

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID

STATEMENT OF DEFICIENCIES AND PLAN OF ACTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>05/20/2010</b>
NAME OF PROVIDER OR SUPPLIER <b>KING'S DAUGHTERS MEDICAL CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2201 LEXINGTON AVENUE ASHLAND, KY 4110</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  A Recertification Survey was conducted 05/18/10 through 05/20/10. A Life Safety Code Survey was conducted on 05/20/10. Deficiencies were cited with the highest scope and severity of a "F". 483.10(b)(5) - (10), 483.10 (b)(1)			
F 156 SS=C	NOTICE OF RIGHTS, RULES, SERVICES, CHARGES  The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.  The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (I) (A) and (B) of this section.	F 156	Information describing how to apply for and use Medicare and Medicaid benefits was posted, by the Director, on the wall of the main corridor of the Transitional Care Unit to the right of the nurse's station on 5/21/2010.	05/22/2010
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Signa Ann Burdette, M.D., Director of Accreditation &amp; Regulatory Affairs</i>		TITLE <i>Director of Accreditation &amp; Regulatory Affairs</i>		DATE <i>07/07/2010</i>

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STATEMENT OF DEFICIENCIES AND PLAN OF ACTION		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:  740190	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED  05/20/2010
NAME OF PROVIDER OR SUPPLIER  KING'S DAUGHTERS MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2201 LEXINGTON AVENUE ASHLAND, KY 4110		
(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 156	<p>Continued From page 1</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicaid or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924 © which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining</p>	F 156		05/22/2010

<p>F 156</p>	<p>Continued From page 2</p> <p>written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the Facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, and interview, it was determined the facility failed to ensure written information related to how to apply for and use Medicare and Medicaid benefits was prominently displayed.</p> <p>The findings included:</p> <p>Observation on 05/18/10 of the posted signs in the facility revealed the facility failed to post information related to applying for and using Medicare and Medicaid benefits.</p> <p>Interview on 05/18/10 at 5:00 PM with the Director revealed he was unaware of the requirement related to posting the information.</p>	<p>F 156</p>		<p>05/22/2010</p>
<p>F 241 SS=D</p>	<p>483.15 (a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p>	<p>F 241</p>	<p>Immediate corrective action included discussion with nurse #2, per Nurse Manager on 5/21/2010, to maintain patient's privacy by pulling curtain or closing door to patient rooms during all patient care processes.</p>	<p>07/02/2010</p>

