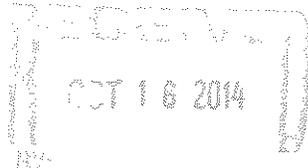


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/10/2014
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517	
(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 An Abbreviated Survey investigating KY#00022200, KY#00022146, KY#00022145 and KY#00022151 was initiated on 08/29/14 and concluded on 09/10/14. KY#00022200 and KY#00022146 were unsubstantiated with no deficiencies. KY#00022145 was unsubstantiated with a related deficiency. KY#00022151 was substantiated with deficiencies cited at a Scope and Severity of a "G".	F 000		
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157	Immediate Corrective Action For Residents Found To Be Affected ♦ Physician was notified by the Wound Care Nurse (WCN) on August 28, 2014 relative to Resident #1 with treatment orders received. Assessment, notifications, treatment orders, and care plan revision completed. Identification of Other Residents With The Potential to be Affected ♦ All Residents with Stasis Ulcers were assessed by the WCN on August 28, 2014 with no further issues identified.	



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

TITLE

(X6) DATE

[Handwritten Signature]

[Handwritten Signature: ADMINISTRATOR]

[Handwritten Date: 10/13/14]

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

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F 157

Continued From page 1 this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to promptly notify the Physician when there was a significant change in the resident's physical status and a need to alter treatment for one (1) of thirteen (13) sampled residents (Resident #1).

On 07/03/14 Resident #1 was noted to have edematous weeping legs with an open area on the right lower extremity measuring three (3) centimeters (cm) x 0.1 cm on 07/03/14, and the Advanced Registered Nurse Practitioner (ARNP) was notified. Lasix (antidiuretic medication) was ordered; however, the nurse who notified the ARNP, did not ensure a treatment was ordered for the wound. On 07/24/14 the resident was noted to have an open area to the right shin and left great toe; however, there was no documented evidence the Physician or ARNP was notified of the progression of skin breakdown in order to obtain a treatment order until 07/25/14, when Vaseline Gauze was ordered to the open areas of the lower extremities. The skin on the resident's lower extremities continued to deteriorate and on 07/31/14 the resident was noted to have open areas to the right inner calf and the top of the right foot. On 08/14/14 the resident was noted to have open blisters to the left foot and an open area to the right foot and right leg. However, there

F 157

100% resident skin audit was performed on September 19-23, 2014 by the Signature Care Consultant (SCC), Director of Nursing (DON), Assistant DON (ADON), Staff Development Coordinator (SDC), MDS Nurse (MDSN), WCN, Evening Shift Nurse Supervisor (ESNS), Weekend Nurse Supervisor (WNS) or Licensed Nurse. Any issues identified were assessed, notifications completed, orders received and care plans developed.

Measures Taken To Assure There Will Not Be a Recurrence

- ◆ Licensed nurses will be educated by the SDC, DON, SCC, ADON, MDSN, or WCN from September 16-26, 2014 as well as during on-boarding for new staff beginning September 26, 2014 regarding the facility policy of Change of Condition, Notification, Wound Measuring and weekly tracking.

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F 157

Continued From page 2

was no documented evidence the Physician was notified of the increased number of wounds and the continued deterioration of the wounds after 07/25/14. On 08/27/14, the ARNP was notified of maggots in the large elongated wound on the right calf; however, there was no documented evidence the ARNP was notified of the the increased number of wounds or the deterioration of the wounds until 08/28/14. Observation of a skin assessment on 08/30/14 by the surveyor revealed a total of six (6) open areas to the lower extremities with two (2) of the larger areas on the right calf having eschar at the edges of the wounds. (Refer to F309)

The findings include:

Review of the facility's "Change in a Resident's Condition or Status" Policy, revised 10/13, revealed the Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or on-call Physician when there has been; a significant change in the resident's physical/emotional/mental condition, or a need to alter the resident's medical treatment.

Review of the medical record revealed the facility admitted Resident #1 on 07/02/10. Continued review revealed diagnoses which included Non Alzheimer's Dementia, Muscle Weakness, Degenerative Joint Disease, Atrial Fibrillation, and Diabetes Mellitus. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/14/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a five (5) out of fifteen (15) indicating the resident was cognitively impaired. Further review revealed the facility assessed the resident as having no arterial or venous ulcers.

F 157

- All condition changes including skin issues will be discussed at daily clinical meeting (*M-F*) with *chart review* to assure all *MD/APRN notification, with* assessments, *orders, treatments, Responsible Party* notifications *completed* and care plans *updated accordingly*.

Monitoring Changes To Assure Continuing Compliance

- The At Risk Committee consisting of a varying mix of DON, ADON, Registered Dietician (RD), Dietary Services Manager (DSM), WCN, and Social Services Director (SSD), will meet weekly to discuss each patients skin issues *as reported via the daily clinical meeting* and to be assured that all assessments are being completed, treatments obtained, notifications and care plan is initiated/reviewed/revise.

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F 157

Continued From page 3

Review of the monthly July 2014 Physician's Orders, revealed orders for Ammonia Lactate 12 % (twelve percent) lotion to the bilateral upper and lower extremities every other day, Hydrophor Ointment to feet and legs daily, and Dermaseptine Ointment topically to affected areas as needed.

Review of the Weekly Skin Integrity Review (WSIR), dated 07/03/14, revealed Resident #1 had two (2) plus edema and an open area measuring three (3) centimeters (cm) x 0.1 cm and the diagram on the WSIR revealed the area was on the right shin.

Review of the Interdisciplinary Progress Notes, dated 07/03/14 at 10:00 AM, revealed Resident #1's bilateral lower extremities were edematous and weeping, the ARNP was notified, and a now dose of Lasix 40 milligrams (mg's) was ordered and given. Review of the Physician's orders dated 07/03/14 revealed orders for Lasix 40 mg "now". However, there was no indication the nurse had requested a treatment order.

Further review of the WSIR dated 07/10/14 revealed Resident #1's skin was dry and there was two (2) plus edema and weeping. Review of the WSIR dated 07/17/14, revealed the residents skin was dry and the right lower extremity had weeping and two (2) plus edema. Review of the Physician's Orders dated 07/17/14 revealed orders for Lasix 40 mg in the AM (morning), and 20 mg at 2:00 PM.

Phone interview on 09/05/14 at 11:05 AM, with Licensed Practical Nurse (LPN) #18, who had signed as completing the WSIR's for 07/03/14,

F 157

Reports of the audits/reviews will be presented to the Quality Assurance (QA) Committee monthly beginning September 24, 2014 for review and follow up with the medical director until at such time consistent substantial compliance has been achieved as determined by the committee.

Date of Completion:

09-27-14

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F 157	<p>Continued From page 4</p> <p>07/10/14, and 07/17/14, revealed she had obtained the Physician's Orders for Lasix on 07/17/14, due to the resident's lower extremities being edematous with weeping fluid. She stated she had notified the ARNP on 07/03/14 of the open area on the resident's leg and the edema to the lower extremities, and the ARNP ordered Lasix and told her to talk to the Wound Nurse about a treatment. Further interview revealed, she had asked the Wound Nurse to assess the leg for a treatment order; however, could not recall if a treatment was ordered and was unsure if the Wound Nurse had assessed the resident. Further interview revealed she could not remember what type of treatment was being performed for the resident's weeping legs during that time period. Review of the Treatment Administration Record (TAR), dated July 2014, revealed there was no treatment orders related to the weeping legs and open area which were noted on 07/03/14, and no indication the Physician/ARNP had been notified of the lack of treatment even though the resident had an open area identified on 07/03/14 and the legs were weeping fluid.</p> <p>Review of the WSIR dated 07/24/14, revealed there was skin breakdown on Resident #1's right shin and left great toe. Interview on 09/04/14 at 9:47 AM, with Registered Nurse (RN) #2/Assistant Director of Nursing (ADON)/Unit Coordinator (UC) for the North Unit who completed this skin assessment, confirmed these areas were open at the time she completed the skin assessment. She further stated she did not call the Physician/ARNP for notification of the areas of skin breakdown and request an order for treatment because she did not realize these areas were new and thought there was already a</p>	F 157		
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F 157	<p>Continued From page 5</p> <p>treatment order in place. However, further review of the TAR dated July 2014, and the Physician's Orders dated July 2014 revealed there was no treatment ordered for the open areas on the right shin and great toe at that time.</p> <p>Review of the Interdisciplinary Progress Note, dated 07/25/14 at 10:00 PM, and completed by LPN #19, revealed Resident #1 had open areas to the right lower extremity and left great toe and new orders were received for Vaseline Gauze and dressings to the areas daily and as needed (prn). Phone interview with LPN #19 on 09/05/14 at 11:00 AM, revealed before 07/25/14, the resident just had orders for creams and lotions to the lower extremities for dry cracked skin; however, the day she obtained the treatment order on 07/25/14 the resident had an open area to the left great toe, and open areas to the right shin and the lateral calf which were small and looked like the top layer of skin was gone.</p> <p>Further review of the WSIR dated 07/31/14, completed by LPN #17, revealed Resident #1 had an open area on the resident's right medial calf and top of the right foot and no documentation addressing the resident's left great toe.</p> <p>Review of the WSIR dated 08/14/14 completed by LPN #17, revealed the resident had open blisters to the left foot and also open areas to the right foot and right leg. The WSIR dated 08/14/14, stated treatment nurse notified. Interview with LPN #17 on 09/04/14 at 12:00 PM, revealed the resident had an area on the right calf and the top of the right foot which was not present on the previous WSIR; however, she thought this area was old. She further stated, according to what she could remember and</p>	F 157		
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F 157	<p>Continued From page 6</p> <p>looking at the WSIR for 08/14/14 the resident had an area to the left great toe and new areas to the left 3rd digit and and a new area to the top of the resident's left foot. She stated she called and informed the Wound Care Nurse because the areas to the left 3rd digit and the top of the resident's left foot were new. LPN #17 stated she assumed the Wound Nurse would call the Physician for a treatment order. However, review of the Interdisciplinary Progress Notes and Physician Progress Notes revealed there was no documented evidence the Physician was notified of these new areas of skin breakdown.</p> <p>Review of the WSIR dated 08/21/14 completed by LPN #18, revealed open areas to the right medial calf, right great toe, and left foot. Further phone interview with LPN #18 on 09/05/14 at 11:00 AM, revealed she was unable to remember just what the wounds looked like on that date; however, she thought there was a treatment order for the wounds.</p> <p>Review of the Nurse's Notes dated 08/27/14 at 2:00 PM, written by LPN #5, revealed the resident's wound was found to have foreign matter in an open area, the wound was cleansed with all foreign matter cleaned out and a treatment was applied. Interview with LPN #5 on 08/29/14 at 2:00 PM, revealed Resident #1 started having weeping in her legs and about a month ago developed open areas to the lower extremities. She stated when starting to remove the bandage on 08/27/14 she noted the resident's wound on the right leg had white round foreign matter which would move and could have been maggots, although she had never seen maggots before.</p>	F 157			

