STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	R-C 03/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

(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 Based on the facility's acceptable plan of correction, the facility is deemed to be in compliance on 03/31/15 as alleged.	{F 000}		

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

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 000	INITIAL COMMENTS A Recertification Survey and Abbreviated Survey investigating KY00022794 was initiated on 02/09/15 and concluded on 02/20/15. KY00022794 was unsubstantiated with no deficiencies cited. The Recertification Survey had deficiencies cited with the highest Scope and Severity of an "F".	F 000	**Plan of Correction** **Cambridge Place** **Abbreviated Standard/Standard Survey 2/20/15** **Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.**	
F 241 SS=E	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 and review of the facility's policy, it was determined the facility failed to ensure residents' dignity was respected for one (1) of twenty-one (21) sampled residents (Resident #20) and five (5) of five (5) unsampled residents (Unsampled Residents A, B, C, D and E). Observation revealed staff failed to knock on the residents' doors prior to entering their rooms. The findings include: Review of the facility's policy titled, "Quality of Life Dignity", dated October 2009, revealed residents should be cared for in a manner that promoted and enhanced their quality of life, dignity, respect and individuality. Further review of the Policy revealed residents' private space and property should be respected at all times, which included knocking and requesting permission before	F 241		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Administrator — TITLE — (X6) DATE: 3/25/15

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 241	Continued From page 1 entering residents' rooms. Review of the facility's, "Resident Rights Policy", dated October 2009, revealed employees should treat all residents with kindness, respect and dignity. Further review revealed the facility would make every effort to assist each resident in exercising his/her rights to assure the resident was always treated with respect, kindness and dignity. 1. Review of Resident #20's medical record revealed the resident resided in room 08, and had diagnoses which included Depressive Disorder, Hypertension and Hypoxemia. Review of the Minimum Data Set (MDS) Assessment dated 01/23/15, revealed the facility assessed Resident #20 to have a Brief Interview for Mental Status (BIMS) score of fourteen (14) indicating the resident was cognitively intact and interviewable. Observation, on 02/19/15 at 7:55 AM, revealed Registered Nurse (RN) #3 entered Resident #20's room, with his/her meal tray without knocking on the resident's door prior to entering, as per the facility's policy. Interview with Resident #20 on 02/20/15 at 10:10 AM, revealed he/she would prefer staff knock on his/her door prior to entering. 2. Review of Unsampled Resident A's revealed the resident resided in room 43, and had diagnoses which included Cerebrovascular Accident (CVA), Epilepsy and Depression. Review of the Quarterly MDS Assessment dated 11/13/14, revealed the facility assessed Unsampled Resident A to have BIMS score of of eight (8) which indicated the resident was	F 241	**F241 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.** **1) Identified residents were interviewed by Social Services Director on 3/10/15 and voiced no concerns regarding the respect offered them by facility staff or any infringements on their dignity.** **2) All residents with a BIMS score of 8 or higher were identified through MDS review by the Social Service Director. Identified residents were interviewed by Social Services Director on or before 3/13/15 and voiced no concerns regarding the respect offered them by facility staff or any infringements on their dignity.** **3) Staff will be educated by the Social Service Director, ADON and/or DON on the provision of care in an environment that maintains or enhances each resident's dignity and respect. This training will be completed before 3/30/15. A CQI tool was developed and approved by QA (Quality Assurance).** **4) The Social Service Director and/or the Director of Nursing (DON) will utilize the developed CQI tool to audit the provision of dignity during care and interview 5 random residents chosen by room number weekly for 4 weeks, monthly for 2 months, and quarterly thereafter as**	

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F 241	Continued From page 2 moderately cognitively impaired and interviewable. Observation on 02/18/15 at 12:30 PM, revealed SRNA #10 delivered Unsampled Resident A's lunch tray, entering his/her room without knocking on the door, as per facility policy. Interview, on 02/18/15 at 12:45 PM, with SRNA #10 revealed by not knocking on the resident's door and gaining permission to enter the room she had disrespected him/her. 3. Review of Unsampled Resident B's medical record revealed the resident resided in room 14, and had diagnoses which included Diabetes Mellitus, Dementia and Cerebral Artery Occlusion with Infarction. Review of the MDS Assessment dated 02/10/15 revealed, the facility assessed Unsampled Resident B to have a BIMS score of six (6) which indicated the resident was not cognitively intact. Observation, on 02/19/15 at 8:01 AM, revealed RN #3 entered Unsampled Resident B's room, with his/her meal tray without knocking on the resident's door prior to entering, as per the facility's policy. Interview with Unsampled Resident B on 02/20/15 at 1:30 PM, revealed it would bother him/her when staff would enter his/her room without knocking. 4. Review of Unsampled Resident C medical record revealed the resident resided in room 04, and had diagnoses which included Cognitive Communication Deficit and Diabetes Mellitus. Review of the MDS Assessment dated 01/27/15,	F 241	**per the CQI calendar under the direction of the Administrator. The QA Committee will review audit findings and revise the plan as needed.** **5) Completion Date:**	**3/31/15**

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F 241	Continued From page 3	F 241		

revealed the facility assessed Unsampled Resident C to have a BIMS score of eight (8) indicating moderate cognitive impairment and the resident was interviewable.

Observation, on 02/19/15 at 8:00 AM, revealed State Registered Nursing Assistant (SRNA) #11 entered Unsampled Resident C's room, with his/her meal tray without knocking on the resident's door prior to entering, as per the facility's policy.

Interview with Unsampled Resident C on 02/20/15 at 1:25 PM revealed it would bother him/her if staff entered his/her room without knocking.

5. Review of Unsampled Resident D's medical record revealed the resident resided in room 11, and had diagnoses which included Malignant Neoplasm of the Thyroid Gland, Atrial Fibrillation, Congestive Heart Failure and status post placement of a Cardiac Pacemaker. Review of the MDS Assessment dated 01/16/15, revealed BIMS score of five (5) which indicated the resident was not cognitively intact.

Observation, on 02/19/15 at 7:58 AM, revealed RN #3 entered Unsampled Resident D's room, with his/her meal tray without knocking on the resident's door prior to entering, as per the facility's policy.

6. Review of Unsampled Resident E's medical record revealed the resident resided in room 06, and had diagnoses which included Anxiety, Depressive Disorder and Alzheimer's Disease. Review of the MDS Assessment dated 01/30/15 revealed the facility assessed the resident to have

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F 241	Continued From page 4	F 241		

a BIMS score of three (3) indicating the resident was not cognitively intact.

Observation, on 02/19/15 at 7:45 AM, revealed RN #3 entered Unsampled Resident D's room, with his/her meal tray without knocking on the resident's door prior to entering, as per the facility's policy.

Interview with Unsampled Resident Unsampled E on 02/20/15 at 10:00 AM, revealed he/she liked for staff to knock on his/her room door before entering the room. Unsampled Resident E stated if staff didn't he/she could be in the "nude".

