by a Certified Nursing Assistant (CNA). The Note stated the resident was lying in the floor in the supine (face up) position and the dining room chair was tipped over beside the resident. The Note further stated the resident was checked for injuries and none were noted. Range of Motion (ROM) was performed to the upper and lower extremities without discomfort.</p> <p>Review of the Incident Report dated 03/14/09 at 8:30 AM revealed the resident had been ambulating in the hallway, and a few minutes later was found lying on the dining room floor. The dining room chair was tipped over on the floor near the resident. The Report indicated the Nurse Practitioner and the family were notified.</p>	F 309	<p><u>Other Residents Potentially affected:</u> All residents have the potential for a negative outcome when the facility does not assure care and services for the highest practicable physical, mental, and psychological well being. A routine review process to identify residents who are fall risk was implemented on 03/03/10. A designated LPN staff member was assigned to complete these assessments (see addendum) and efforts are on going at the time of this report.</p> <p><u>Systematic Changes:</u> A revision titled "Fall Risk Assessment and Documentation Protocol" was presented to RN/LPN staff at the mandatory meeting/training session on 03/03/10 by the QA Director. The requirements mandate vital signs every shift for 24hrs after a fall, a complete body audit and functional assessment by all staff as well as neuro checks if a blow to the head is suspected (see addendum) as with a un-witnessed fall. The fall risk assessment and documentation instruction was given to all RN/LPN staff by the QA Director on 03/03/10. All requirements were posted in the nursing communication guide for reference and orientation of new hires and agency staff.</p>		

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F 309	<p>Continued From page 14</p> <p>The section of the Report labeled vital signs was not completed.</p> <p>There was no indication of vital signs obtained after the fall on either the Nurses' Note or the Incident Report. In addition, there was no indication of neurological checks obtained, although there was no documented evidence the fall was witnessed as to whether the resident hit his/her head.</p> <p>Further review of the Nurses' Notes revealed there was no evidence of vital signs or neurological checks obtained during the seventy-two hour follow up charting.</p> <p>Also, review of the Nurses' Notes dated 04/01/09, 3-11 shift (no time noted), revealed " Resident fell in hallway. Was walking real fast and fell. No injury noted at the time of fall. Refused to let vital signs be taken". The Note further stated the spouse and Physician were notified.</p> <p>Review of the Incident Report dated 04/01/09 at 5:55 PM revealed the resident fell in the hallway while trying to walk too fast. The Report further stated the resident refused vital signs to be taken.</p> <p>The next entry in the Nurse's Notes dated 04/02/09 at 1:00 AM, stated "Resident in bed quietly resting. No complaints of pain or discomfort voiced related to previous fall. No injury noted". The Note further stated the Pressure Alarm was in use and activated and there were no signs and symptoms of distress. "Will continue to monitor".</p> <p>The next entry in the Nurses' Notes dated 04/02/09 at 9:00 AM revealed staff reported the</p>	F 309	<p><u>Monitoring:</u> Will include review of Incident/Accident Reports, Resident Fall Tracking log (see addendum), and documentation in the nursing notes. This review process was assigned to an LPN charge nurse per weekly review form (see addendum). The LPN will immediately report concerns and documentation issues to the DON. Compliance review will be maintained weekly by the Administrative team meetings. Documentation of meeting minutes will be retained for QA records. Completion Date: 03/04/10</p> <p>N199</p>	