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F 157 Continued From page 7

Review of Resident #1's Non Pressure Skin Condition Record, completed by the Wound Nurse, dated 08/28/14, revealed the following: Left Great Toe Metatarsal 1.4 cm Length (L) x 1.7 cm Width (W)-partial thickness, Right Lower Extremity Calf Posterior measuring 13.5 cm L x 5 cm W x 0.3 cm depth-full thickness, serous drainage, and slough described as moist yellow or gray necrotic tissue, Right Great Toe lateral metatarsal 0.8 cm L x 1 cm W-partial thickness, Right Proximal Lower Extremity 2 cm L x 1 cm W-partial thickness, serosanguinous exudate, and slough-moist yellow or gray necrotic tissue, and Right Distal Lower Ext 0.9 cm L x 0.7 cm W-partial thickness. Further review of the Non Pressure Skin Condition Record for each wound revealed an area marked Physician notified 08/28/14.

Observation of Resident #1's skin assessment performed by LPN #17 on 08/30/14 at 10:15 AM, revealed the resident had an open area to the left great toe medial base which measured 1.5 cm L x 1.5 cm W and the wound bed was beefy red; an open area to the right great toe medial base which measured 1 cm x 0.9 cm and the wound bed was red; an open area to the right shin with a red wound bed with a yellow center which measured 1.5 cm L x 1 cm W; an open area on the lower shin which had a red wound bed and measured 0.8 cm L x 0.6 cm W; an open area to the right medial/posterior calf which measured 3 cm L x 1.9 cm W with a red wound bed and white middle surrounded by eschar; an area just below the previous area to the right medial/posterior calf which measured 6 cm L x 3.5 cm W x 0.4 cm depth with a red wound bed with yellow/green areas on the wound bed surrounded by eschar; and, an area on the right lower medial/posterior

F 157

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F 157

Continued From page 8
calf which measured 5 cm W x 7 cm L and appeared as scar tissue.

Interview, with the Wound Nurse on 08/30/14 at 12:15, and 09/09/14 at 6:50 PM, revealed she had initially seen Resident #1 late June or early July 2014, related to the lower extremities having weeping and edema. She stated she did not document her observation and thought the nurses had a treatment in place. She further stated she was not notified of any open areas or any wounds in the resident's lower extremities until 08/27/14 when she was told the resident had a deterioration in the wounds and also had maggots in one of the wounds as she was walking out the door to go to class.

Interview on 08/29/14 at 2:50 PM and 09/05/14 at 11:11 AM, with the ARNP revealed she was notified of the staff finding maggots in the Resident #1's wound. She stated she was informed the resident had weeping in the lower extremities earlier this summer and the diuretic had been increased; and she was in to assess the wounds on 09/02/14. She stated the last time she had seen the resident's lower extremities they were "nothing like now". "I was surprised the wounds were that bad". Continued interview revealed a dry dressing would have been sufficient for weeping legs; however, staff needed to notify her of any change in status such as deteriorating wounds or any new wounds. She stated she did not know at what point the wounds worsened because she had not been notified. Further interview revealed the staff was her eyes and ears and she was not notified of the deterioration of the wounds or the numerous wounds until the resident had developed a large elongated wound which was possibly necrotic

F 157

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F 157	Continued From page 9 with maggots. She further stated she did not know if the Attending Physician was notified; however, there was no documentation to support the Physician had been notified. Further interview revealed she would have ordered a wound consult sooner had she been aware of the condition of the residents lower extremities. The resident's Physician was out of the country at the time of the investigation and unavailable for an interview. Interview with the Director of Nursing (DON) on 09/05/14 at 11:20 AM, revealed the Physician was to be notified of any new area of skin breakdown or any change in wound status. She stated at the point a wound was identified, or for any change in a wound, staff should have notified the Physician/ARNP for a treatment order. However, the DON indicated, by reviewing the record for Resident #1, the Physician or ARNP was not kept informed of this resident's change in condition related to wounds.	F 157			
F 280 SS=G	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	F 280	F 280 Immediate Corrective Action For Residents Found To Be Affected ◆ Physician was notified by the WCN on August 28, 2014 relative to Resident #1 with treatment orders received. Resident wounds were added to the care plan and wound tracking log on same day.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/10/2014
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517	

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F 280 Continued From page 10
disciplines as determined by the resident's needs, and, to the extent practicable, the participation of 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 observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure the Comprehensive Plan of Care was revised for one (1) of thirteen (13) sampled residents (Resident #1).

On 07/03/14 Resident #1 was noted to have edematous weeping legs with an open area on the right lower extremity measuring three (3) centimeters (cm) x 0.1 cm on 07/03/14, and the Advanced Registered Nurse Practitioner (ARNP) was notified. Lasix (antidiuretic medication) was ordered; however, the nurse who notified the ARNP, did not ensure a treatment was ordered for the wound. On 07/24/14 the resident was noted to have an open area to the right shin and left great toe; however, there was no documented evidence the Physician or ARNP was notified of the progression of skin breakdown in order to obtain a treatment order until 07/25/14, when Vaseline Gauze was ordered to the open areas of the lower extremities. The skin on the resident's lower extremities continued to deteriorate and on 07/31/14 the resident was noted to have open areas to the right inner calf and the top of the right foot. On 08/14/14 the resident was noted to

**Identification of Other Residents
F 280 With The Potential to be Affected**

- ◆ All Residents with Stasis Ulcers were assessed by the WCN on August 28, 2014 with no further issues identified.
- ◆ 100% resident skin audit was performed on September 19-23, 2014 by the SCC, DON, ADON, SDC, MDSN, ESNS, WNS, WCN or licensed nurse. Any issues identified were assessed, interventions and orders obtained, notification, and care plan developed.

Measures Taken To Assure There Will Not Be a Recurrence

- ◆ Licensed nurses will be educated by the SDC, DON, SCC, ADON, MDSN, ESNS, WNS or WCN from September 16-26, 2014, as well as during on-boarding for new staff beginning September 26, 2014 regarding the facility policy of Change of Condition, assessments,

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

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F 280	Continued From page 11 have open blisters to the left foot and an open area to the right foot and right leg. However, there was no documented evidence the Physician was notified of the increased number of wounds and the continued deterioration of the wounds after 07/25/14. On 08/27/14, the ARNP was notified of maggots in the large elongated wound on the right calf; however, there was no documented evidence the ARNP was notified of the the increased number of wounds or the deterioration of the wounds until 08/28/14. Observation of a skin assessment on 08/30/14 by the surveyor revealed a total of six (6) open areas to the lower extremities with two (2) of the larger areas on the right calf having eschar at the edges of the wounds. Although this resident had multiple ulcers to the lower extremities, and the ulcers were continuing to deteriorate, there was no documented evidence the facility evaluated and revised the Care Plan as the resident's status changed related to the development of venous ulcers to the lower extremities. (Refer to F309) The findings include: Review of the facility "Care Plans-Comprehensive", revised October 2010, revealed Assessments of residents were ongoing and care plans were revised as information about the resident and the resident's condition changed. Further review revealed the Care Planning/Interdisciplinary Team was responsible for the review and updating of care plans when there was a significant change in the resident's condition, when the desired outcome was not met, and at least quarterly. Review of the clinical record revealed the facility admitted Resident #1 on 07/02/10. Further review	F 280	notifications, treatments, and care plans. ♦ All residents with new skin issues will be reviewed at daily clinical meeting M-F to be assured that care plans are initiated/reviewed and revised as needed <i>to match current interventions as per orders. WNS will assure care plans are updated/revised on weekends.</i> ♦ <i>Weekly wound rounds will be performed by a varying mix(if not all) of DON, ADON, Licensed Nurse, WCN, SRNA, Dietician, DSM and SSD to assure current interventions match care plan.</i> ♦ The At Risk Committee consisting of a varying mix of DON, ADON, RD, DSM, WCN, SSD, will review care plans <i>weekly</i> for at risk residents with skin issues <i>as reported via the daily clinical meeting</i> for any further review/revision.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280 Continued From page 12
revealed diagnoses including Non Alzheimer's Dementia, Muscle Weakness, Degenerative Joint Disease, Atrial Fibrillation, and Diabetes Mellitus. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/14/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a five (5) out of fifteen (15) which indicated cognitive impairment. Continued review revealed the facility assessed the resident as having no arterial or venous ulcers.

Review of the Comprehensive Plan of Care with an onset date of 11/14/11, revealed Resident #1 was at risk for developing skin breakdown and had a history of pressure related areas. The goal stated the resident would have intact skin, free of redness, blisters, or discoloration over a bony prominence through next review. There was several approaches listed including a notation under the approaches, undated, which stated the resident had an open area to the right lower extremity and the left great toe. However, the care plan did not address this resident's actual venous ulcers to the lower extremities with specific individualized interventions in an attempt to heal the venous ulcers, and keep further ulcers from developing. Also, there was no documented evidence the Care Plan had been reviewed and evaluated despite the non healing wounds and despite the development of new wounds.

Review of the WSIR, dated 07/03/14, revealed Resident #1 had two (2) plus edema and an open area measuring three (3) centimeters (cm) x 0.1 cm and the diagram on the WSIR revealed the area was on the right shin.