Interview with SRNA #11 on 02/19/15 at 9:00 AM, revealed he/she had received training on dignity, and when entering the residents' room, which was their home, she should have knocked on the residents' doors prior to entering their rooms.

Interview with RN #3 on 02/19/15 at 8:30 AM, revealed she received training during orientation on dignity and privacy. Per interview, she did not knock on residents' room doors because the doors were open and why would she knock if the door was open. Further interview revealed however, she should have knocked on the residents' doors for their privacy and dignity.

Interview, on 02/20/15 at 3:03 PM, with the Director of Nursing (DON) revealed it was her expectation for staff to knock on residents' room doors before entering the room, as that was a lack of respect for the resident and a dignity issue. Further interview revealed staff received training on dignity during orientation and should following the policy.

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F 241	Continued From page 5 Interview, on 2/20/15 at 3:48 PM, with the Administrator revealed she expected all staff to knock before entering a resident's room, and if they didn't it was a lack of respect for the resident.	F 241		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced	F 278		

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F 278	Continued From page 6	F 278	**F278 ASSESSMENT ACCURACY/ COORDINATION/CERTIFIED**	

by:
Based on observation, interview, record review and Resident Assessment Instrument (RAI) Minimum Data Set (MDS) 3.0 User Manual, it was determined the facility failed to ensure each resident was accurately assessed to reflect their status for one (1) of twenty-one (21) sampled residents (Resident #3).

Review of Resident #3's MDS Assessment revealed the facility did not accurately reflect the resident's eating status which was coded as a total of assist with eating. However, observation of Resident #3 revealed the resident eating without assistance.

The findings include:

Review of the RAI MDS 3.0 Manual, dated May 2011, revealed when conducting an MDS Assessment staff were to speak with direct care staff from each shift who had cared for the resident to determine his/her needs. Continued review revealed when reviewing records, interviewing staff and observing the resident staff conducting the MDS Assessment must be specific when evaluating each component as listed in the Activities of Daily Living (ADL) activity definition. Further review of the Manual revealed for Section G, the Functional Status section revealed under eating for the Activities of Daily Living (ADL) portion, if a resident did not participate in the eating process and required assistance of one (1) staff person to feed him/her the resident was to be coded as total dependence with one (1) person physical assist.

Review of Resident #3's medical record revealed the facility admitted him/her on 07/11/12, with

The facility must ensure that each resident receive an assessment that accurately reflects the resident's status.

1) A new MDS assessment was completed by the MDS Coordinator for Resident #3 on with an assessment reference date of 2/4/15 that accurately reflects eating abilities and needs.

2) An audit was completed by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) for all Residents' MDS assessments Section G0110 Eating to assure MDS coding accurately reflects eating abilities and needs. This audit was completed on 3/13/15.

3) The MDS/Care Plan Coordination nurses will be reeducated on the proper coding of MDS Section G0110 Eating by the DON. This training will be completed by 3/30/15. A CQI (Continuous Quality Improvement) audit tool was developed and approved by QA (Quality Assurance) Committee.

4) The DON, ADON, Staff Development, and/or Unit Coordinator will conduct random audits using the developed CQI audit tool of the coding of MDS Section G0110 using a sample of residents with MDS assessments

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F 278	Continued From page 7 diagnoses which included Alzheimer's Disease, Anxiety and Depression. Review of the Quarterly MDS Assessment dated 08/08/14 and Annual MDS Assessment dated 11/05/14, revealed the facility assessed Resident #3 to have a Brief Interview for Mental Status (BIMS) score of eight (8), which indicated moderate cognitive impairment and the resident was interviewable. Continued review of the MDS Assessments revealed the facility assessed Resident #3 to require total assistance of one (1) staff for eating. Review of Resident #3's Comprehensive Care Plan dated 11/27/14, revealed the facility had care planned the resident for Activities of Daily Living (ADL) deficit, with interventions which included the resident was a "total assist with meals and snacks". However, review of the Nurse's Notes revealed no documented evidence Resident #3 required total assistance with his/her meals. Observation on 02/18/15 at 12:32 PM, revealed Resident #3 sitting up in his/her wheelchair in the dining room for the lunch meal. Continued observation revealed Resident #3's tray was set up by staff, and the resident proceeded eating without assistance from staff. Additional observation on 02/19/15 at 8:20 AM, revealed Resident #3 was again sitting up in his/her wheel chair at the dining room table eating without assistance after his/her tray was set up by staff. Interview, on 02/20/15 at 10:35 AM, State Registered Nursing Assistant(SRNA) #6 revealed Resident #3 was able to eat without assistance once his/her tray was set up. Continued interview with SRNA #6 revealed Resident #3 had never been a total assist with his/her meals.	F 278	**completed during audit time frame weekly for 4 weeks, monthly for 2 months and quarterly thereafter as per the CQI calendar, under the direction of the Director of Nursing. The QA Committee will review audit findings and revise the plan as needed.** **5) Date of Completion:**	**3/31/15**

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F 278	Continued From page 8 Interview, on 02/20/15 at 3:55 PM, with Unit Coordinator (UC) #1 revealed Resident #3 ate without assistance once staff had set his/her meal tray up. Interview, on 02/20/15 at 1:15 PM, with the Assistant MDS Coordinator revealed she looked at residents' medical record for information when coding the MDS Assessments. Per interview, Resident #3 was a total feeder which meant he/she needed extensive assistance at meals and with eating. Interview, on 02/20/15 at 3:35 PM, with the Director of Nursing (DON) revealed the MDS nurses should be looking at residents' medical records, as well as, performing the MDS Assessment. Per interview, the MDS nurse should be following the RAI process to ensure the facility provided a complete and accurate assessment of residents in order to plan for their care.	F 278		
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	F 279		

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F 279	Continued From page 9 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). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure a Comprehensive Care Plan was initiated seven (7) days after the comprehensive assessment was completed for one (1) of (21) sampled residents, Resident #20. The findings include: Record review revealed the facility admitted Resident #20 on 01/16/15, with diagnoses which included Malnutrition, Schizophrenia, Hypertension, Hypoxemia and Depressive Disorder. Review of the 01/23/15 Minimum Data Set (MDS) Assessment revealed the facility assessed Resident #20 to have a Brief Interview for Mental Status (BIMS) score of fourteen (14) which indicated he/she was intact cognitively. However, continued record review revealed no documented evidence of a Comprehensive Care Plan, which should have been completed within twenty-one (21) days of admission (02/06/15). Interview with the Minimum Data Set (MDS) Coordinator on 02/20/15 at 10:50 AM, revealed the facility had a total of twenty-one (21) days after admission to develop and complete a Comprehensive Care Plan. Continued interview	F 279	**F279 DEVELOPMENT COMPREHENSIVE CARE PLANS** **The facility must use the results of the assessment to develop, review and revise the resident's comprehensive care plan.** **1) Resident #20's care plan was completed by the MDS/Care Plan Coordinator on 2/21/15.** **2) An audit was completed by the DON on all resident care plans to assure every resident had a comprehensive plan of care developed within 21 days. This audit was completed on 3/13/15.** **3) The MDS/Care Plan Coordination Nurses will be reeducated by the DON on the requirement that a comprehensive care plan be developed within 21 days of admission. This training will be completed by 3/30/15. A CQI audit tool was developed and approved by QA Committee.** **4) The DON, ADON, Staff Development, and/or Unit Coordinator will audit the timely completion of all new admission care plans (within 21 days of admission) weekly for 4 weeks, monthly for 2 months and quarterly thereafter as per the CQI calendar under the direction of the Director of Nursing. The QA Committee will review audit findings and revise the plan as needed.** **5) Date of Completion:**	**3/31/15**