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F 309	<p>Continued From page 15</p> <p>resident complained of pain while elevating the bed to feed the resident breakfast. The Note further revealed the pain was in the resident's right leg related to a recent fall, and the Mobile x-ray was notified per Physician's Orders.</p> <p>The next entry in the Nurses' Notes dated 04/02/10 at 1:45 PM revealed the results of the x-ray indicated an Acute Left Femur Fracture and Physician's Orders were received to transfer the resident to the hospital.</p> <p>Review of the Hospital Discharge Summary dated 04/13/09 revealed the resident fell at the facility and sustained a Hip Fracture. The Summary further revealed the resident underwent an Open Reduction Internal Fixation (ORIF) on 04/03/09.</p> <p>Review of the Nurses' Notes on 04/01/09 at 5:55 PM at the time of the fall, revealed there was no documented evidence of a thorough assessment after the fall to include neurological checks, skin assessment, range of motion, pain assessment or a description of how the resident was found to be sitting or lying at the time of the fall on either the Nurses' Notes or the Incident Report. In addition, there was no evidence of a thorough assessment with the follow up documentation in the Nurses' Notes for the 04/02/09 1:00 AM entry, and 04/02/09 9:00 AM entry.</p> <p>Although the resident sustained a fall on 04/01/09 at 5:56 PM, there was no evidence the resident received a thorough nursing assessment. On 04/02/09 at 1:10 PM a portable x-ray revealed an Acute Femur Fracture.</p> <p>Interview on 02/12/10 at 2:30 PM with the Director of Nursing (DON) revealed a nursing assessment</p>	F 309			

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F 309	Continued From page 16 after a fall did not necessarily need to include vital signs; however, the vital signs could be an assessment used to assess the resident for dizziness. She further stated the initial assessment after the resident's fall on 03/14/09 should have included neurological checks since there was no evidence of a witness as to whether the resident hit his/ her head. In addition, the DON stated the initial assessment and documentation each shift for the seventy-two (72) hour follow up for the 04/01/09 fall should have included an assessment of the resident's range of motion, pain, and skin. Also, she stated the nurse should have described the position in which the resident was found at the time of the fall on 04/01/09. Continued interview, revealed neurological checks should have been completed since there was no evidence staff were aware if the resident hit his/her head. The DON indicated the Nurses' Notes were not reviewed on a regular basis, and she was unaware of the incomplete assessment, monitoring, and documentation after this resident's fall. Review of the facility Fall Protocol revealed "the resident must be assessed by the Charge Nurse (per full body audit) to determine if an injury was present. A detailed description of all identified injuries must be documented by charge staff in the Nurse's Notes. A 72 hour observation period must be initiated. Staff are then required to review resident for injuries or change in function every shift for 72 hours. Documentation of observation and findings is required per Nurse's Notes".	F 309			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315	F315 <u>Immediate Corrective Action:</u> Resident #3 was assessed by DON and report of improper catheter /perineal care was related to the N.P. with no new orders. Instruction was given to Nursing Assistant (see addendum) regarding proper catheter and perineal care by the DON and QA Director on 02/17/10.		

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F 315	<p>Continued From page 17</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure residents received appropriate treatment and services to prevent Urinary Tract Infections (UTI's) for one (1) of ten (10) sampled residents (Resident #3).</p> <p>The findings include:</p> <p>Review of Resident #3's medical record revealed diagnoses which included Alzheimer Dementia and a History of Urinary Tract Infections (UTIs). Review of the Quarterly Minimum Data Set (MDS) Assessment dated 11/17/09 revealed the facility assessed the resident as being as being incontinent of bowel, continent of bladder and having an indwelling catheter.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 05/21/09 revealed the resident was at risk for Urinary Tract Infections related to Incontinence. The RAPS further stated the resident had no perception of bowel and bladder function and was unable to comprehend toileting.</p>	F 315	<p><u>Other Residents Potentially Affected:</u> All residents have the potential to be affected when proper procedures are not followed by facility staff to prevent infection risk factors. There are currently no other residents with foley catheters or receiving treatment for UTI.</p> <p><u>Systematic Changes:</u> In-service was held on 02/22/10 for all direct care staff (nursing assistants) by the DON. Copies of facility P&P for perineal care and catheter care were given to responsible staff (nurse aides). Instruction for proper procedure and technique was given by the DON at the in-service training sessions on 02/22/10. A schedule was developed to continue with the training sessions (3) times annually. Perineal care was added to the orientation check list for SRNA new hire training. Charge staff (RN/LPN) were instructed per 03/03/10 meeting (see addendum) to monitor care and technique by observation of direct care staff per rounds regarding peri/cath care and infection control concerns.</p>		