Review of the Interdisciplinary Progress Notes dated 07/03/14 at 10:00 AM, revealed the

F 280
Monitoring Changes To Assure Continuing Compliance

- Reports of the audits/reviews will be presented to the QA Committee monthly beginning September 24, 2014 for review and follow up with the medical director until at such time consistent substantial compliance has been achieved as determined by the committee.

Date of Completion: 09-27-14

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	<p>Continued From page 13</p> <p>resident's bilateral lower extremities were edematous and weeping, the ARNP was notified, and a new dose of Lasix (diuretic medication) forty milligrams (40 mg's) was ordered and administered.</p> <p>Continued review of the WSIR dated 07/10/14 revealed Resident #1's skin was dry and there was two (2) plus edema and weeping, and the WSIR dated 07/17/14, revealed the residents skin was dry and the right lower extremity had weeping and two (2) plus edema. Further review of Physician's Orders dated 07/17/14 revealed orders were obtained for Lasix 40 mgs in the AM (morning), and 20 mgs at 2:00 PM. There was a notation on the care plan, which stated Lasix 40 mg po now 07/03/14, and Lasix per order 07/17/14. However, there was no documented evidence the Care Plan was revised related to the actual new area of skin breakdown which was identified on 07/03/14, or updated related to the actual edematous and weeping lower extremities.</p> <p>Review of the WSIR dated 07/24/14, revealed there was skin breakdown on Resident #1's right shin and left great toe and interview with Registered Nurse (RN) #2/Assistant Director of Nursing/Unit Coordinator for the North Unit who completed this skin assessment verified these areas were open when she assessed the resident's skin. She stated she did not realize these were new areas that required care plan revision and she did not check the care plan at the time of the assessment to see if it needed to be revised.</p> <p>Review of the Interdisciplinary Progress Note, dated 07/25/14 at 10:00 PM, and completed by LPN #19, revealed Resident #1 had open areas</p>	F 280		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	<p>Continued From page 14</p> <p>to the right lower extremity and left great toe and new orders were received for Vaseline Gauze and dressings to the areas daily and as needed (pm). There was a notation, undated, on the Care Plan under approaches which stated the resident had an open area to the right lower extremity and to the left great toe and treatment per order.</p> <p>Further review of the WSIR dated 07/31/14 and completed by LPN #17, revealed there was an open area with a diagram indicating areas on the right medial calf and top of the right foot; however, there was no documentation addressing the residents left great toe. Review of the WSIR dated 08/14/14 completed by LPN #17, revealed the resident had open blisters to the left foot and open areas to the right foot and right leg. The diagram indicated there was an old area of skin breakdown on the right medial calf and and an area on the top of the right foot and also new areas to the left foot. However, there was no documented evidence the Care Plan was revised related to the new areas of skin breakdown.</p> <p>Review of the WSIR dated 08/21/14 completed by LPN #18, revealed Resident #1 had open areas to the right medial calf, right great toe, and left foot.</p> <p>Review of the Nurse's Notes dated 08/27/14 at 2:00 PM, written by LPN #5, revealed Resident #1's wound was noted to have foreign matter in an open area, the wound was cleansed with all foreign matter cleaned out and a treatment was applied. Interview with LPN #5 on 08/29/14 at 2:00 PM, revealed the resident started having weeping in the lower extremities and about a month ago developed open areas to the lower extremities. She stated on 08/27/14 she noted</p>	F 280		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	<p>Continued From page 15</p> <p>the resident's wound on the right leg had white round foreign matter which would move about and could have been maggots.</p> <p>Review of the Non Pressure Skin Condition Record for Resident #1, completed by the Wound Nurse, dated 08/28/14 revealed the following skin assessment; Left Great Toe Metatarsal 1.4 cm Length (L) x 1.7 cm Width (W)-partial thickness, Right Lower Extremity Calf Posterior measuring 13.5 cm L x 5 cm W x 0.3 cm depth-full thickness, serous drainage, and slough described as moist yellow or gray necrotic tissue, Right Great Toe lateral metatarsal 0.8 cm L x 1 cm W-partial thickness, Right Proximal Lower Extremity 2 cm L x 1 cm W-partial thickness, serosanguinous exudate, and slough-moist yellow or gray necrotic tissue, Right Distal Lower Ext 0.9 cm L x 0.7 cm W-partial thickness.</p> <p>Observation of Resident #1's skin assessment performed by LPN #17 on 08/30/14 at 10:15 AM, revealed the resident had an open area to the left great toe medial base which measured 1.5 cm L x 1.5 cm W and the wound bed was beefy red; an open area to the right great toe medial base which measured 1 cm x 0.9 cm and the wound bed was red; an open area to the right shin with a red wound bed with a yellow center which measured 1.5 cm L x 1 cm W; an open area on the lower shin which had a red wound bed and measured 0.8 cm L x 0.6 cm W; an open area to the right medial/posterior calf which measured 3 cm L x 1.9 cm W with a red wound bed and white middle surrounded by eschar; an area just below the previous area to the right medial/posterior calf which measured 6 cm L x 3.5 cm W x 0.4 cm depth with a red wound bed with yellow/green areas on the wound bed surrounded by eschar;</p>	F 280		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	<p>Continued From page 16</p> <p>and, an area on the right lower medial/posterior calf which measured 5 cm W x 7 cm L and appeared as scar tissue.</p> <p>Interview, with the Wound Nurse on 08/30/14 at 12:15, and 09/09/14 at 6:50 PM, revealed she had seen Resident #1 in late June or early July 2014, related to the lower extremities having weeping and edema. Further interview with the Wound Nurse revealed she assessed the wounds on the resident's lower extremities on 08/28/14 and was "surprised" to see five (5) open areas to the lower extremities which she would classify as vascular ulcers (she stated she measured three (3) ulcers as one (1) on the right posterior calf), and the resident also had ulcers on the left and right great toe and right lower extremity posterior and anterior areas. Further interview revealed any nurse could revise the care plan, but she was responsible for revising the care plans for the wounds which she was tracking. She stated there was no care plan in place to indicate this resident had actual stasis ulcers, and she completed a care plan when she became aware of the resident's wounds.</p> <p>Interview, on 08/30/14 at 10:15 AM, LPN #17 stated she knew any nurse could update the care plan but she thought the Wound Care Nurse was following this resident and she would have revised the care plan.</p> <p>Interview, on 08/29/14 at 2:00 PM, with LPN #5 revealed she was aware any nurse could revise the care plan but she failed to look at the care plan to see if it required revision and she thought the Wound Care Nurse was revising the care plans when there were new open areas identified.</p>	F 280		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	<p>Continued From page 17</p> <p>Interview on 08/29/14 at 2:50 PM and 09/05/14 at 11:11 AM, with the ARNP revealed she was aware Resident #1 had weeping in the lower extremities earlier this summer and the diuretic had been increased; however, she assessed the wounds on 09/02/14 and the previous time she had seen the resident's lower extremities they were "nothing like now". "I was surprised the wounds were that bad".</p> <p>Interview on 09/09/14 at 3:00 PM with the MDS Nurse on the North Unit, revealed she had completed the resident's last MDS on 07/14/14 and the resident had no ulcers and just dry skin to the lower extremities at that time. She stated she obtained information for the MDS from the skin assessments which the Wound Nurse completed and also observed resident's skin during the assessment period. She further stated she revised care plans for the Admission, Quarterly, Yearly, and Significant Change MDS's and the floor nurses were to update the care plans between assessments. Continued interview revealed the wound care plans were to be completed by the Wound Nurse because she tracked the wounds. However, she stated in July 2014, she was still responsible for updating the care plans from Physician's Orders and she or the Wound Nurse should have ensured the Care Plan was revised related to the venous ulcers when new Physician's Orders were received related to the edematous weeping legs and the treatment for Vaseline Gauze to the areas.</p> <p>Interview with the Director of Nursing (DON) on 09/05/14 at 11:20 AM, revealed there was no Care Plan in place to address this resident's actual stasis ulcers and risk factors with individualized interventions related to the venous</p>	F 280		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280 Continued From page 18
ulcers until the Wound Nurse completed a care plan on 08/28/14. The DON stated, usually the Wound Nurse revised the wound care plans, but other staff including the floor nurses or MDS nurses could also revise the care plans.

F 309
SS=G 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, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of facility's policy, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one (1) of four (4) sampled residents who was diagnosed with stasis ulcers (Resident #1), out of a total sample of thirteen (13) residents.

On 07/03/14 Resident #1 was noted to have edematous weeping legs with an open area on the right lower extremity measuring three (3) centimeters (cm) x 0.1 cm on 07/03/14, and the Advanced Registered Nurse Practitioner (ARNP) was notified. Lasix (antidiuretic medication) was ordered; however, the nurse who notified the ARNP, did not ensure a treatment was ordered

F 280

F 309

**F 309
Immediate Corrective Action For Residents Found To Be Affected**

- ◆ Physician was notified by the WCN on August 28, 2014 relative to Resident #1 with treatment orders received. Assessment, notifications, treatment orders, and care plan revision completed.

Identification of Other Residents With The Potential to be Affected

- ◆ All Residents with Stasis Ulcers were assessed by the WCN on August 28, 2014 with no further issues identified.
- ◆ 100% resident skin audit was performed on September 19-23, 2014 by the SCC, DON, ADON, SDC, MDSN, ESNS, WNS, WCN or licensed nurse. Any issues

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	Continued From page 20 Breakdown-Clinical Protocol" Policy, revised 10/2013, revealed the physician would assist staff to determine etiology (for example, arterial or stasis ulcer) and characteristics (necrotic tissue, status of wound bed) of the skin alteration. Further review revealed the Physician would authorize pertinent orders related to wound treatments, including wound cleansing and debriding approaches, dressings, and applications of topical agents if indicated for type of skin alteration. Continued review revealed the Physician would evaluate and document the progress of wound healing and would help staff review and modify the care plan especially when wounds were not healing as anticipated or new wounds developed despite existing interventions. Interview with the Director of Nursing on 09/05/14 at 11:20 AM, revealed this was the policy which was to be used for Pressure Ulcers as well Stasis Ulcers. Review of the medical record revealed the facility admitted Resident #1 on 07/02/10. Further review revealed diagnoses which included Non Alzheimer's Dementia, Muscle Weakness, Degenerative Joint Disease, and Atrial Fibrillation, and Diabetes Mellitus. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/14/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a five (5) out of fifteen (15) indicating cognitive impairment. Further review revealed the facility assessed the resident as requiring extensive assist of two (2) staff for bed mobility and transfers, and limited assist of one (1) staff for ambulation. Continued review revealed the facility assessed the resident as having no arterial or venous ulcers.	F 309	<i>reported via the daily clinical meeting. This will be reviewed against the weekly wound rounds information to assure appropriate interventions are in place.</i> ♦ All condition changes as identified via physician orders, 24 hour report or daily assessments performed including skin issues will be discussed at daily clinical meeting to assure all assessments, treatments, notifications and care plans have been completed and reviewed and revised as needed. WNS will assure care plans are updated/revised on weekends. ♦ All condition changes including skin issues will be discussed at daily clinical meeting (M-F) with chart review to assure all MD/APRN notification, with assessments, orders, treatments, Responsible Party notifications completed and care plans updated accordingly.		