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F 279	Continued From page 10 revealed if Resident #20 did not have a Comprehensive Care Plan in his/her chart, it was because she had not been able to initiate one for the resident. The MDS Coordinator stated she because she had completed Resident #20's Comprehensive Care Plan, as she had numerous resident admissions and had not had time to do the Comprehensive Care Plan. Interview with the Director of Nursing (DON) on 02/20/15 at 3:35 PM, revealed the MDS Coordinator should have followed the Resident Assessment Instrument (RAI) process and completed the Comprehensive Care Plan for Resident #20 as required. Continued interview revealed she had been unaware Resident #20's Comprehensive Care Plan had not been completed because the MDS Coordinator had not had time to complete the Care Plan. She further stated a Comprehensive Care Plan was needed to provide complete and accurate resident care.	F 279		
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

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F 280	Continued From page 11	F 280	**F280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP**	

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.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to revise the Comprehensive Care Plan to reflect changes in the care and treatment for three (3) of twenty-one (21) sampled residents (Resident #3, Resident #4 and Resident #8).

Resident #4 was care planned to be nothing by mouth (NPO); however, Physician's Orders revealed the resident was to receive a pureed diet with nectar thick liquids.

Resident #3 was care planned to be a total assist with eating; however, observation and interview revealed the resident ate without assistance.

Resident #8 was care planned to have anti-rollbacks on his/her wheelchair; however, observation and interview revealed the resident did not have anti-rollbacks on his/her wheelchair due to having a lower seat and the anti-rollbacks were removed in December 2014.

The findings include:

Review of the facility's policy titled, "Development of a Care Plan", undated, revealed the care plan was to be reviewed/revised as per the Resident

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; developed by and interdisciplinary team and periodically reviewed and revised by a team of qualified persons after each assessment.

1) **Care plans for Residents #3 and #4 were reviewed and updated by the MDS/Care Plan Coordinator to accurately reflect eating abilities and needs on 3/10/15. Anti-rollbacks were removed from Resident #8's care plan on 3/10/15.**

2) **An audit will be completed on or before 3/18/15 by DON and/or ADON for all residents' care plans to assure each care plan accurately reflects eating abilities and needs and specialized w/c equipment.**

3) **The MDS/Care Plan Coordination nurses will be reeducated by the DON on the requirement that a care plan accurately reflect each resident's eating ability and needs, specialize w/c equipment and be updated with new physician orders. This training will be completed on or before 3/30/15. A CQI audit tool was developed and approved by QA Committee.**

4) **The DON, ADON, Staff Development, and/or Unit**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

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CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

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F 280	Continued From page 12 Assessment Instrument (RAI) manual with significant changes, and changes in orders as received by the Minimum Data Set (MDS) Coordinator. Further review of the Policy revealed care plan updates/changes were to be done in accordance with the RAI Manual as part of an ongoing process. 1. Review of Resident #4's medical record revealed the facility admitted the resident on 04/28/14, with diagnoses which included Hypertension, Cerebral Vascular Accident, Dysphagia, Diabetes, status post Gastric Tube Placement and Seizures. Review of the Physician's Order, dated 11/25/14, revealed an order for Resident #4 to have a pureed diet with nectar thick liquids for all meals and snacks, which indicated he/she was not on an NPO status as care planned. However, review of Resident #4's Comprehensive Care Plan, dated 01/07/15, revealed the facility had care planned the resident to be at nutritional risk related to receiving his/her nutrition via a tube related to his/her NPO (nothing by mouth) status. Interview with the Unit Coordinator (UC), on 02/20/15 at 2:00 PM, revealed it was important to update and revise the care plan when Physician's Orders changed, to ensure the actual/current care and treatments were in place for the residents. Interview with the MDS Coordinator, on 02/20/15 at 3:00 PM, revealed care plans should be updated daily when staff reviewed new Physician's Orders to ensure the residents were receiving the appropriate care and treatment as ordered by the Physician.	F 280	**Coordinator will conduct random audits using the developed CQI audit tool of the care planned eating abilities and needs, specialized w/c equipment and new physician orders using a sample of residents randomly chosen based by room number weekly for 4 weeks, monthly for 2 months and quarterly thereafter as per the CQI calendar under the direction of the Director of Nursing. This CQI audit tool is to ensure compliance through visual observation of the residents as compared to the care planned interventions. The QA Committee will review audit findings and revise the plan as needed.** 5) Date of Completion:	3/31/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 13	F 280		

Interview with the Director of Nursing (DON), on 02/20/15 at 3:35 PM, revealed if a resident was NPO and then began taking fluids or eating by mouth, the care plan should be updated to reflect those changes.

Interview with the Administrator, on 02/20/15 at 3:50 PM, revealed if a resident was care planned to have an NPO status, and they were not NPO, it could affect their current level of care.

2. Review of Resident #3's medical record revealed an admission date of 07/11/12, and diagnoses which included Anxiety, Depression and Alzheimer's Disease. Review of Resident #3's Comprehensive Care Plan dated 11/27/14, revealed the facility had care planned the resident for Activities of Daily Living (ADL) deficit, with interventions which included "total assist with meals and snacks". Review of the Physicians's Orders dated February 2015 revealed no documented evidence Resident #3 had orders for specialized eating utensils or need for total assistance at meals.

Observation of Resident #3 on 02/18/15 at 12:32 PM, revealed he/she was sitting in his/her wheelchair in the dining room consuming his/her lunch meal without assistance of staff. Continued observation of Resident #3 on 02/19/15 at 8:20 AM, revealed he/she was again sitting in his/her wheel chair in the dining room eating without staff's assistance after his/her tray set up.

Interview with State Registered Nursing Assistant (SRNA) #6 on 02/20/15 at 10:35 AM, revealed Resident #3 had never been a total assist with his/her meals. Per interview, Resident #3 always ate without assistance once his/her meal tray was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

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F 280	Continued From page 14	F 280		

set up.

Interview with UC #1 on 02/20/15 at 3:55 PM, revealed Resident #3 ate without assistance once his/her tray was set up.

3. Review of Resident #8's medical record revealed the facility re-admitted him/her on 01/12/12, with diagnoses which included Vascular Dementia, Diabetes, Depression and Psoriasis. Review revealed Resident #8 was discharged 01/18/15 to the hospital, and readmitted to the facility on 01/24/15. Review of the Quarterly MDS Assessment dated 12/03/14, revealed the facility assessed Resident #8 to be moderately cognitively impaired and to be at risk for PU.