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F 315	<p>Continued From page 18</p> <p>Review of the Comprehensive Plan of Care dated 11/17/09 revealed the resident was at risk for UTIs due to incontinence and a Foley Catheter was required related to Urinary Retention. The Interventions included peri-care after episodes of incontinence.</p> <p>Further review of the medical record revealed the resident was diagnosed with UTIs on 10/28/09, 11/11/09, and 12/13/09 and treated with antibiotics.</p> <p>Observation on 02/11/10 at 9:50 AM of peri-care performed by Certified Nursing Assistant (CNA) #2, revealed the CNA used a wet wash cloth with soap and washed the peri-area from back to front and proceeded to use the same wash cloth to cleanse the catheter tubing from vagina toward the urinary drainage bag.</p> <p>Interview with CNA #2 on 02/11/09 at 10:00 AM revealed perineal care was to be performed from "front to back" and improper perineal care caused cross contamination, especially when an indwelling Foley catheter was present. She further stated, she was unable to do proper technique with this resident because of "the way the resident's legs are positioned".</p> <p>Further interview revealed she washed back to front of the vaginal area and then proceeded to cleanse the catheter tubing from the vagina downwards. She stated there were monthly staff meetings, and she may have had in-services on peri-care with the meetings in the past. However, she stated she had never been observed by a nurse at the facility while performing peri-care.</p> <p>Review of the facility Perineal Care Policy</p>	F 315	<p><u>Monitoring:</u> Will be maintained by observation of direct care staff per charge staff (RN/LPN) of observation of technique per rounds. Tracking/trending issues will be addressed by review of the monthly listing (see addendum) required from infection control RN monthly. This will be reviewed by the QA team at monthly meetings. Completion Date: 03/04/10</p> <p>N214</p>		

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F 315	Continued From page 19 revealed " Use one gloved hand to stabilize and separate the labia, with the other hand wash from front to back "	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure supervision to prevent accidents for one (1) of ten (10) sampled residents (Resident #3). Resident #3 sustained a fall on 03/14/09. There was no documented evidence the facility evaluated the cause of the fall, or the need for further interventions to prevent subsequent falls. The resident fell again on 04/01/09 and sustained a Hip Fracture. The findings include: Review of Resident #3's medical record revealed diagnoses which included Alzheimer's Dementia, and a History of a Left Hip Fracture/ Status Post Open Reduction and Internal Rotation. Review of the Minimum Data Set (MDS) Assessment dated 11/17/09 revealed the resident was severely impaired in cognitive skills and was totally dependent on staff for all Activities of Daily Living (ADLs).	F 323	F323 <u>Immediate Corrective Action:</u> Meeting was scheduled with attendance of all charge staff mandated. Resident #3 was assessed in regards to current status and environmental risk factors by the QA Director. No new interventions were required. <u>Other Residents Potentially Affected:</u> All residents have the potential to be affected when efforts are not maintained to assure that assessment for environmental hazards and assistive devices are implemented.	