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

PRINTED: 09/24/2014
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F 309	<p>Continued From page 21</p> <p>Review of the Comprehensive Plan of Care dated 11/14/11, revealed Resident #1 was at risk for developing skin breakdown and had a history of pressure related areas. The goal stated the resident would have intact skin through next review. There was a notation, that was undated, which stated the resident had an open area to the right lower extremity and the left great toe and treatment per order.</p> <p>Review of the monthly July 1, 2014, Physician's Orders revealed orders for Ammonia Lactate 12 % (twelve percent) lotion to bilateral upper and lower extremities every other day, Hydrophor Ointment to feet and legs daily, and Dermaseptine Ointment.</p> <p>Review of the WSIR, dated 07/03/14, revealed Resident #1 had two (2) plus edema and an open area measuring three (3) centimeters (cm) x 0.1 cm and the diagram on the WSIR revealed the area was on the right shin.</p> <p>Review of the Interdisciplinary Progress Notes, dated 07/03/14 at 10:00 AM, revealed the resident's bilateral lower extremities were edematous and weeping, the ARNP was notified, and a "now" (one time) dose of Lasix 40 milligrams (mg) was ordered and administered. Review of the Physician's orders dated 07/03/14 revealed orders for Lasix 40 mg now; however, there was no orders for treatment to the area.</p> <p>Further review of the WSIR dated 07/10/14 revealed the resident's skin was dry and there was two (2) plus edema and weeping. The WSIR dated 07/17/14, revealed the resident's skin was dry and the right lower extremity had weeping and two (2) plus edema. Further review of Physician's</p>	F 309	<ul style="list-style-type: none"> ◆ <i>Weekly wound rounds will be performed by a varying mix(if not all) of DON, ADON, Licensed Nurse, WCN, SRNA, Dietician, DSM and SSD to assure current interventions match care plan.</i> ◆ Reports of the audits/reviews will be presented to the QA Committee monthly beginning September 24, 2014 for review and follow up with the medical director until at such time consistent substantial compliance has been achieved, as determined by the committee. <p>Date of Completion: 09-27-14</p>	

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

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F 309	<p>Continued From page 22</p> <p>Orders dated 07/17/14 revealed orders for Lasix 40 mgs in the AM, and 20 mgs at 2:00 PM.</p> <p>Phone interview on 09/05/14 at 11:05 AM, with Licensed Practical Nurse (LPN) #18, who had signed as completing the WSIR's for 07/03/14, 07/10/14, and 07/17/14, and had obtained the Physician's Orders for Lasix on 07/17/14, revealed she had noted the resident had edema to the lower extremities and the resident's legs were weeping fluid. She stated she had called the ARNP on 07/03/14 and informed her of the open area on the resident's leg and the edema to the lower extremities, and the ARNP ordered Lasix and instructed her to talk to the Wound Nurse about a treatment. She further stated she had asked the Wound Nurse to assess Resident #1's leg for a treatment order; however, could not recall if a treatment was ordered and was unsure if the Wound Nurse had assessed the resident. LPN #18 stated she could not recall if the resident still had an open area on 07/10/14 and 07/17/14 when she completed the skin assessments; however, the resident's legs were edematous and she obtained an order for increased Lasix on 07/17/14. She further stated she could not remember what type of treatment was being performed for the resident's weeping legs during that time period. Review of the Treatment Administration Record (TAR), dated July 2014, revealed there was no treatment orders related to the weeping legs and open areas which were noted on 07/03/14.</p> <p>Interview, with the Wound Nurse on 08/30/14 at 12:15 PM, and 09/09/14 at 6:50 PM, revealed she had initially seen the resident late June or early July 2014, related to the lower extremities having weeping and edema. She stated she did not</p>	F 309		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/24/2014
FORM APPROVED
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F 309	<p>Continued From page 23</p> <p>make a note and thought the nurses had a treatment in place. She further stated she was not notified of any open areas or any changes in the lower extremities until 08/27/14.</p> <p>Review of a Physician's Note dated 07/18/14, written by the Attending Physician, revealed the resident had weeping lower extremity areas that she/he refused to let staff dress.</p> <p>Review of the WSIR dated 07/24/14, revealed a diagram indicating there was skin breakdown on the resident's right shin and left great toe and interview with Registered Nurse (RN) #2/Assistant Director of Nursing/Unit Coordinator for the North Unit who completed this skin assessment, confirmed these areas were open at the time she completed the assessment. She stated these were not pressure ulcers so she did not measure and describe the wounds; however, in hindsight felt she should have measured the wounds. She further stated she did not call the Physician for an order because she thought there was already an order in place. Continued interview revealed she was only assessing the resident's skin due to the facility doing a skin sweep and was not familiar with the resident's wounds at the time. She further stated she had removed Kerlix from the resident's bilateral extremities before assessing the skin and thought the treatment was for Skin Repair to the legs, avoiding the open areas, and Kerlix to the legs bilaterally. However, further review of the TAR dated July 2014, and the Physician's Orders dated July 2014 revealed there was no treatment in place for the open areas on the right shin and great toe at that time.</p> <p>Review of the Interdisciplinary Progress Note for</p>	F 309		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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F 309 Continued From page 24

Resident #1, dated 07/25/14 at 10:00 PM, and completed by LPN #19, revealed the resident had open areas to the right lower extremity and left great toe and new orders were received for Vaseline Gauze and dressings to the areas daily and as needed (prn). However, there was no documented evidence of measurement or description of the areas. Review of the Physician's Orders, dated 07/25/14, revealed orders to cleanse the open area to the right lower extremity with Normal Saline and pat dry, and apply Vaseline Gauze wrap with Kerlix and cover with Ace Wrap every day and pm. Further review revealed orders to cleanse the open area to the left great toe with Normal Saline, pat dry, and apply Vaseline Gauze and dry dressing every day and pm.

Phone interview with LPN #19 on 09/05/14 at 11:00 AM, revealed before 07/25/14, the resident just had orders for creams and lotions to the lower extremities for dry cracked skin; however, the day she obtained the treatment order on 07/25/14 the resident had an open area to the left great toe, and open areas to the right shin and the lateral calf which were small and looked like the top layer of skin was gone. She stated she did not know why she did not measure the areas, but should have measured them.

Further review of the WSIR dated 07/31/14 and completed by LPN #17, revealed there was an open area with a diagram indicating areas on the right medial calf and top of right foot and no documentation addressing Resident #1's left great toe. Review of the WSIR dated 08/14/14 completed by LPN #17, revealed the resident had open blisters to the left foot and open areas to the right foot and right leg. The diagram indicated

F 309

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

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/10/2014
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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F 309	<p>Continued From page 25</p> <p>there was an old area of skin breakdown on the right medial calf and and an area on the top of the right foot and new areas to the left foot. The WSIR dated 08/14/14, stated treatment nurse notified.</p> <p>Interview with LPN #17 on 09/04/14 at 12:00 PM, revealed by looking at the WSIR for 07/31/14, the resident had an area on the right calf and the top of the right foot which was not present on the previous WSIR; however, she thought these areas were old. She further stated, according to what she could remember and looking at the WSIR for 08/14/14 the resident had an area to the left great toe and new areas to the left 3rd digit and a new area to the top of the resident's left foot, and she called and informed the Wound Care Nurse because the areas on the left 3rd digit and the top of the resident's left foot were new. Continued interview revealed she assumed the Wound Nurse would call the Physician for a treatment order and also assumed the Wound Nurse was measuring and describing this resident's wounds weekly. LPN #17 stated she used to be wound certified and stasis ulcers were to be measured and described weekly and the Physician was to be notified of any new areas of skin breakdown. However, review of the medical record including Interdisciplinary Progress Notes and Physician Progress Notes revealed there was no documented evidence the Physician was notified of these new areas of skin breakdown.</p> <p>Review of Resident #1's WSIR dated 08/21/14, completed by LPN #18, revealed a diagram indicating open areas to the right medial calf, right great toe, and left foot; however, no measurements were noted. Further phone interview with LPN #18 on 09/05/14 at 11:00 AM,</p>	F 309		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/24/2014
FORM APPROVED
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3576 FIMLICO PARKWAY LEXINGTON, KY 40517	