Review of Resident #8's CCP revised on 12/03/14 for the resident's risk for falls revealed the resident had impaired cognition, dependence on staff for mobility assistance and was non-compliant with waiting for or asking for assistance. Further review of the care plan revealed interventions which included anti-rollbacks to wheelchair dated 05/29/14. Review of the SRNAs "Daily Care Plan Record" for Resident #8 for January and February 2015 revealed the resident was to have anti-rollbacks to his/her wheelchair.

Review of the January 2015 monthly Physicians's Orders revealed under safety devices an order dated 05/29/14 for "anti-rollbacks to wheel chair". However, review of the February 2015 monthly Physician's Orders revealed no documented evidence of the order for the "anti-rollbacks to wheelchair".

Observation on 02/19/15 at 2:30 PM revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

(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 280	Continued From page 15	F 280		

Resident #8's wheelchair had no anti-rollbacks present.

Interview, on 02/20/15 at 1:00 PM, with Assistant MDS Coordinator #1 revealed Resident #8 might have had a hospital stay, returned and did not have anti-rollbacks on the wheel chair now. Per interview, it was the responsibility of Maintenance to put the anti-rollbacks on residents' wheelchairs, and take them off per Physician Orders. Assistant MDS Coordinator #1 stated Maintenance told the MDS staff about any changes to a resident's anti-tippers (anti-rollbacks). Further interview revealed Resident #8 might have needed a re-evaluation by physical therapy (PT) after his/her return from the hospital, and might not need the anti-tippers (anti-rollbacks).

Interview, on 02/20/15 at 1:25 PM, with the Maintenance Director revealed he changed all the hardware on residents' wheelchairs. He revealed he kept a Maintenance Book with Physician's Orders for installing or removing hardware on the wheelchairs. Per interview and review of his Maintenance Book, Resident #8's anti-tippers (anti-rollbacks) were removed in December 2014; however, he could not provide a specific date.

Interview, on 02/20/15 at 1:27 PM, Occupational Therapy (OT)/Rehabilitation Director revealed she had been using a different wheelchair with a lower seat for Resident #8. Per interview, the anti-tippers (anti-rollbacks) could not be used on Resident #8's wheelchair due to the lower seat, and therefore had been removed until the resident was evaluated for a new wheelchair.

Continued interview with the DON, on 02/20/15 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

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F 280	Continued From page 16 3:35 PM, revealed all changes to residents' care should be updated on the care plan to reflect their individual care needs and other changes. Per interview, when a resident's care plan was not revised to ensure it was accurate; the resident might not be receiving the proper care required. She revealed residents' care plans should be updated with any new Physician's Orders. Interview on 02/20/15 at 3:48 PM and continued interview at 3:50 PM, with the Administrator revealed it was the facility's responsibility to make sure care plans were updated as necessary and followed. Per interview, if residents' care plans were not being updated, the residents might not be receiving the proper care they required.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure the Medication Administration Record (MAR) transcription from month to month was accurate for one (1) of twenty-one (21) sampled residents (Residents #2). Review of Resident #2's MAR revealed incomplete dosing of his/her prescribed antibiotic therapy, as two (2) days were left off of the MAR. The findings include: Review of the facility's, "Medication Orders"	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

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F 281 Continued From page 17

Policy, dated ???, revealed each medication order was to be documented in the resident's medical record with the date, time, and signature of the person receiving the order. Per the Policy, the order should be recorded on the Physician Order sheet, or the Telephone Order sheet if it was verbal order, and the medication orders were to be placed on the MAR.

Review of the Physician's Progress Note dated 01/30/15 revealed the Physician noted Resident #2 was started on Levaquin 500 mgs daily times ten (10) days to treat his/her diagnosis of Pneumonia.

Review of the Physician/Prescriber Order, dated 01/30/14, revealed an order for Resident #2 to receive Levaquin (an antibiotic medication) 500 milligrams (mgs) by mouth daily for ten (10) days. Continued review of the Physician's Orders revealed a clarification order dated 02/05/15, to continue Resident #2's Levaquin as ordered until finished.

Review of Resident #2's January MAR, revealed the Levaquin order had been transcribed, and the nurses' initialed the antibiotic as administered on on 01/30/15 and 01/31/15. Review of the February MAR revealed the Levaquin order was transcribed on it, and the nurses had initialed the antibiotic as administered on 02/01/15, 02/02/15, 02/03/15, 02/04/15, 02/05/15 and 02/06/15. Continued review of the February MAR revealed the Levaquin medication was noted with "stop" on 02/07/15. Therefore, Resident #2 only received eight (8) days of the Levaquin antibiotic, instead of the ten (10) days as ordered by the Physician for the Pneumonia diagnosis.

F 281 **F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS**

The services provided by or arranged by the facility must meet professional standards of quality.

1) Resident #2 was assessed by Licensed Nurse on 3/12/15 with no signs/symptoms of infection. Resident #2's physician was updated with assessment findings on 3/12/15 with no new orders received.

2) An audit was conducted by the DON to identify those residents with antibiotic orders and to assure proper transcription on the MAR for the identified residents. This audit was completed on 3/10/15.

3) Nurse Managers who are assigned to assist with monthly change-over of MARs will be educated on proper transcription of orders month to month by the DON. This education will be completed by 3/30/15. A CQI tool was developed and approved by QA.

4) The ADON, DON, Staff Development, or assigned Nurse Manager will audit all antibiotic orders on the 1st of the month to assure proper transcription of orders month to month. This audit will be completed monthly x 3 months then quarterly thereafter as per the CQI calendar under the direction of the Director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

(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 281	Continued From page 18 Interview, on 02/10/15 at 1:20 PM, with the Advanced Practice Registered Nurse (APRN), who was one (1) of Resident #2's healthcare providers, revealed it was her expectation for staff to follow her orders, and if there was a problem she expected to be notified. Interview, on 02/20/15, at 2:20 PM, with Licensed Practical Nurse (LPN)/ Unit Coordinator (UC) revealed Resident #2 should have received all ten (10) doses of the Levaquin as ordered. LPN/UC stated Resident #2 not receiving all the doses of the antibiotic as ordered could hinder his/her healing process. Interview, on 02/20/15, at 3:10 PM, with the Director of Nursing (DON) revealed she expected accuracy on the MARs when the "change over" took place at the end of the month. Per interview, Resident #2 should not have missed doses of his/her antibiotic, and all doses should have been completed to make sure the infection was properly treated.	F 281	**Nursing. The QA Committee will review audit findings and revise the plan as needed.** **5) Date of Completion:**	**3/31/15**
F 282 SS=E	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, record review and review of the facility's policy, it was determined the facility failed to ensure staff followed residents' Comprehensive Care Plans	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