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F 323	<p>Continued From page 20</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 05/21/09 revealed the resident was no longer ambulatory and behaviors caused safety concerns. The RAPS further stated the resident could not sit in a wheelchair or straight back due to the resident sliding hips off the chair in a purposeful manner, therefore; a Geri-chair was used for positioning.</p> <p>Review of the Plan of Care dated 11/17/09 revealed the resident was at risk for falls and injury related to the lack of safety awareness. There were several interventions including using a Geri-chair for positioning.</p> <p>Review of the Nurses' Notes dated 03/14/09 at 8:30 AM revealed Registered Nurse (RN) #1 passed the resident in the hallway and the resident was ambulating independently without difficulty. A few minutes later the nurse was called to the dining room by a Certified Nursing Assistant (CNA) and the resident was lying on the dining room floor in the supine position (face up). The dining room chair was tipped over and next to the resident on the floor and the resident was unable to relate how the fall occurred. The Note further stated the resident was checked for injuries and range of motion was performed to the upper and lower extremities without discomfort. The resident was assisted to the chair and a moment later the resident was walking in the hallways and ambulating without difficulty.</p> <p>Review of the Incident Report dated 03/14/09 at 8:30 AM revealed the resident had been ambulating in the hallway and a few minutes later was found lying on the floor of the dining room, with the dining room chair tipped over on the floor</p>	F 323	<p><u>Systematic Changes:</u> Revision of facility fall protocol was implemented. A risk assessment process and monitoring system to assure compliance by RN/LPN staff was presented at a training session on 03/03/10 for charge staff. The requirements and documentation guidelines were given to the staff by the QA Director at the session. A fall risk assessment will be completed for all residents and maintained in accordance with the MDS schedule as well as on admission. All requirements were posted for review by RN/LPN charge staff in the Nursing Communication guide. This is used for reference with new hires and agency staff (refer to addendum for monitors/changes). <u>Monitoring:</u> Will be maintained by weekly review of LPN designee and DON. Reporting of review process will occur at Adm. Team meetings weekly. The form will be used to reflect weekly meeting minutes and will serve as the QA record to reflect compliance. Completion Date: 03/04/10</p> <p>N219</p>		

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NAME OF PROVIDER OR SUPPLIER ROSE MANOR HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516		
(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 323	<p>Continued From page 21</p> <p>near the resident. " No injuries noted" . Further review of the Incident Report revealed a section labeled, "additional comments and/or steps to prevent recurrence" which was not completed. The Incident Report was signed by the DON.</p> <p>Review of the Nurses' Notes dated 04/01/09, 3-11 shift (no time noted), revealed the "Resident fell in hallway. Was walking real fast and fell. No injury noted at the time of fall. Refused to let vital signs be taken" .</p> <p>Review of the Incident Report dated 04/01/09 at 5:55 PM revealed the resident fell in the hallway trying to walk too fast, and refused to have vital signs taken. Further review of the Incident Report revealed a section labeled, " additional comments and/or steps to prevent recurrence" which was not completed. The Incident Report was signed by a Licensed Practical Nurse (LPN).</p> <p>Further review of the Nurse's Notes dated 04/02/09 at 9:00 AM, revealed staff reported the resident complained of pain in the right leg related to a recent fall. Mobile x-ray was called per Physician's Orders. The next entry in the Nurse's Notes dated 04/02/10 at 1:45 PM revealed the results of the left hip, left femur x-rays indicated an Acute Left Femur Fracture and an order was received from the Physician to transfer the resident to the hospital for further evaluation and treatment.</p> <p>Review of the Hospital Discharge Summary dated 04/13/09 revealed the resident fell at the facility and sustained a Hip Fracture. Further review of the Summary revealed the resident was admitted to the hospital on 04/02/09 and underwent an ORIF on 04/03/09.</p>	F 323			