<p>F 241</p>	<p>Continued from page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, and interview, it was determined the facility failed to ensure care was provided for residents in a manner which maintained residents' dignity for one (1) of five (5) sampled residents (Resident #2).</p> <p>The findings include:</p> <p>Review of Resident #2's medical record revealed an admission date of 05/17/10 with diagnoses which included Debility, INDIVIDUALITY</p> <p>and Status Post Cerebral Vascular Accident (CVA).</p> <p>Observation on 05/18/10 at 2:45 PM revealed Resident #2 was in the bed and wearing a gown. Licensed Practical Nurse (LPN) #2 was observed to remove a urine sample from the resident's indwelling Foley catheter tubing while the resident's door was open to the hallway. The LPN was then noted to close the door prior to removing the resident's indwelling Foley catheter.</p> <p>Interview on 05/18/10 at 3:40 PM with LPN #2 revealed she was unaware the resident's door was open at the time the urine sample was collected. She stated the door should have been closed for privacy.</p>	<p>F 241</p>	<p>On 5/25/2010, Nurse Manager had formal discussion with LPN #2 who was given a "Reminder One (1)" in accordance with KDMC's disciplinary process, "Discipline Without Punishment" (DWP), for not observing the patient's right for privacy while she obtained a urine sample from a resident's foley catheter.</p> <p>To ensure ongoing compliance with the requirement of maintaining patient privacy during all aspects of patient care, LPN #2 will be observed by the Nurse Manager/Director of Nursing (DON) randomly and for a minimum of once a week, for 12 weeks to assure that the privacy and dignity of the residents is protected. If LPN #2 is found to be non-compliant at any time, the DWP process will be continued, with the second offense being a "Reminder Two (2)", the third step being a "Reminder Three (3)", which is a "decision making leave (DML)" for performance.</p> <p>In addition, starting 06/25/2010 the DON will observe all TCU nurses individually regarding protecting the privacy and preserving the dignity of the resident. This will be done at least monthly for a minimum of six months. The DON will keep a log, and will deal with noncompliance per KDMC DWP policy.</p> <p>Respect of individuality of the residents, as well as protecting and preserving the privacy and dignity of the residents was addressed per the DON during the Transitional Care Unit (TCU) meetings held on 06/2/2010 at 7:00 AM and on 06/03/2010 at 7:00 AM. Seven out of the 12</p>	<p>07/02/2010</p>
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F 241	Continued from page 4	F 241	<p>nurses that work TCU attended and received this information at the unit meeting. The other 5 nurses were given the information in writing.</p> <p>To further ensure ongoing compliance with the requirement of maintaining patient privacy during all aspects of patient care, on 05/25/2010, the DON scheduled the TCU social worker to present a formal in-service to the TCU nurses during their 7/1/10 department meeting, regarding preserving the dignity and respect of individuality protecting and preserving the privacy and dignity of the residents.</p> <p>Protecting and preserving the privacy and dignity of the residents was added to the unit specific competency validations on 06/08/2010. Included will be a verbal presentation given by the social worker, written information given to the nurses, and a post test that will require 100% passage. This mandatory competency validation was initiated 06/23/2010 and completed 07/01/2010.</p> <p>All new hired TCU nurses will be required to complete the protecting and preserving the privacy and dignity of the residents competency validation process before the completion of their 90-day evaluation.</p>	07/02/2010
F 281 SS=E	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation interview and record review, it was determined the facility failed to ensure services met professional standards of care for three</p>	F281	<p>Immediate action to ensure that each patient's plan of care was professional and met the patient's care needs, the nursing staff initiated new plans of care on 5/21/2010 for residents #2, #3, and #4. regarding antiplatelet agents, antidiabetic agents, and chronic conditions.</p> <p>On 05/17/10 resident #2's care plan was updated by the</p>	07/02/2010

<p>F 281</p>	<p>Continued from page 5</p> <p>(3) of five (5) sampled residents (Residents #2, #3, and #4).</p> <p>The facility failed to ensure Initial Plans of Care were developed to meet the needs of newly admitted residents for three (3) of five (5) sampled residents (Residents #2, #3, and #4).</p>	<p>F 281</p>	<p>charge nurse to include risk factors associated with anti-platelet agents, risk factors associated with Diabetes Mellitus and anti-diabetic agents.</p> <p>On 05/17/10 resident #4's care plan was updated by the charge nurse to include risk factors associated with anti-platelet agents.</p>	<p>07/02/2010</p>
<p>F 281</p>	<p><b>PROFESSIONAL STANDARDS</b></p> <p>Additionally, the facility failed to ensure Physician's Orders were followed for one (1) of five (5) sampled residents (Resident #3).</p> <p>The findings include:</p> <p>1. Review of Resident #2's medical record revealed the resident was admitted to the facility from the hospital on 05/17/10 with diagnoses including Status Post Cerebral Vascular Accident (CVA) and Diabetes Mellitus. Further review of the medical record revealed the Minimum Data Set (MDS) Assessment had not been completed due to the recent admission date.</p> <p>Review of the Physician's Orders dated 05/10 revealed orders for Plavix 75 milligrams (mg) (anti-platelet agent) by mouth daily, Aggrenox 200-25 mg (anti-platelet agent) by mouth twice a day, Metformin 2.5-500mg (anti-diabetic agent) per tab, 2 tabs twice a day before meals, and Novolog insulin per Sliding Scale (SS) (anti-diabetic agent), sliding scale (&lt;150 = 0 units, 151-200 = 2 units, 201-250= 4 units, 251-300 = 6 units, 301-350 = 8 units,&gt; 350 = 10 units).</p> <p>Review of the Initial Plan of Care dated 05/18/10 revealed there was no Plan of Care for the resident related to managing the risk factors associated with anti-platelet agents. Further review of the Initial Plan of Care revealed there was no Plan of Care for the resident related to managing the risk factors associated with Diabetes Mellitus and anti-diabetic agents.</p> <p>2. Review of Resident #4's medical record revealed the resident was admitted to the facility from the hospital on 04/30/10 with diagnoses which included Lower</p>	<p>F281</p>	<p>On 05/17/10 resident #3's care plan was updated by the charge nurse to include risk factors associated with anti-platelet agents, management of COPD including effect and side effects of medications for COPD, and use of oxygen.</p> <p>Multidisciplinary committee met on 05/27/2010 to review the current care plans for all residents. Their goal was to make the care plan more individualized and comprehensive for each resident.</p> <p>During the unit meetings scheduled at 7:00 AM on 06/29/2010 and 07/01/2010, the DON educated all the nurses on systemic changes related to care plans. This education was mandatory with 100% of team members receiving the education. This information was incorporated into unit specific validations and orientation for new hires and agency staff, and will be provided to all new hires and agency nurses by their designated preceptors. The DON will review each new hire's and agency nurse's orientation documentation and will initiate DWP process with preceptor if care plan education not completed within the new hire's or agency nurse's first 30 days of their 90 day probation and orientation period.</p> <p>Starting 06/24/2010 each new resident will be assigned to an RN to follow throughout their</p>	<p>07/02/2010</p>