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F 282	Continued From page 19 (CCP) for six (6) of twenty-one (21) sampled residents (Residents #1, #2, #3, #6, #8 and #16). Record review revealed care plan interventions for skin assessments; however, there was no documented evidence the skins assessments were completed. Additionally, Resident #6 and #16 were care planned to have anti-embolism (TED) hose on in the morning and off at night. However, Resident #6 was observed without the TED hose on as care planned, and Resident #16 reported not wearing his/her TED hose for a week. The findings include: Review of the facility's policy titled, "Wound Care", dated 07/08/13 revealed, the facility would identify residents at risk for developing Pressure Ulcers (PU) and implement preventative and supportive precautions to maintain the resident's skin integrity. Per the Policy, the procedure for assessments of residents' skin consisted of staff routinely monitoring the skin condition of all residents and intervening as appropriate. Further review revealed the licensed nurses would assess residents for any skin irregularities when weekly skin assessment were performed. 1. Review of Resident #1's medical record revealed the facility admitted the resident on 11/17/09, with diagnoses which included Diabetes Mellitus, Muscular Wasting and Atrophy, Alzheimer's Disease, Anemia, Cellulitis and Abscess of the leg and Debility. Review of the Annual Minimum Data Set (MDS) Assessment dated 10/16/14 and the Quarterly MDS Assessment dated 01/05/15, revealed the facility assessed Resident #1 to be at risk for developing	F 282	**F282 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.** **1) Skin assessments were completed for Residents #1, 2, 3, 6, 8 and 16 by the Wound Nurse, Licensed Nurse and/or ADON on or before 3/13/15. TED hose are applied per MD order for Residents #6 and 16 by SRNA, Licensed Nurse or ADON as verified by visual inspection by DON on 3/13/15.** **2) An audit was completed by the Wound Nurse on 3/9/15 to assure skin assessments had been completed according to the care plan. An audit will be completed by the DON and/or ADON on or before 3/18/15 to assure that TED hose were applied according to care plan.** **3) Nursing staff will be educated by DON and/or ADON on or before 3/30/15 regarding the provision of care according to each resident's individualized care plan that included but was not limited to: weekly skin assessments and TED hose. A CQI audit tool was developed and approved by QA Committee.** **4) The DON, ADON, Staff Development, and/or Unit Coordinator will conduct audits**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

(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 282	Continued From page 20 PU. Review of Resident #1's CCP dated 11/06/14, updated 01/05/15 revealed the facility care planned the resident to be at risk for alteration in skin integrity related to impaired cognition, mobility, incontinence, history of pressure areas, recurring bilateral lower extremity Cellulitis and was dependent on staff for mobility. Continued review revealed interventions which included routine skin assessments per the licensed nurses. Review of the facility's "Resident Skin Assessment" forms for Resident #1 revealed no documented the resident's skin was assessed on 01/23/15, as per the Policy. Interview with Unit Manager (UM) #9 on 02/20/15 at 2:20 PM, revealed Resident #1 should have had a skin assessment completed by a licensed nurse on 01/23/15. Per interview, the State Registered Nursing Assistants (SRNAs) utilized a "Shower Sheet" as a guide for the SRNA to report any new skin issue areas to the nurses. 2. Review of Resident #2's medical record revealed the facility admitted him/her on 10/13/14, with diagnoses which included Senile Dementia, Cerebrovascular Accident (CVA) and Muscle Weakness. Review of the Admission MDS Assessment dated 09/10/14, revealed the facility assessed Resident #2 to be severely cognitively impaired and to be at risk for PU. Review of Resident #2's CCP dated 09/12/14, updated on 11/19/14 for Resident #2's risk for impaired skin integrity revealed the resident had periods of incontinence and had a history of	F 282	**using the developed CQI audit tool of the provision of services according to each resident's individualized care plan using a sample of residents randomly chosen based on room number weekly for 4 weeks, monthly for 2 months and quarterly thereafter as per the CQI calendar under the direction of the Director of Nursing. This CQI audit tool is to ensure compliance through visual observation of the residents as compared to the care planned interventions. The QA Committee will review audit findings and revise the plan as needed.** **5) Date of Completion:**	**3/31/15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

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F 282	Continued From page 21	F 282		

dependence on staff for assistance. Further review of the care plan revealed interventions which included weekly skin assessments per the licensed nurse as per the facility's protocol.

Review of Resident #2's "Resident Skin Assessment" forms revealed no documented evidence of skin assessments for the weeks of: 01/04/15 through 01/10/15; 01/11/15 through 01/17/15; 01/18/15 through 01/24/15; 01/25/14 through 01/31/15; and 02/01/15 through 02/07/15.

Review of the Shower Sheets dated 01/09/15, 01/13/15, 01/13/15, 01/22/15, and 01/30/15 revealed the resident received a shower and the nurses signed off on the sheets no new areas noted. Continued review revealed on 02/03/15 the resident refused a shower; however, the nurse signed off no new areas noted.

Interview on 02/20/15, at 2:20 PM, With Licensed Practical Nurse (LPN) Unit Coordinator revealed the shower sheet is a guide for the aides, and they will report to the nurses if the resident had a new skin area. She stated a licensed nurse should complete all skin assessments.

3. Review of Resident #3's medical record revealed the facility admitted him/her on 07/11/12, with diagnoses which included Alzheimer's Dementia, Anxiety, Depression and Behaviors. Review of the Annual MDS Assessment dated 11/05/14, revealed the facility assessed Resident #2 to be moderately cognitively impaired and to be at risk for PU.

Review of Resident #3's CCP revised on 11/27/14 for the resident's risk for impaired skin integrity revealed the resident had periods of bowel and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

(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 282	Continued From page 22	F 282		

bladder incontinence, required assistance with mobility, had a history of impaired skin integrity and was "noncompliant" with turning and repositioning. Further review of the care plan revealed interventions which included weekly skin audits per the facility's protocol.

Resident #3's "Resident Skin Assessment" forms were requested for December; however, only one (1) skin assessment dated 12/05/14 was provided. Continued record review revealed no documented evidence of current skin assessments for the weeks of: 12/28/14 through 01/03/15; 01/25/14 through 01/31/15; and 02/01/15 through 02/07/15.

4. Review of Resident #8's medical record revealed the facility re-admitted him/her on 01/12/12, with diagnoses which included Depression, Diabetes, Psoriasis and Vascular Dementia. Review of the Quarterly MDS Assessment dated 12/03/14, revealed the facility assessed Resident #8 to have moderate impaired cognition and to be at risk for PU.

Review of Resident #8's CCP revised on 12/03/14 for the resident's risk for impaired skin integrity, with interventions which included weekly skin assessments per licensed nurse per the facility's protocol.

Review of Resident #8's "Resident Skin Assessment" forms revealed no documented evidence of skin assessments for the weeks of: 01/25/14 through 01/31/15; and 02/08/15 through 02/14/15. Continued review revealed one (1) skin assessment present which had no documented evidence of the date it was performed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

(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 282	Continued From page 23	F 282		

5. Review of Resident #6's medical record revealed the facility admitted him/her on 11/26/13, with diagnoses which included Dementia with Behaviors and Mood Disturbance, Deep Vein Thrombosis (DVT), Gastrostomy Tube placement and Anxiety. Review of the Quarterly MDS Assessment dated 11/17/14, revealed the facility assessed Resident #6 to be moderately cognitively impaired and to be at risk for PU.