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F 323	<p>Continued From page 22</p> <p>Continued review of the medical record revealed there was no documented evidence of an assessment of risk factors related to falls prior to or after the falls on 03/14/10 and 04/01/09. In addition, there was no documented evidence the facility assessed the cause of the fall on 03/14/09 to determine if new interventions needed to be implemented on the Plan of Care to prevent further falls. The resident fell again on 04/01/09 and sustained a Hip Fracture.</p> <p>Interview on 02/12/10 at 2:30 PM with the DON and Licensed Practical Nurse (LPN) #2/Quality Assurance Nurse revealed the facility used to do fall risk assessments on admission and quarterly on the residents; however, no longer completed them due to they did not find them useful. Further interview, revealed there was no evidence this resident received a fall risk assessment.</p> <p>Continued interview with the DON and QA Nurse, revealed they attempted to interview staff after a fall to find out the circumstances and try to evaluate the cause of the fall. Further interview revealed a Falls Tracking Log was kept on each resident in the medical record to track and trend each individual residents falls in order to find the cause and implement new interventions to prevent falls on the Plan of Care.</p> <p>However, review of Resident #3's Falls Tracking Log revealed there were no falls listed on the Log since 08/08. The 03/14/09 and 04/01/09 falls had not been added to the Log; although, the resident had sustained a Fracture with the 04/01/09 fall. Further interview with the DON and QA Nurse revealed any nurse who documented a fall was responsible for completing the Fall Tracking Log.</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER ROSE MANOR HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40518		
(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 323	Continued From page 23 The DON stated, either she or the QA nurse were responsible to ensure the Fall Tracking Log was completed and the Falls Protocol was followed after each fall. However, both the DON and the QA Nurse were unaware the Falls Tracking Log was not completed and the Falls Protocol was not followed for this resident. Further interview with the QA Nurse revealed the facility looked at all falls which occurred within the month for all residents to evaluate if there was an increase or decrease in falls; however, there was no indication the residents individual falls were evaluated for the need for further safety measures through the QA process. Review of the facility Fall Protocol, revealed " facility staff must ensure that each resident received adequate supervision and assistance devices to prevent accidents. Risk factors must be immediately identified with appropriate interventions implemented as events occur. The Protocol further stated " a Falls Tracking Log must be implemented or updated with each fall. This form must be completed front and back and signed by staff with each occurrence. Risk factors and interventions are to be added to the resident Plan of Care as identified/ implemented. Staff must evaluate each event and implement changes with each event to demonstrate efforts to assure safety. "	F 323			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids;	F 328	F328 <u>Immediate Corrective Action:</u> The nebulizer tubing and mask for resident #4 was placed in a large Ziploc storage bag. Medication nurses were informed to assure proper storage after each use. This was also conveyed through shift report for required follow up by all charge staff (RN/LPN).		

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NAME OF PROVIDER OR SUPPLIER ROSE MANOR HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516	
(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 328	<p>Continued From page 24</p> <p>Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure proper storage of the nebulizer tubing and nebulizer mask for one (1) of ten (10) sampled residents (Resident #4).</p> <p>The findings include:</p> <p>Review of Resident #4's medical record revealed diagnoses which included Dementia, Chronic Obstructive Pulmonary Disease, Hypertension, Coronary Artery Disease, and Diabetes.</p> <p>Review of the Physician's orders dated 02/01/10 through 02/28/10, revealed nebulizer treatments were ordered every six (6) hours.</p> <p>Observation on 02/10/10 at 4:10 PM revealed, Resident #4's nebulizer tubing and mask were not bagged and lying on the resident's nightstand. Observations on 02/11/10 at 8:15 AM through 02/12/10 at 8:15 AM, revealed Resident #4's nebulizer tubing and mask remained un-bagged on the nightstand.</p> <p>Interview on 02/12/10 at 8:25 AM, with Licensed Practical Nurse #3 (LPN), revealed the facility's policy was to wash, dry and store nebulizer tubing and mask in a plastic bag after</p>	F 328	<p><u>Other Residents Potentially Affected:</u> There is potential for undesirable affects to residents who receive special services when proper treatment and care of equipment/devices are not assured by the facility staff. There are currently no other residents receiving nebulizer treatments.</p> <p><u>Systematic Changes:</u> Policy & Procedure (see addendum) for storage of nebulizer equipment was presented to all charge staff per in-service training at the mandatory meeting on 03/03/10. Instruction was given to all (RN/LPN) staff by the QA Director.</p> <p><u>Monitoring:</u> Will be maintained per rounds daily by the DON, and the infection control nurse. Compliance will be assured by weekly review at the administrative team meeting(see addendum) and minutes will become part of the QA record.</p> <p>Completion Date: 03/04/10</p> <p>N228</p>	