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F 309	Continued From page 26 revealed she was unable to remember just what the wounds looked like on that date; however, she thought there was a treatment already in place for the wounds and thought the Wound Nurse was following Resident #1 for measurements. Review of the Nurse's Notes dated 08/27/14 at 2:00 PM, written by LPN #5, revealed the resident's wound was found to have foreign matter in an open area, wound cleansed with all foreign matter cleaned out and treatment applied. Further review, revealed the ARNP was notified with no new orders, dressing changes to continue daily, and the resident had no signs and symptoms of pain, infection, or deterioration. Interview with LPN #5 on 08/29/14 at 2:00 PM, revealed the resident started having weeping in her legs about a month ago and developed open areas to the lower extremities. She stated on 08/27/14 she noted the resident's wound on the right leg had white round foreign matter which would move and could have been maggots, although she had never seen maggots before. She stated she had RN #2/ADON/UC for the North Unit, come to the room to assess what she had seen. She further stated she took the dressings and the bed linens, and placed them in a red biohazard bag and handed them to the housekeeper to dispose of. LPN #5 stated she flushed the wounds with Normal Saline until they were clean. Continued interview revealed RN #2/ADON/UC called the ARNP and notified her of the white foreign matter, although she (LPN #5) had written the Note stating the ARNP was notified on 08/27/14 at 2:00 PM. Further interview with RN #2/ADON/UC of the North Unit, on 09/04/14 at 9:47 PM, revealed she	F 309		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 27</p> <p>was asked to come in Resident #1's room on 08/27/14 and she noticed maggots on the bed covers; however, she did not see maggots in the resident's wounds. She stated she had notified the ARNP; however, had LPN #5 make the Note. She stated the ARNP did not give orders or instructions except to clean the wounds. She further stated the staff threw away the bed covers and notified housekeeping to clean and disinfect the room.</p> <p>Interview, with State Registered Nurse Aide (SRNA) #28, on 09/03/14 at 4:00 PM, revealed on 08/27/14, she saw LPN #5 remove the bandage on the resident's leg and maggots rolled out on to the bed spread, mattress. SRNA #28 stated she had never seen maggots before this. She stated she had seen flies and gnats in Resident #1's room daily and was not sure if she or anyone else had reported this. She stated the resident's meal trays stayed in the room longer than they should because the resident refused to allow them to take the tray at times.</p> <p>Interview, with SRNA #41 on 09/03/14 at 4:20 PM, revealed she was assigned to Resident #1 on 08/27/14 when LPN #5 called the SRNA into the resident's room. She stated when LPN #5 opened the dressing on the resident's leg, maggots were everywhere, on the bed linens, and on the floor, and there was about forty (40) of them. Continued interview revealed this was the first time she had seen maggots in the resident's room; however, she had noticed flies in the resident's room this summer as well as the resident had old food and milk at the bedside on occasion.</p> <p>Interview, with SRNA #14 on 09/03/14 at 4:30</p>	F 309		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 309	<p>Continued From page 28</p> <p>PM, revealed she witnessed maggots on the floor while the nurse was cleaning the residents wounds on 08/27/14 and assisted with giving the resident a bed bath afterwards. She stated she had seen flies, gnats, and spiders everywhere and had reported it to a nurse; however, could not remember which nurse. She further stated Resident #1 had flies and gnats in the room at times and she threw away old food which was left at the bedside.</p> <p>Review of Resident #1's Non Pressure Skin Condition Record, completed by the Wound Nurse, dated 08/28/14, revealed the areas were first observed on 08/28/14, including the following: Left Great Toe Metatarsal 1.4 cm Length (L) x 1.7 cm Width (W)-partial thickness, Right Lower Extremity Calf Posterior measuring 13.5 cm L x 5 cm W x 0.3 cm depth-full thickness, serous drainage, and slough described as moist yellow or gray necrotic tissue, Right Great Toe lateral metatarsal 0.8 cm L x 1 cm W-partial thickness, Right Proximal Lower Extremity 2 cm L x 1 cm W-partial thickness, serosanguinous exudate, and slough-moist yellow or gray necrotic tissue, Right Distal Lower Ext 0.9 cm L x 0.7 cm W-partial thickness.</p> <p>Observation of Resident #1's skin assessment performed by LPN #17 on 08/30/14 at 10:15 AM, revealed the resident had an open area to the left great toe medial base which measured 1.5 cm L x 1.5 cm W and the wound bed was beefy red; an open area to the right great toe medial base which measured 1 cm x 0.9 cm and the wound bed was red; an open area to the right shin with a red wound bed with a yellow center which measured 1.5 cm L x 1 cm W; an open area on the lower shin which had a red wound bed and</p>	F 309		

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

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

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F 309	Continued From page 29 measured 0.8 cm L x 0.6 cm W; an open area to the right medial/posterior calf which measured 3 cm L x 1.9 cm W with a red wound bed and white middle surrounded by eschar; an area just below the previous area to the right medial/posterior calf which measured 6 cm L x 3.5 cm W x 0.4 cm depth with a red wound bed with yellow/green areas on the wound bed surrounded by eschar; and, an area on the right lower medial/posterior calf which measured 5 cm W x 7 cm L and appeared as scar tissue. Interview, with the Wound Nurse on 08/30/14 at 12:15, and 09/09/14 at 6:50 PM, revealed she was not notified of any open areas or any changes in the lower extremities until 08/27/14 when she was told the resident had a deterioration in the wounds and also had maggots in the wound as she was walking out the door to go to class. The Wound Nurse stated she assessed Resident #1's wounds on the lower extremities on 08/28/14 and was surprised to see five (5) open areas to the lower extremities which she would classify as vascular ulcers (she stated she measured three (3) ulcers as one (1) on the right posterior calf), and the resident also had ulcers on the left and right great toe and right lower extremity posterior and anterior areas. Continued interview revealed she was to be notified of any new areas of skin breakdown until 08/27/14, and therefore had not been tracking the resident's wounds with measurements and descriptions of the wounds, and had not been corroborating with the Physician or ARNP related to the wounds. Further interview revealed staff was to fill out a Communication Form to the Wound Nurse and flag it in the skin assessment book which was read daily by the Wound Nurse or the Assistant Director of Nursing in the	F 309		

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

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
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F 309	<p>Continued From page 30</p> <p>morning meetings; however, she did not remember being told verbally or by the Communication Form of the resident's wounds. Continued interview revealed any nurse could revise the care plan, but she was responsible for revising the care plans for the wounds which she was tracking. She stated there was no care plan in place to indicate the resident's actual stasis ulcers, and she completed a care plan when she became aware of the residents wounds.</p> <p>Interview, on 08/29/14 at 2:50 PM and 09/05/14 at 11:11 AM, with the ARNP revealed she was notified of the staff finding maggots in Resident #1's wound and staff also said there was a lot of flies in the building this summer. She stated she was aware the resident had weeping in the lower extremities earlier this summer and the diuretic had been increased; however, she saw the wounds on 09/02/14 and the previous time she had seen the resident's lower extremities they were "nothing like now". "I was surprised the wounds were that bad". She further stated the wounds were not pressure ulcers but were venous stasis ulcers related to Peripheral Artery Disease and the resident also had Diabetes Mellitus. The ARNP stated, a dry dressing would have been sufficient for weeping legs; however, staff needed to notify her of any change in status such as deteriorating wounds or any new wounds and she did not know at what point the wounds worsened. She stated the staff was her eyes and ears and she was not notified of the decline in the wounds or the numerous wounds until the resident had a large elongated wound which was possibly necrotic with maggots. Further interview revealed, she was available except from 08/18/14 through 08/25/14 when she was on vacation. She stated she did not know if the Attending</p>	F 309		

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

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/10/2014
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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F 309 Continued From page 31

Physician was notified of the worsening wounds; however, there was no documentation to support the Physician had been notified. Continued interview revealed the Wound Nurse should have been following Resident #1 to give recommendations for further treatment. She stated the Wound Nurse guided her related to wound treatments because she (Wound Nurse) was aware of the latest treatments available. The ARNP indicated she had ordered a wound consult after she assessed the wounds which she would have done sooner had she been aware of the condition of the residents lower extremities.

The resident's Physician was out of the country at the time of the investigation and unavailable for an interview.

Interview with the Director of Nursing (DON), on 09/05/14 at 11:20 AM, revealed the Physician was to be notified of any new area of skin breakdown or any change in wound status. She stated at the point a wound was identified, or for any change in a wound, staff should have notified the Physician for a treatment order as well as obtained measurements and documented the measurements and description of the wounds on a Non Pressure Skin Condition Record which was the facility's tracking form for a stasis ulcer. However, she indicated by reviewing the record the Physician or ARNP was not kept informed of this resident's change in condition related to wounds, and the wounds were not being measured weekly. She stated in the morning clinical meeting Monday through Friday they discussed anything which occurred the previous day as well as the new Physician's Orders and also reviewed skin assessments. She stated the ADON's, the Wound Care Nurse, the MDS

F 309

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

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/10/2014
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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F 309 Continued From page 32
Nurses, Medical Records, Social Services, Staff Development attended the meetings; however, she was unaware if the Wound Care Nurse would have been at the meeting the day they discussed the new Physician's Orders received on 07/25/14 for the wound treatment. She stated the nurses were to fill out a communication sheet for the Wound Nurse if there was new or worsened skin breakdown; however, she was unsure if this was done for this resident. Further interview revealed the nurses should have ensured the Wound Nurse was notified of changes in the wound and an appropriate treatment was in place; however, there was no indication the Wound Nurse was following this resident. When reviewing the record, the DON stated there was no skin assessment completed from 07/31/14 through 08/14/14; however, staff had addressed but not measured the resident's wounds on the 08/07/14 weekly summary. Review of the Comprehensive Plan of Care and further interview with the DON, revealed there was no Care Plan in place to address Resident #1's actual stasis ulcers and risk factors as well as individualized interventions related to the ulcers until 08/28/14. She stated usually the Wound Nurse revised the wound care plans, but other staff including the floor nurses or MDS nurses could also revise the care plans.

F 309

F 441 483.65 INFECTION CONTROL, PREVENT SS=D SPREAD, LINENS

F 441

F 441

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

Immediate Corrective Action For Residents Found To Be Affected

- ◆ Resident #1 was assessed on September 19, 2014 by the ADON

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

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/10/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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(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 33
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(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, record review, and review of the facility's policy, it was determined the facility failed to 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 for two

F 441 and #3 was assessed on September 22, 2014 by the ESNS and SCC with no issues identified by the alleged deficient practice.

Identification of Other Residents With The Potential to be Affected

- ◆ All Residents with Stasis Ulcers were assessed by the WCN on August 28, 2014 with no other residents were identified to be at risk.
- ◆ DON reviewed the Infection Control tracking and trending log for the previous thirty (30) days with no other residents identified.