Review of Resident #6's CCP revised on 12/01/14, for the resident's risk for impaired skin integrity revealed the resident was incontinent of bowel and bladder, dependent on staff for transfers and bed mobility and had a history of skin tears. Further review of the care plan revealed interventions which included weekly skin assessments per licensed nurse per the facility's protocol.

Review of Resident #6's "Resident Skin Assessment" forms revealed no documented evidence of skin assessments performed by a licensed nurse for the weeks of: 12/14/13 through 12/20/14; 12/21/14 through 12/27/14; 01/11/15 through 01/17/15; 01/18/15 through 01/24/15; 01/25/15 through 01/31/15; or 02/01/15 through 02/07/15, as per the care plan.

Interview, on 02/20/15 at 3:20 PM, with the Director of Nursing (DON) revealed the facility's process for skin assessments was for the nurses to complete weekly skin assessments of residents. Per interview, the "Shower Sheets" were a tool for the SRNAs, to assist them with notifying the nurse when a new skin issue was observed during showers. The DON revealed she was not sure why there were missing skin assessment sheets for residents. Further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

(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 282	Continued From page 24	F 282		

interview revealed the expectation was for staff to follow residents' care plans.

Continued record review revealed the February 2015 monthly Physician's Orders for Resident #6 had an order for the resident to have TED hose on every morning and off at bedtime.

6. Continued review of Resident #6's CCP, dated 12/01/14, revealed the facility had also care planned Resident #6 to be at risk for alteration in cardiovascular status related to a history of DVT with an intervention for TED hose on in the morning (AM) and off at bedtime (HS).

However, observations of Resident #6 on 02/10/15 at 2:40 PM, at 3:50 PM and on 02/11/15 at 10:15 AM revealed Resident #6 was not wearing the TED hose, as per the care plan.

Interview with State Registered Nursing Assistant (SRNA) #1, on 02/19/15 at 2:30 PM, revealed she had just put Resident #6 back in bed and she stated the resident did not have TED hose on when placed in bed. Additional interview with SRNA #1, on 02/20/15 at 10:32 AM, revealed since Resident #6's CCP stated the resident was to have TED hose on in the AM and off at bedtime, then he/she should have had TED hose on during the dayshift of 02/19/15 when she was assigned to Resident #6.

Interview with Registered Nurse (RN) #2, on 02/19/15 at 3:45 PM, revealed Resident #6 should have TED hose on during the day, as per the Physician Orders and CCP. Per interview, typically the SRNAs put residents' TED hose on them in the morning when they were getting them dressed. She stated she did not realize Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

(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 282	Continued From page 25	F 282		

#6 was not wearing his/her TED hose until she was assisting SRNA #1 to transfer Resident #6 back to bed on 02/19/15 at approximately 2:30 PM.

Interview with the LPN Unit Coordinator for the East Unit, on 02/20/15 at 1:35 PM and 2:20 PM, revealed her expectation would be for the Physician Orders and CCP to be followed by staff. Per interview, Resident #6 should have had his/her TED hose on during the day, as per orders and CCP. Further interview revealed skin assessments should be completed by Continued record review revealed the February 2015 monthly Physician's Orders for Resident #6 had an order for the resident to have TED hose on every morning and off at bedtime.

7. Review of Resident #16's medical record revealed the facility re-admitted him/her on 06/14/13, with diagnoses which included Congestive Heart Failure, Anxiety, Dementia and Chronic Obstructive Airway Disease. Review of the monthly September 2014 Physician's Orders revealed an order for Resident #16 to have bilateral TED hose to be applied every morning and removed at bedtime. Review of the Quarterly MDS Assessment dated 11/19/14, revealed the facility assessed Resident #16 to cognitively intact.

Review of Resident #16's CCP revised on 11/19/14 for the resident requiring assistance with his/her Activities of Daily Living (ADLs) revealed an intervention for the resident to have TED hose "on in the AM and off at HS".

However, interview on 02/20/15 at 10:30 AM, with Resident #16 revealed he/she had not worn the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

(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 282	Continued From page 26 TED hose for a week. Per interview, Resident #16 had reported to the nurse the TED hose were too tight. Interview on 02/20/15 at 1:20 PM, with SRNA #9 revealed Resident #16 refused to wear his/her TED hose, and she had reported the resident's refusal to the nurse. Interview on 02/20/15 at 2:18 PM, with LPN Unit Coordinator revealed she was not aware Resident #16 did not wear his/her TED hose. She stated if Resident #16 was not wearing the TED hose, then the nurses were not following the care plan. Interview on 02/20/15 at 2:30 PM, with LPN #4 revealed she was aware Resident #16 did not wear his/her TED hose, and she should have contacted the Physician and documented the refusal on the care plan. Interview on 02/20/15, at 3:35 PM, with the DON revealed she expected residents' care plans to be followed as written. Per interview, when a resident refused a treatment, it should be documented. Continued interview revealed the care plan should be accurate in order to provide proper care to residents.	F 282		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

(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 371	Continued From page 27	F 371	**F371 FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY**	

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and review of the facility's policy, it was determined the facility failed to store, prepare and serve food under sanitary conditions as evidenced by observation of: the soda dispenser gun not clean; food containers and floor with residue; no thermometer in the "walk-in" refrigerator; dietary staff performing improper food temperature technique; and dietary staff going from dirty to clean in the dishwashing area without washing or sanitizing hands prior to application of new gloves. Additionally, review of the Dietary Department records revealed incomplete food temperature, equipment and cleaning logs.

The findings include:

Review of the facility's policy titled, "Sanitation", undated, revealed the policy of the facility was to maintain equipment, work surfaces, walls and floors in sanitary condition through daily and ongoing cleaning procedures. Per the Policy, cleaning schedules were assigned by specific tasks to scheduled employees on a daily, weekly and monthly basis.

Review of the facility's policy titled, "Dry Storage", undated, revealed thermometers should be present in all food storage areas, all foods were to be labeled and dated and, rotated on a "first in and first out" (FIFO) system. Per the Policy, food

The facility must store, prepare, distribute, and serve food under sanitary conditions.