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F 328	Continued From page 25	F 328		
F 441 SS=D	<p>each use.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>F441</p> <p><u>Immediate Corrective Action:</u> Instruction for proper performance and technique was given to SRNA#2 by the Don and the QA Director regarding infection control and relation to catheter care on 02/17/10 (see addendum). <u>Other Residents Potentially Affected:</u> All residents are at risk for adverse effects when proper procedures for infection control are not maintained. There are no residents currently requiring treatment for UTI. A review of antibiotic use was done by the DON on 03/10/10.</p> <p><u>Systematic Changes:</u> Training/instruction for proper peri/catheter care began at mandatory in-service given by the DON on 02/22/10. Instruction and observation requirements were given to RN/LPN staff on 03/03/10 by the QA director (minutes for both meetings are included in addendum). A plan to continue review of peri/catheter care procedure and technique will continue for at least (3) sessions annually as presented by DON. Observation and demonstration have been added as a requirement for new hires and agency staff per the orientation check list (see addendum).</p>	

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F 441	<p>Continued From page 26</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain an effective Infection Control Program to help prevent the development and transmission of disease for one (1) of ten (10) sampled residents (Resident #3).</p> <p>The findings include:</p> <p>Review of Resident #3's medical record revealed diagnoses which included Alzheimer Dementia and a History of Urinary Tract Infections. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 11/17/09 revealed the facility assessed the resident as being incontinent of bowel, continent of bladder, and as having an indwelling catheter. Further review of the MDS revealed the facility assessed the resident as having a Urinary Tract Infection in the last thirty (30) days.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 05/21/09 revealed the facility identified the resident was at risk for UTIs related to incontinence</p> <p>Review of the Comprehensive Plan of Care dated 11/17/09 revealed a Foley Catheter was required due to the diagnosis of Urinary Retention and the resident was at risk for UTIs. The interventions included catheter care each shift.</p> <p>Review of clinical laboratory results revealed recurrent UTIs on 10/28/09, 11/11/09, and 12/13/09 resulting in the resident receiving</p>	F 441	<p><u>Monitoring:</u> Will be maintained by rounds per charge staff (RN/LPN). In-service training records and orientation check list will reflect training compliance.</p> <p>Tracking/trending of infection occurrence will be monitored by the monthly infection control listing (see addendum) submitted for QA team review at monthly meetings. Additional training sessions will occur if increase occurrence is identified by team review.</p> <p>Completion Date: 03/04/10</p>		

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NAME OF PROVIDER OR SUPPLIER ROSE MANOR HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3087 NORTH CLEVELAND ROAD LEXINGTON, KY 40516		
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F 441	<p>Continued From page 27 antibiotics.</p> <p>Observation on 02/11/09 at 9:50 AM of Foley Catheter Care/ Peri-care, revealed Certified Nurse Assistant (CNA) #2 cleansed the resident from back to front (anal area to urinary meatus) and used the same wash cloth to cleanse the Foley Catheter tubing from vagina towards the urinary drainage bag.</p> <p>Interview with CNA # 2 on 02/11/09 at 10:00 AM revealed perineal care was to be performed from "front to back" and improper perineal care caused cross contamination, especially when an indwelling Foley catheter was present. She acknowledged she had washed back to front when performing perineal care however, stated she was unable to do proper technique with this resident because of "the way the resident's legs are positioned".</p> <p>Interview on 02/02/10 at 8:45 AM with the Director of Nursing (DON) revealed training for proper perineal care and prevention of urinary tract infections was incorporated into infection control staff inservices. She stated there was no specific inservice presented for perineal or Foley care.</p> <p>Record review of the facility "Inservice Training Reports" from 02/11/08 through 02/08/10 revealed the last inservice on perineal care was completed on 3/24/08.</p>	F 441			

Rose Manor Health Care
3057 North Cleveland Road
Lexington, Ky. 40516
Phone:299-4117 Fax:299-2836