Measures Taken To Assure There Will Not Be a Recurrence

- ◆ Licensed nurses will be educated by the SDC, DON, SCC, ADON, MDSN, or WCN from September 16-26, 2014 as well as during on-boarding for new staff beginning September 26, 2014 regarding the

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

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/10/2014
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517	
(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	<p>Continued From page 34</p> <p>(2) of four (4) residents who were observed for Perineal care, skin assessments and/or dressing changes out of a total sample of thirteen (13) residents (Residents #1 and #3).</p> <p>Observation of a skin assessment and dressing change for Resident #1, revealed staff removed kerlex bandages from the resident's lower extremities by cutting them and then placed the soiled scissors on the bedside table which did not have a barrier. Further observation revealed the nurse cleaned multiple wounds without washing her hands and changing gloves between wounds.</p> <p>Observation of perineal care/incontinence care for Resident #3, revealed after staff cleaned stool from the resident's rectum and buttocks, staff failed to wash hands and change gloves prior to assisting the resident to sit up in bed by holding the resident's hands with soiled gloves.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility "Dressings, Dry/Clean" Policy, revised October 2013, revealed steps in the procedure included cleaning the bedside stand and establishing a clean field, then placing the equipment on the clean field. Further review of the policy revealed, clean wound with ordered cleanser, apply the ordered dressing and secure with tape or bordered dressing per order, discard disposable items, remove gloves, and wash hands. The policy did not address cleaning and dressing multiple wounds. <p>Review of the medical record revealed the facility admitted Resident #1 on 07/02/10. Further review revealed diagnoses which included Non Alzheimer's Dementia, Diabetes and Venous</p>	F 441	<p>facility policy and procedures for dressing changes, hand washing and glove use.</p> <ul style="list-style-type: none"> ◆ All clinical staff will be educated by the SDC, DON, SCC, ADON, MDSN, or WCN from September 16-26, 2014 as well as during on-boarding for new staff beginning September 26, 2014 regarding the facility policy and procedures relative to proper infection control techniques during peri care and dressing changes. ◆ Beginning September 23, 2014 incontinency care observations will be completed for five residents daily by licensed nurse and results will be reviewed by the Administrator, DON, ADON, ESNS, WNS or WCN. Any identified concerns will be investigated by the Administrator, DON, ADON, SDC, HRD/AIT, licensed nurse SSD or DOA.

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

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/10/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
--	--

(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

Stasis Ulcers. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/14/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a five (5) out of fifteen (15) indicating cognitive impairment.

Observation of a dressing change for Resident #1, on 08/03/15 at 10:15 AM, revealed Licensed Practical Nurse (LPN) #17 cut the soiled bandages from the resident's lower extremities with scissors and placed the soiled scissors on the bedside table which had no barrier. Further observation revealed the nurse cleansed Resident #1's wound on the left great toe with a vial of Normal Saline (NS) and a gauze pad, then washed her hands and changed gloves. The nurse then cleansed five (5) wounds to the right lower extremity (RLE) by using a new NS vial and using a clean gauze pad for each wound. However, the nurse failed to wash hands and change gloves between cleaning each wound on the RLE.

Interview, on 08/30/14 at 11:55 AM with LPN #17, revealed she should not have placed the soiled scissors on the bedside table without a barrier, and had not thought about it until the interview but would need to clean the table with a bleach wipe. She further stated she used to be wound certified and she had used one gauze to clean each wound and had ensured the NS did not run from one wound to the other. She stated she did not feel she needed to wash hands and don new gloves between cleansing different wounds on the same extremity.

Interview, on 09/05/14 at 11:20 AM, with the Director of Nursing (DON) revealed the nurse

F 441

♦ *Two (2) clean dressing change observations competencies will be completed daily by SCC, DON, ADON, SDC, ESNS, WNS, MDSN or WCN on shift dressing change occurs (Residents will not be inconvenienced nor caused undo discomfort in order to accommodate competencies) for the licensed nurses to monitor compliance and results will be reviewed by the Administrator, DON, ADON, ESNS, WNS or WCN. Any identified concerns will be investigated by the Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA with re-education and/or disciplinary action as warranted when identified by the SCC, DON, ADON, WCN or SDC.*

Monitoring Changes To Assure Continuing Compliance

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

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/10/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
--	--

(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 36

should not have placed soiled scissors on a bedside table without a barrier. She further stated the nurse should have washed hands and donned new gloves between cleaning each wound due to the potential for spread of infection.

2. Review of the facility's "At-A-Glance-Hand Washing and Use of Gloves" policy, effective December 2010, revealed handwashing was the single most important measure of preventing the spread of infections. Continued review revealed handwashing was to be performed before and after resident care and after handling contaminated articles.

Review of Resident #3's medical record revealed diagnoses which included Alzheimer's Disease, Psychotic Disorder, and a History of Urinary Tract Infections (UTI). Review of the Quarterly Minimum Data Set (MDS) Assessments dated 07/05/14 revealed the facility assessed the resident as having both short and long term memory loss and as severely cognitively impaired.

Observation, on 09/08/14 at 10:00 AM, revealed State Registered Nurse Aide (SRNA) #4 cleansed stool from Resident #3's rectum and buttocks, then without washing hands or changing gloves, pulled the resident's pants up and assisted the resident to a sitting position in the bed by holding on to the resident's hands while wearing the soiled gloves. SRNA #4 then placed a gait belt around the resident, and assisted the resident to stand and pivot transfer to a wheelchair.

Interview, on 09/08/14 at 10:25 AM, with SRNA #4 revealed she realized she should have washed her hands after providing incontinence

F 441

- Reports of the audits/reviews will be presented to the QA Committee monthly beginning September 24, 2014 for review and follow up with the medical director until at such time consistent substantial compliance has been achieved as determined by the committee.

Date of Completion: 09-27-14

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

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/10/2014
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 37 care and prior to assisting the resident to pull his/her pants up and transferring the resident to the wheelchair. She confirmed she did hold the resident's hands while wearing the soiled gloves. Interview, on 09/08/14 at 10:30 AM, with the Infection Control Nurse revealed the SRNA should have washed her hands and changed her gloves after incontinence care and prior to pulling the resident's pants up, holding the resident's hands, and transferring the resident to the wheelchair. She stated the facility had ongoing inservices related to perineal care, incontinence care and handwashing. She further stated staff including herself, and the Assistant Directors of Nursing (ADON's) were doing ongoing observations of hand washing, glove usage and perineal care/incontinence care and had been doing this since the last survey.	F 441			
F 469 SS=F	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. 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 maintain an effective pest control program to ensure the facility was free of pests as evidenced by no documented evidence actions were initiated after a complaint of flies in the building was reported, on 07/29/14, to facility	F 469	F 469 Immediate Corrective Action For Residents Found To Be Affected ◆ Rooms of Residents #1, 2, 9 & 10 as well as room #s 6 and 8 were inspected with any flies found removed. Identification of Other Residents With The Potential to be Affected		

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

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/10/2014
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517	
(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)
F 469	<p>Continued From page 38</p> <p>staff. On 08/27/14, another complaint regarding flies in the building was reported to facility staff and maggots were observed in Resident #1's wound and dressing by staff. Observation and interview revealed related actions initiated by the facility were not completed/enforced as evidenced by a door entrance was not completely sealed, an open dumpster beside the kitchen door contained discarded food and had multiple flies observed around the site, flies were observed at multiple locations in the building, and residents and staff reported flies in the building.</p> <p>The findings include:</p> <p>Review of the facility's policy: "Pest Control", dated January 2005, revealed the facility was to maintain an on-going pest control program to ensure the building was kept free of insects and rodents.</p> <p>Interview with the Ombudsman, on 09/04/14 at 10:30 AM, revealed on 07/29/14 she spoke to the previous Administrator about the flies building. The Ombudsman revealed she shared what rooms she had found flies and some previous actions she had seen work in the past which may help rid the flies. In addition, she spoke to the Plant Operations Manager (POM) about the flies.</p> <p>Interview with the former Administrator, on 09/04/14 at 4:15 PM, revealed if someone complained about seeing insects/flyes they called the exterminator and they usually responded the next day or within that week. He stated the Ombudsman had reported she had seen flies in the facility, in July or August but he was not sure of the exact date, and he had notified the POM and told him to call the exterminator and request</p>	F 469	<ul style="list-style-type: none"> Resident council minutes were reviewed for the previous three months with no complaints noted. However, given a fly could potentially be found in any area within the facility, all residents have the potential to be affected. <p>Measures Taken To Assure There Will Not Be a Recurrence</p> <ul style="list-style-type: none"> Door seal on South entrance door was replaced on September 04, 2014 by the Plant Operations Director (POD) and Plant Operations Assistant (POA). Contractor contacted on September 17, 2014 by POD to provide quote for replacement. Dumpster outside dietary door was emptied and cleaned on September 04, 2014 by the DSM.

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

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/10/2014
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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(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 469 Continued From page 39 they come out. Further interview revealed flies were an infection control problem.

Interview, on 09/04/14 at 3:42 PM and on 09/05/14 at 9:26 AM, with the POM revealed staff was supposed to notify him about pests, but staff and residents had not reported any problems with flies. The POM revealed the Ombudsman had reported, a few weeks ago, seeing a fly in the hallway. He stated he had checked the building but had not seen any flies and also checked the fly boards, but did not see a problem. The POM revealed he was unable to recall if the Administrator had discussed the fly concern with him, but if he had asked him to call pest control he would have called.

Review of the Pest Control Service Report revealed a monthly general service visit was performed on 08/07/14.

Further interview with the Ombudsman, on 09/04/14 at 10:30 AM, revealed she had also seen flies on a visit on 08/25/14 and reported the fly problem to the Social Services Director on 08/27/14. In addition she stated on 08/27/14 she had observed a large gap in the side entrance door.

Interview with the Social Services Director (SSD), on 09/04/14 at 2:06 PM, revealed last week the Ombudsman commented she had seen flies in the facility, but the SSD had not done anything because the Administrator had also spoken to the Ombudsman about the flies.

Observation and interview, on 08/29/14 at 2:40 PM, revealed two (2) live flies in Resident #9's room and one (1) dead fly on the window ledge.

F 469 Five additional wall scone fly traps were purchased and installed September 09-17, 2014 by the POD and/or POA.