1)

a. The soda gun, dry storage area scoops, dry storage bins, and dry storage room floor was cleaned on 2/20/15 by the Dietary Manager (DM). Thermometer was purchased and placed in walk in refrigerator on 2/23/15 by the DM. Unlabeled frozen product was discarded on 2/20/15 by DM. Cereal located in identified bin was discarded on 2/23/15 by DM. Substance in measuring cup was discarded and measuring cup was sanitized on 2/20/15/15 by DM.

b. Assistant Dietary Manager was educated on handwashing between soiled and clean areas and glove changes on 3/13/15 by DM.

c. All cooks were reeducated on proper food temperature taking techniques on 3/13/15 by DM.

d. All temperatures were taken by DM on 3/12/15 and temperature logs completed. All dietary staff were reeducated on temperature logs and responsibilities on 3/13/15. All cooks were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

(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 371	Continued From page 28 should be stored to protect from splash and other other contaminants, to provide easy cleaning of storage areas. Review of the facility's policy titled, "Refrigerated Storage", undated, revealed all foods should be properly wrapped, stored in sealed containers, with a date and label. Review of the current Health Department Report dated 10/23/14, during the initial observational tour of the kitchen on 02/18/15 at 11:20 AM, revealed it noted the soda dispenser gun and the dry storage area was unclean during the inspection. Observations during the initial tour of the kitchen on 02/18/15 at 11:20 AM revealed: the soda dispenser gun and holder were not clean, as previously cited on the Health Department inspection; in the dry storage area scoop bins had dust like particles on the lids of the dried ingredients stored in them, and on the floor around the bins; dust like particles on the floor in dry storage; no thermometer in the walk-in refrigerator; a case of frozen food products not labeled or dated in the freezer; a cereal bin open with the lid not replaced after the breakfast tray service prior to lunch service; a measuring cup under the resident service line with a white powdery substance in it which was not covered, labeled or dated. Interview on 02/18/15 at 3:05 PM Assistant Dietary Manager (ADM) revealed the measuring cup with the white substance was possibly food thickener they use on the tray line. The ADM stated however, the white substance/food thickener should have been covered, labeled and dated or left in the original container. Per interview, all foods should be labeled and dated,	F 371	**reeducated on proper food temperature taking techniques and proper completion of food temperature log on 3/13/15 by DM. Pot and Pan Sanitizer was checked on 3/13/15 by DM and results logged. All dietary staff were reeducated on completion of sanitizer checks and proper completion of sanitizer log on 3/13/15 by DM. Cleaning schedule and tasks were reviewed to verify completion on 3/13/15 by DM. All dietary staff were reeducated on the completion of assigned cleaning tasks per schedule and proper completion of log on 3/13/15 by DM.** **2) The RD (Registered Dietitian) will inspect the kitchen on her next scheduled visit on 3/18/15 to assure sanitation compliance.** **3) Dietary staff will be reeducated by the DM on kitchen sanitization practices that will include but not limited to; proper cleaning of soda gun and dry storage area, storage bins, proper temperatures, obtaining storage and food temperatures and proper completion of temperature logs, proper food storage including but not limited to labeling of all stored food items, proper hand washing between clean and dirty areas and glove changes, proper completion of sanitizer checks**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

(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 371	Continued From page 29 as per the policy. According to the ADM, the thermometer for the walk-in refrigerator could not be located and this was an issue because food needed to be kept at the proper temperature so bacteria would not grow. Continued interview revealed bacteria grows with a temperature of forty (40) degrees or higher, and there were foods which could be potentially hazardous in the walk-in refrigerator like eggs. Interview, on 02/19/15 at 10:30 AM, Dietary Manager (DM) revealed foods were to be labeled and dated with the date they were opened. The DM stated foods remain on the shelves for three (3) days and then discarded. 2. Review of the facility's policy titled, "Dishwashing Procedures", undated, revealed dietary staff were to properly sanitize dishes and to establish systems to avoid improper handling of dishware. Per the Policy, the dietary employee working in the soiled area of the dishroom after touching soiled dishes, was to wash their hands prior to touching and/or putting away clean dishes. Further review of the Policy revealed clean dishes were to air dry and not be dried with a paper towel. Observation, on 02/18/15 at 2:35 PM, revealed the Assistant Dietary Manager (ADM) was handling soiled dishes in the soiled area, removed his gloves, and without washing or sanitizing his hands put a new pair of gloves on and stacked clean dishes. Interview, on 02/18/15 at 2:35 PM, with the ADM revealed he had changed his gloves between the soiled and clean side of the dishwasher and did	F 371	**and proper completion of log, interpretation and completion of cleaning tasks according to schedule and proper completion of cleaning logs. This education will be completed on 3/13/15. A CQI audit tool was developed and approved by QA Committee.** **4) The DM and/or RD will conduct random audits using the developed CQI audit tools of the sanitary conditions of the kitchen, proper handwashing practices, and taking/logging proper food temperatures weekly for 4 weeks, monthly for 2 months and quarterly thereafter as per the CQI calendar under the direction of the Administrator. The QA Committee will review audit findings and revise the plan as needed.** **5) Date of Completion:**	**3/31/15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

(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 371	Continued From page 30	F 371		

not need to wash his hands because of the protection of gloves.

Interview, on 02/19/15 at 10:30 PM, with the DM revealed there should always be two (2) staff on the dishwasher line to prevent cross contamination. The DM stated dietary staff should always wash their hands between the soiled and clean sides of the dishmachine.

3. Review of the facility's policy titled, "Food Holding Temperatures on Food Service Line", undated, revealed it was the policy of the facility to maintain food holding temperatures on the tray line to meet quality standards and Federal, State and Local Sanitary Codes.

Observation, on 02/19/15 at 11:10 AM, revealed Dietary Cook #1 was taking food temperature of foods on the resident tray line. Continued observation revealed Dietary Cook #1 wiped his clothes with one hand after he sanitized the thermometer prior to taking additional food temperatures.

Interview, on 02/19/15 at 1:20 PM, with Dietary Cook #1 revealed he should not be wiping his hand on his clothes due to the possibility of cross contamination.

Interview, on 02/19/15 at 1:50 PM, with the DM revealed Dietary Cook #1 should use wipes between food items and should not touch his clothes because of the possibility of cross contamination.

4. Continued review of the facility's policy titled, "Sanitation", undated, revealed cleaning schedules were assigned by specific tasks to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

(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 371	Continued From page 31	F 371		

scheduled employees on a daily, weekly and monthly basis.

Review of the facility's policy titled, "Refrigerated Storage", undated, revealed each refrigerator was to have a thermometer, and temperatures documented at least two (2) times daily.

Review of the Dietary Department records for February 2015, revealed the "Temperature Chart-Storage Areas", for the "reach-in" refrigerator located there revealed no documented evidence of an "AM" (morning) temperature for the dates of 02/10/15, 02/12/15, 02/16/15 and 02/17/15. Review of the "Temperature Chart-Storage Areas", for the "walk-in" refrigerator located there revealed "AM" and "PM" (afternoon) temperatures were documented for thirteen (13) days. However, observation during the initial tour of the kitchen on 02/18/15 at 11:20 AM revealed no evidence of a thermometer located in the walk-in refrigerator. Additionally, continued review of the "Temperature Chart-Storage Areas", for the "walk-in" refrigerator revealed no documented evidence of an "AM" temperature for the dates of 02/12/15, 02/16/15 and 02/17/15, and no "PM" temperature for the date of 02/13/15.