Weekly Administrative Team Meeting Minutes: Date _____

Time _____

Members Present: _____

Review Transfer/Discharge Compliance

Missing Item Review /State Agency Notification Compliance

24 Hour Report Review Significant Change

Fall Documentation Compliance

Care Plan Update Compliance

Nebulizer Storage Compliance

Additional Concerns/Action Required

*****This form will be maintained to reflect compliance per QA record****

Signature _____

Adjourned _____

LINE LISTING OF PATIENT INFECTIONS

Month _____ Year _____

Room Name Admission date Type of Infection If UTI, foley present? Yes/ No	Symptoms	Cultures: Date/Site/Results	Treatment	Other actions (if needed)	Does not meet infection criteria	NI	CAI
Room _____ Unit _____ Name _____ Admission date _____ Type of Infection _____ If UTI, foley present? Yes/ No	Symptoms	Cultures: Date/Site/Results	Treatment	Other actions (if needed)	Does not meet infection criteria	NI	CAI
Room _____ Unit _____ Name _____ Admission date _____ Type of Infection _____ If UTI, foley present? Yes/ No	Symptoms	Cultures: Date/Site/Results	Treatment	Other actions (if needed)	Does not meet infection criteria	NI	CAI
Room _____ Unit _____ Name _____ Admission date _____ Type of Infection _____ If UTI, foley present? Yes/ No	Symptoms	Cultures: Date/Site/Results	Treatment	Other actions (if needed)	Does not meet infection criteria	NI	CAI
Room _____ Unit _____ Name _____ Admission date _____ Type of Infection _____ If UTI, foley present? Yes/ No	Symptoms	Cultures: Date/Site/Results	Treatment	Other actions (if needed)	Does not meet infection criteria	NI	CAI

NI = nosocomial infection CAI = community acquired infection
4 Surveillance

F315 Tracking / Trending
F441

WEEKLY SKIN REVIEW /VITAL SIGNS & CARE PLAN REVIEW

CHARTING FOR 3/1 - 3/5 *< this date will change to 3/22 - 3/26 to begin a new cycle*

	MON	TUES	WED	THURS	FRI
7-3	7B 8A	8B 9 18A	11A 11B	14A 15A	14B 15B
3-11	1A 2A 17A	1B 2B	3A 4B	5A 12B	10 16A
11-7	3B 4A	6A 5B	6B 7A 17B	12A 13A	13B 16B 18B

Schedule is notated weekly for a review by every shift.

WEEKLY SKIN REVIEW /VITAL SIGNS & CARE PLAN REVIEW

CHARTING FOR 3/8 - 3/2

	MON	TUES	WED	THURS	FRI
7-3	3B 4A	6A 5B	6B 7A 17B	12A 13A	13B 16B 18B
3-11	7B 8A	8B 9 18A	11A 11B	14A 15A	14B 15B
11-7	1A 2A 17A	1B 2B	3A 4B	5A 12B	10 16A

WEEKLY SKIN REVIEW /VITAL SIGNS & CARE PLAN REVIEW

CHARTING FOR 3/15 - 3/19

	MON	TUES	WED	THURS	FRI
7-3	1A 2A 17A	1B 2B	3A 4B	5A 12B	10 16A
3-11	3B 4A	6A 5B	6B 7A 17B	12A 13A	13B 16B 18B
11-7	7B 8A	8B 9 18A	11A 11B	14A 15A	14B 15B

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NAME OF PROVIDER OR SUPPLIER ROSE MANOR HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516
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K 067	<p>Continued From page 2</p> <p>Reference: NFPA 101 2000 edition 9.2.2 Ventilating or Heat-Producing Equipment. Ventilating or heat-producing equipment shall be in accordance with NFPA 91, Standard for Exhaust Systems for Air Conveying of Vapors, Gases, Mists, and Noncombustible Particulate Solids; NFPA 211, Standard for Chimneys, Fireplaces, Vents, and Solid Fuel-Burning Appliances; NFPA 31, Standard for the Installation of Oil-Burning Equipment; NFPA 54, National Fuel Gas Code; or NFPA 70, National Electrical Code, as applicable, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 91 1999 edition 7-1 General. Exhaust systems shall be tested, inspected, and maintained to ensure safe operating conditions.</p>	K 067		
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ROSE MANOR HEALTH FACILITY

Resident Room Door Check

Room #	Date	Problem	Initial
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			