- ◆ Education was provided to all stakeholders SDC, DON, SCC, ADON, MDSN, WCN, DSM, POD, POA, HRD/AIT, DOA, SSD, QoLD, QoLA, ESNS or WNS from September 19-23, 2014 as well as during on-boarding for new staff beginning September 24, 2014 regarding the facility policy on pest control.
- ◆ All windows, doors and screens were inspected on September 17, 2014 by the POD and POA with request to contractor same day for a quote on replacing identified bent/missing screens as well as the South entrance door.

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

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/10/2014
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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(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 469

Continued From page 40

Interview with Resident #9 revealed there were flies in his/her room as observed and they were a problem. Review of Resident #9's medical record revealed the Quarterly Minimum Data Set (MDS) Assessment, completed on 05/28/14, revealed the facility assessed the resident as cognitively intact, per the Brief Interview of Mental Status (BIMS) assessment score of 14 (fourteen).

Observation, on 08/30/14 at 10:05 AM revealed a fly on the North Unit Snack cart.

Observation and interview with the POM, on 09/03/14 at 12:24 PM, revealed outside of the kitchen door (approximately four (4) to five (5) feet away from the door) was an open dumpster with discarded card board boxes and a green food item. Multiple flies were observed to be swarming the dumpster. Further observation revealed the outside door, by the parking lot on the South Unit, had a gap between the door edge and the door frame and the door was not sealed completely when closed. Interview with the POM revealed the dumpster was used for recyclable card board and no food items were to be placed in the dumpster. He stated the concern with the discarded food was fly attraction and verified multiple flies were around the dumpster. Further interview with the POM revealed the South Unit door swelled and contracted and needed a new seal. He stated the seal was replaced last month, but noticed last week the seal needed to be replaced again, and he had not yet repaired the seal. Further interview revealed because the door was not sealed properly insects had access to the building.

Interview with the Dietary Manager, on 09/03/14 at 12:56 PM, revealed the dumpster by the

F 469

- ◆ POD requested dumpster switch or cleaning of existing dumpsters to Waste Management on September 03, 2014.
 - ◆ Beginning September 20, 2014, POD or POA will inspect all entrance doors and window screens monthly to assure they are sealing appropriately and all window screens monthly during warm weather. This will continue until directed otherwise by the QA Committee.
 - ◆ Beginning September 20, 2014, POD or POA will inspect wall sconce fly traps daily and replace baits as warranted.
- Monitoring Changes To Assure Continuing Compliance**
- ◆ Reports of the audits/reviews will be presented to the QA Committee monthly beginning September 24,

Oct. 16. 2014 9:51AM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 469	Continued From page 41 kitchen door was for boxes only and staff had been trained on the proper disposal of food. She stated they did not want flies close to the kitchen door and the discarded food was drawing flies. Interview with the Vice President of Pest Control company contracted by the facility, on 09/08/14 at 3:13 PM, revealed to help control flies, the facility needed to keep discarded foods and trash cans away from the building. Observation and interview, on 09/03/14 at 1:05 PM, revealed a fly was observed in the dining room area on a food cover near a resident's meal. Interview with Registered Nurse (RN) #2/Assistant Director of Nursing (ADON)/North Unit Coordinator (UC) at the time of the observation, revealed she had not noticed the fly, but they were supposed to observe and had manual fly swatters just in case. Continued interview revealed it was summer time and flies were in the facility sometimes. Observation, on 09/03/14 at 1:50 PM, revealed a fly was observed flying around Resident #2's room. Interview with Resident #2 at the time of the observation revealed he/she ate in his/her room and noticed the fly at meals and told the nurse today. Resident #2 further stated the flies were not as bad this year, but the resident had seen flies in the facility the last one (1) to two (2) months with the warm weather. Review of Resident #2's medical record revealed the Significant Change MDS Assessment, completed 05/05/14, revealed the facility assessed the resident as cognitively intact, per the BIMS assessment score of 15 (fifteen). Observation, on 09/04/14 at 11:16 AM, revealed a	F 469	2014 for review and follow up with the medical director until at such time consistent substantial compliance has been achieved as determined by the committee. Date of Completion:	09-27-14	

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F 469 Continued From page 42
fly was observed flying around Resident #10's room. Interview with Resident #10 at the time of the observation revealed the facility kept his/her room clean, but he/she had observed a fly in his/her room at times. Review of Resident #10's medical record revealed the Annual MDS Assessment, completed on 05/24/14, revealed the facility assessed the resident as cognitively intact, per the BIMS assessment score of 13 (thirteen).

Interview, on 09/03/14 at 3:40 PM, with State Registered Nursing Assistant (SRNA) #28 revealed she had seen flies in rooms #6 and #8 and reported it to the prior Administrator, but the flies were still a problem. Further interview with SRNA #28 revealed food attracted flies and they had some residents who were slow eaters and the food trays were not always picked up after meals.

Interview, with SRNA #28, on 09/03/14 at 4:00 PM, revealed she had seen flies and gnats in Resident #1's room daily and was not sure if it had been reported. She stated, at times, the resident refused to allow staff to take meal trays and they stayed in the room longer than they should. She further stated, on 08/27/14, maggots had rolled out of the wound onto the bed spread and mattress after the nurse removed the dressing.

Interview, with SRNA #41, on 09/03/14 at 4:20 PM, revealed she was assigned to Resident #1 on 08/27/14, and when Licensed Practical Nurse (LPN) #5 removed the dressing on the resident's leg, she observed about forty (40) maggots which were everywhere, on the bed linen and floor. She further revealed she had noticed flies in the

F 469

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 469 Continued From page 43
resident's room this summer as well as old food and milk at the bedside on occasion.

Interview, with SRNA #14, on 09/03/14 at 4:30 PM, revealed she had seen flies, gnats, and spiders everywhere and reported it to a nurse, but could not remember which nurse. She further stated Resident #1 had flies and gnats in the room at times and she threw away old food which was left at the bedside. In addition, SRNA #14 revealed she witnessed maggots on the floor when a nurse cleaned the resident's wounds on 08/27/14.

Interview with RN #2/ADON/UC of the North Unit, on 09/04/14 at 9:47 PM, revealed she was asked to come in Resident #1's room on 08/27/14 and she noticed maggots on the bed covers.

Interview, on 08/29/14 at 2:50 PM and 09/05/14 at 11:11 AM, with the Advanced Registered Nurse Practitioner (ARNP) revealed she was notified of the staff finding maggots in the resident's wound and staff also said there was a lot of flies in the building this summer.

Observations on 09/04/14 of the facility's "Fly Light" boards revealed: observation at 9:51 AM of the front lobby "Fly Light" board revealed ten (10) dead flies; observation at 9:58 AM on the South East hall of the "Fly Light" board revealed nine (9) dead flies; observation at 10:00 AM on the South West hall of the "Fly Light" board revealed twenty-four (24) dead flies; observation at 10:03 AM of the "Fly Light" board in the dining room revealed nine (9) dead flies on the fly board; observation at 10:06 AM on the North East hall of the "Fly Light" board revealed fifty-three (53) dead flies; and observation at 10:08 AM of the North

F 469

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F 469	Continued From page 44 West hall "Fly Light" board revealed eight (8) dead flies. Interview, on 09/04/14 at 10:10 AM and on 09/05/14 at 9:26 AM, with the POM revealed the fly boards were not that bad last week. The POM revealed they looked at the boards each week to see if they need to be changed and if they were full they knew they had a fly problem, but there was no pattern as the number of flies on the board varied week to week. The POM stated they usually changed the fly boards routinely at the beginning or end of each month, and thought the maintenance assistant had changed them sometime last week. Further interview with the POM, on 09/04/14 at 3:42 PM and on 09/05/14 at 9:26 AM, revealed he had been made aware of the maggot observation at a morning meeting. He stated the Administrator had them spray around the dumpster with a chemical recommended by the pest guy and also poured bleach around the dumpster last week. Further interview revealed he had checked the doors/window seals and was aware of the side door seal problem last week. He also stated pest control routinely came out the first of the month and in the past if had an insect problem they would call pest control. However, the POM revealed he had not called pest control this summer regarding the flies but they were out on 09/04/14 and they advised him flies were attracted to food and urine and thought he reported this to the Administrator. Review of the Pest Control Service Report, dated 09/04/14, revealed a general service was performed on the exterior of the building. The document noted operations asked for help with fly	F 459			

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F 469 Continued From page 45
relief and they advised them fly problems in residents' rooms were from food debris and also urine.

Interview with the Vice President (VP) of the Pest Control company contracted by the facility, on 09/08/14 at 3:13 PM, revealed for an extra fee they assisted facilities with fly control, they looked to see what caused the fly problems and made recommendations to facilities on what to do. The VP stated the facility was advised by the technician, during the routine visit, flies were attracted by food debris and urine.