Review of Dietary Department's "Food Temperature Record" log for February 2015, revealed no documented evidence of food temperatures recorded for the "supper" meal on 02/13/15. Continued review of the "Food Temperature Record" log revealed: on 02/15/15, 02/16/15, 02/17/15 and 02/18/15, no documented evidence of food temperatures for the meal, except for the "milk"; on 02/03/15, 02/15/15 and 02/16/15, no documented evidence of food

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

(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 371	Continued From page 32	F 371		

temperatures for the "lunch" meal except for the "salad/dessert" and "cold beverage" temperatures; on 02/04/15, the "lunch" meal temperatures revealed no documented evidence of temperatures for the "entree", "starch", pureed vegetable, "salad/dessert" for regular and pureed diets, or cold or hot beverages; and on 02/18/15, no documented evidence of temperatures for the "entree", "gravy", "starch", "vegetable", "soup" or "hot beverage". Further review on 02/04/15, 02/05/15, 02/06/15, 02/11/15, 02/12/15, no documented evidence of the "milk" temperatures. Additionally, review revealed two (2) of the meal temperatures recorded on the "Food Temperature Record" log were not legible.

Review of facility's "Pot and Pan Sink Sanitizer Chart" for February 2015, revealed on 02/06/15, 02/07/15, 02/12/15, 02/16/15 and 02/17/15, no documented evidence of sanitizer check results for the "AM" and "Noon" sanitizer checks. Continued review revealed on 02/13/15, revealed no documented evidence of the sanitizer check results for the "Noon" check.

Review of the Dietary Department's Weekly Cleaning Schedule for February 2015, revealed no documented evidence of signatures for nineteen (19) of nineteen (19) days to show completion of assigned cleaning tasks by the assigned staff.

Continued interview, on 02/18/15 at 3:05 PM, with the ADM revealed equipment temperatures needed to be checked and documented on all equipment. Per interview, the DM monitored equipment temperatures. The ADM stated the cleaning list was posted and dietary staff were to sign off on when their assigned task was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

(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 371	Continued From page 33 completed. Further interview revealed the DM checked the cleaning list every two (2) weeks. Interview, on 02/19/15 at 10:30 AM, with the Dietary Manager (DM) revealed all foods temperatures were expected to be recorded to maintain food within normal limits. Per interview, refrigerator temperatures and freezer temperatures should be recorded daily. The DM revealed the cleaning schedule should be completed and recorded after staff finished the assigned task. Continued interview revealed the Registered Dietician (RD) completed sanitization audits as needed and she completed walk through sanitization inspections through monthly audits. Per the DM, all documentation should be recorded on the various logs without question.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 34 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. (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 observation, interview and review of the facility's policy, it was determined the facility failed to ensure infection control practices were followed on one (1) of twenty-one (21) sampled residents (Resident #8) and one (1) of five (5) unsampled residents (Unsampled Resident A). Observation revealed staff changed Resident #8's urine saturated brief without providing perineal care prior to applying the new brief. Additionally, staff used their bare hands and touched Unsampled Resident A's food during mealtime. The findings include: Review of the facility's policy titled, "Infection	F 441	**F441 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.** **1) Resident #8 was assessed by Licensed Nurse on 3/13/15 and is free from signs/symptoms of complications r/t improper incontinence care. Resident #A was assessed by Licensed Nurse on 3/13/15 and is free from signs/symptoms of illness r/t food handling.** **2) All residents dependent upon staff for meal set up were identified by the DON and/or ADON on 3/10/15 through review of MDS assessments. Identified residents will be assessed by Licensed Nurses on or before 3/18/15 to identify and address any signs/symptoms of illness r/t food handling. All residents dependent upon staff for assistance with pericare were identified by the DON and/or ADON on or before 3/16/15 through review of MDS assessments. Identified residents were assessed by Licensed Nurses on or before 3/18/15 to identify and address any signs/symptoms of complications r/t improper pericare.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

(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 441	Continued From page 35 Control", dated August 2014, revealed the facility's policy was to maintain a safe, sanitary and comfortable environment and help prevent and manage transmission of diseases and infections. Further review revealed the objective of the policy was to maintain a safe, sanitary and comfortable environment for personnel, residents, visitors and general public. 1. Observation on 02/10/15 at 3:30 PM revealed, the Wound Care Nurse was removing a urine saturated brief from Resident #8 and then replaced with a new one. However, observation revealed the Wound Care Nurse failed to provide perineal care to include cleansing the urine from the resident's perineal area. Interview with State Registered Nursing Assistant (SRNA) #2 on 02/13/15 at 12:12 PM and SRNA #3 at 1:24 PM, revealed when changing a resident's soiled brief, the perineal area should be cleansed with wipes or soap and water to remove the urine prior to applying the new brief. SRNA #3 stated if perineal care was not provided it could cause residents' skin to break down and it was also a dignity concern. Interview with the Wound Care Nurse on 02/13/15 at 9:47 AM, revealed she should have performed perineal care for Resident #8 after removing the urine saturated brief and prior to applying the new one. Interview, on 02/11/15 at 2:20 PM, with the Administrator revealed SRNAs and nurses followed the guidelines regarding what they were taught in school for providing perineal care. The Administrator stated Resident #8 should have had perineal care provided by the Wound Care	F 441	3) Nursing staff will be educated by the DON and/or ADON on proper food handling techniques to prevent spread of infection and the provision of pericare following each incontinent episode. This training will be completed by 3/30/15. A CQI audit tool was developed and approved by QA Committee. 4) The DON, ADON, Staff Development, and/or Unit Coordinator will conduct random audits using the developed CQI audit tool of the food handling practices in the dining room and the provision of pericare following incontinent episodes using a sample of residents randomly chosen based on room number weekly for 4 weeks, monthly for 2 months and quarterly thereafter as per the CQI calendar under the direction of the Director of Nursing. This CQI audit tool is to ensure infection control compliance through visual observation of the employees providing care to the residents. The QA Committee will review audit findings and revise the plan as needed. 5) Date of Completion:	3/31/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 36	F 441		

Nurse after removal of the old brief and prior to application of the new one.

2. Observation of the lunch meal on 02/18/15 at 12:30 PM, revealed SRNA #10 used her bare hands to hold Unsampled Resident A's sandwich in place while cutting it in half.

Interview, on 02/18/15 at 12:45 PM, with SRNA #10 revealed she should have used a fork to steady the sandwich and cut it in half, and not her bare hands. SRNA #10 stated she could have made the resident sick because her hands had germs on them.

Interview, on 02/20/15 at 2:15 PM, with Licensed Practical Nurse (LPN)/Unit Coordinator (UC) revealed she expected staff to follow proper guidelines and not touch residents' food with their bare hands. She stated it could cause the resident to get sick and was an infection control issue.

Interview, on 02/20/15 at 3:05 PM, with the Director of Nursing (DON) revealed she expected staff to follow sanitary precautions and never use their bare hands. She stated the potential harm was there could be germs on the staff's hands which could cause a resident to become ill.