Interview with the current Administrator, on 09/04/14 at 4:32 PM and on 09/10/14 at 1:50 PM, revealed nothing was passed onto him about the Ombudsman's concern about flies that was reported to the prior Administrator. He stated before the maggot incident he had seen flies on occasion and they had no complaints from residents, but checked into the fly problem more after the incident. The Administrator revealed the Ombudsman had talked to him about seeing flies but it was after the maggots were observed by staff on 08/27/14. The Administrator further stated he had told maintenance to check door seals, window seals/screens and anywhere they thought insects could enter the facility. He stated the seal on the south door should have been fixed right away when it was noted the seal was not tight. The Administrator revealed the food was not supposed to have been in the dumpster by the kitchen door, the Dietary Manager had just inserviced staff. He revealed after the maggots were observed additional fly lights were ordered, maintenance staff had sprayed bleach and another products the pest control company provided that attracted/killed flies by the trash

F 469

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 469	Continued From page 46 containers and dumpsters. He stated he was not sure if the pest control company had been called to come out after the incident, but they had come out on 09/04/14 and staff inservices on fly control started on 09/01/14 and was ongoing.	F 469			
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility's policy, it was determined the facility failed to obtain laboratory services to meet the needs of its residents for one (1) of three (3) sampled residents who had a diagnoses of an Urinary Tract Infection (UTI) out of thirteen (13) sampled residents (Resident #5). Physician's Orders were received on 08/17/14 for a urinalysis and culture and sensitivity if indicated for Resident #5; however, there was no documented evidence the urine specimen was obtained. On 08/24/14, the resident was sent to the hospital emergency room and diagnosed with a UTI. The findings include: Review of the facility's "Laboratory Protocol-Diagnostic Testing" policy, effective 12/10, revealed the procedure included; providing laboratory, radiological and diagnostic services as necessary and appropriate, assuring the	F 502	F 502 Immediate Corrective Action For Residents Found To Be Affected ♦ Resident #26 received treatment for UTI and course of treatment is completed. Identification of Other Residents With The Potential to be Affected ♦ 100% resident lab audit was completed from 9/19/2014 to 9/22/2014 by the SCC, DON, ADON, SDC, all labs were validated to be completed with MD notifications and follow-up as needed. Measures Taken To Assure There Will Not Be a Recurrence ♦ Licensed nurses were educated by the SDC, DON, SCC, ADON,		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 502	<p>Continued From page 47</p> <p>residents receive laboratory, radiological and diagnostic services as ordered by the Attending Physician/Advanced Registered Nurse Practitioner (ARNP), and assuring the results of all diagnostic services were promptly reported to the resident's Attending Physician/ARNP.</p> <p>Review of Resident #5's medical record revealed the facility admitted the resident on 07/23/12, with diagnoses which included Depressive Disorder, Difficulty Walking, Muscle Weakness, and a history of Urinary Tract Infections (UTI's). Review of the Annual Minimum Data Set (MDS) Assessment, dated 06/23/14, revealed the facility assessed Resident #5 to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) which indicated the resident was cognitively intact.</p> <p>Review of the Nurse's Note dated 08/17/14 at 11:30 AM, revealed Resident #5 was having tremors to the bilateral upper and lower extremities. Further review revealed; Blood Pressure 130/70, Pulse 84, Respirations 18, even and unlabored, Temperature 98, and oxygen saturation 97% (percent). The Note stated, the Physician was notified and orders were received.</p> <p>Review of the Physician's Order for Resident #5, dated 08/17/14 revealed orders for a Thyroid Stimulating Hormone (TSH), Thyroxine (T4), Complete Blood Count (CBC), Comprehensive Metabolic Panel (CMP), and a urinalysis; culture and sensitivity as indicated.</p> <p>Further review revealed the laboratory results for the labs ordered on 08/17/14 were noted in the medical record as collected on 08/18/14, except for the urinalysis; culture and sensitivity.</p>	F 502	<p>MDSN, or WCN from 9/19/2014 through 9/26/2014 as well as during on-boarding for new staff beginning 9/26/2014 regarding the facility policies and procedures on lab process.</p> <ul style="list-style-type: none"> A Lab log system was implemented by the DON and ADONs on 9/23/2014 to monitor daily <i>including weekends (by the WNS, SCC, DON, ADON, WCN, SDC or ESNS)</i> that all lab orders have been received, completed and results communicated to MD as needed for orders. <p>Monitoring Changes To Assure Continuing Compliance</p> <ul style="list-style-type: none"> Beginning 9/23/2014 all lab orders and the lab log will be reviewed by DON, and ADON M-F during morning clinical meeting to assure scheduled labs are being completed per orders and results are communicated to the MD as needed. 	

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F 502	Continued From page 48 Continued review of the Nurse's Notes dated 08/24/14 at 12:00 PM, revealed Resident #5 was leaning to the left side in the recliner and had slurred speech, orbital edema and no urine output noted from 7:00 AM to 12:00 PM. Further review revealed the resident's skin was clammy, warm, and pale, range of motion was difficult, lung sounds were diminished bilaterally, and abdomen was soft, round, non distended with positive bowel sounds all four (4) quadrants. Further review revealed; Blood Pressure 70/40, Pulse 96, Respirations 20 and shallow, and Temperature 97.6. The Note stated, the Physician was notified and orders were received to send the resident to the hospital emergency room. Review of the Hospital Emergency Department Notes, revealed Resident #5 arrived on 08/24/14 at 12:37 PM. Further review revealed during the the Emergency Room visit the resident received a chest x-ray, intravenous fluids, and laboratory data was ordered including a urinalysis. Review of the laboratory data for the urinalysis collected on 08/24/14 revealed Gram Negative Rods, and the resident was started on Ciprofloxacin 500 milligrams (mg's) (antibiotic medication) every twelve (12) hours for a UTI. Further review of Nurse's Notes dated 08/24/14 at 6:30 PM, revealed Resident #5 returned to the facility and new orders were received for the resident to receive Ciprofloxacin 500 mg's by mouth twice a day for seven (7) days. Review of the laboratory data for the urine culture obtained on 08/24/14, final report verified 08/27/14, revealed a UTI with the organism-Escherichia Coli which was resistant to	F 502	Reports of the audits/reviews will be presented to the QA Committee monthly beginning 9/23/3014 for review and follow up with the medical director until at such time consistent substantial compliance has been achieved as determined by the committee. Date of Completion:	09-27-14	

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F 502 Continued From page 49
Ciprofloxacin. New orders were received on 08/30/14 to discontinue the Ciprofloxacin and start Macrobid (antibiotic medication) 100 mg's twice a day for seven (7) days.

Interview with Licensed Practical Nurse (LPN) #20, on 09/08/14 at 11:45 AM, who transcribed the Physician's Order for the urinalysis; culture dated 08/17/14, revealed when she received an order for a urinalysis; culture, she either called the laboratory or entered the information related to the lab order in the computer. She further stated, she then documented the lab which was ordered in the Laboratory Book, and completed a Lab Requisition slip in which she either taped to the nurses station until the urine sample was obtained or placed in the lab accordion file box under the current date or the next days date depending on when the specimen was to be collected. Continued interview revealed, on 08/17/14 she had obtained an order from the Physician for a urinalysis and other labs because Resident #5 was having tremors in the upper extremities. LPN #20 stated this was not new for the resident because she/he had them before on occasion; however, wanted to inform the Physician. Continued interview revealed the resident had no complaints of pain or frequency with urination or any signs and symptoms of a UTI, and the resident's vital signs were stable during her assessment on 08/17/14. Further interview revealed she asked Resident #5 for a urine sample; however, the resident did not want to try to urinate right then, and soon afterwards lunch was delivered. LPN #20 stated she thought the next shift had obtained the urine sample because she worked the next day and would have known if the sample had not been collected by shift report from the nurses. She stated the

F 502

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F 502 Continued From page 50

nurses were to check the Laboratory Book at the beginning of each shift to see which labs were obtained and which labs were to be drawn and also check the lab accordion file box to see if there was Lab Requisition slips. LPN #20 did not remember if she had placed the Laboratory Requisition slip in the lab accordion file box or taped the slip to the nurses station on 08/17/14. Further interview revealed on 08/24/14 she was assigned to the resident and noted the resident was lethargic, had a low blood pressure and was not having urine output, and she notified the Physician and had the resident transferred to the hospital emergency room.

Interview on 09/08/14 at 10:40 AM with Registered Nurse (RN) #4, Assistant Director of Nursing (ADON)/ Unit Coordinator (UC) for the South Unit, revealed when a urinalysis; culture was ordered a Lab Requisition slip was completed in triplicate form and was to be taped to the nurses station until the specimen was obtained. She stated, once the urine specimen was collected, all copies of the Lab Requisition slip was placed in the lab accordion file box and the urine specimen was placed in the lab refrigerator on the North Unit. Continued interview revealed the nurse who transcribed the Physician's Order for the urinalysis; culture was to write the order in the Laboratory Book. She stated the nurse who transcribed the order was responsible for collecting the urine specimen or ensuring it was collected on the next shift. Further interview revealed the nurses were to check the Laboratory Book every day before they leave to ensure the labs were collected or drawn as ordered. She further stated she also checked the Laboratory Book every day or every few days to ensure the lab results were received. Review

F 502

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 502

Continued From page 51
of the "Lab Tracking" Form inside the Laboratory Book, revealed Resident #5's name was written in and the diagnostic test was written in including a CBC, CMP, TSH, T4, and Urinalysis. However, the columns including date completed, MD/ARNP response or follow up call was not signed as completed for either of the labs. RN #4/ADON/UC confirmed these labs were not signed off as date completed, MD/ARNP response or follow up call was not signed for the labs; however, stated the nurses should have followed up with ensuring the labs were tracked. Continued interview revealed if a urine specimen was not collected on the shift in which it was ordered, it should be written on the Twenty-Four (24) Hour Report so the next shift would know it was to be collected; however, she stated she had checked the 24 Hour Reports and this was not carried over. Further interview revealed the system may have failed due to not having consistent staff on the same halls. RN #4/ADON/UC revealed if a urine was not collected and a resident had a UTI, the resident could get septic.

F 502

Interview on 09/08/14 at 11:14 AM with the Infection Control Nurse, revealed the ADON's on for the North and South Units were responsible for tracking labs. She stated she did not receive copies of Physician's Orders or copies of laboratory results. However, she stated she learned of new Physician's Orders for labs or antibiotics from the morning meeting, and if she was unable to attend, the ADON's were to tell her if an antibiotic was started. She further stated, once she learned an antibiotic had been started, she would pull the laboratory results and track the infection from there. The Infection Control Nurse explained it could be a concern if a urine specimen was not collected as ordered due to the

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/10/2014
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 502	Continued From page 52 risk of becoming ill or septic with a UTI. Interview with the DON on 09/09/14 at 1:36 PM, revealed she was unable to find any lab results for the urinalysis; culture which was ordered on 08/17/14 for Resident #5. She stated the ADON/UC was the safety check and was to bring a copy of all requisition slips to the morning meeting Monday through Friday and compare the slips to the Laboratory Book to ensure the labs were obtained or drawn as ordered. She further stated she checked the computer and all the labs including the urinalysis; culture for Resident #5 were ordered in the computer. She further stated the laboratory staff was to have the nurse sign the computerized laboratory requisition slip after the labs were drawn so the nurse could ensure all the labs had been drawn or collected. However, review of the computerized Requisition Slip dated 08/18/14 revealed the nurse did not sign the computerized Requisition Slip dated 08/18/14, for Resident #5's labs.	F 502			