<p>F 281</p>	<p>Continued from page 6</p> <p>Extremity Weakness and a History of a Myocardial Infarction. Review of the Minimum Data Set (MDS) Assessment dated 05/12/10, revealed the facility assessed the resident as having no cognitive loss, and requiring limited to extensive assistance with Activities of Daily Living. The facility had not yet developed a Comprehensive Plan of Care.</p> <p>Review of the Physician's Orders dated 05/10, revealed orders for Plavix 75 mg's (anti-platelet agent) by mouth every day.</p> <p>Review of the Initial Plan of Care dated 05/18/10 revealed there was no Plan of Care for the resident related to managing the risk factors associated with anti-platelet agents.</p> <p>3. Review of the clinical record revealed Resident #3 was admitted to the facility from the hospital on 05/12/10 with diagnoses including Status Post Coronary Artery Bypass Graft (CABG) Coronary Atherosclerotic Disease (CAD), Chronic Obstructive Pulmonary Disease (COPD) and Anticoagulant use. Further review of the medical record revealed the Minimum Data Set (MDS) Assessment had not been completed due to the recent admission date.</p> <p>Review of the Physician's Orders dated 05/10 revealed orders for Plavix 75 milligrams (mg's) (antiplatelet agent) by mouth every day.</p> <p>Review of the Initial Plan of Care dated 05/12/10 revealed there was no Plan of Care for the resident related to managing the risk factors associated with anti-platelet agents.</p> <p>Further review of the Physician's Orders dated 05/10 revealed orders for oxygen per nasal cannula at two liters, Xopenex nebulizer (medication used for the prevention and treatment of bronchospasm), every six hours scheduled and every three hours as needed, Ventolin Inhaler (bronchodilator) four times a day as needed, and Spiriva Inhaler (used for the treatment of bronchospasm for COPD), one cap every day.</p>	<p>F 281</p>	<p>stay. The RN will initiate the care plan and ensure its comprehensiveness, to include diagnosis, new physician orders, and current problem list, as well as follow the resident to make sure any new problems are addressed on the plan of care as they arise. The RN will review the care plan with the chart on a weekly basis, looking at labs, imaging, new medications, physician's orders, etc., to assure that as new problems arise, they are addressed on the care plan. Each staff RN will follow 2-3 residents at all times. All night shift nurses will continue to review and revise the care plans daily of their assigned residents. The charge nurse who attends the weekly care plan meetings will also review the care plan with the multidisciplinary team, the resident, and the family, to assure that all problems are addressed in the care plan. The charge nurse will incorporate the care plans in to the weekly care plan meetings to assure they are individualized, accurate, and comprehensive. This will start on 06/10/2010, and will continue to be reviewed weekly for the duration of the calendar year.</p> <p>The care plan will continue to be reviewed and updated every 24 hours by multidisciplinary staff consisting of nursing and therapy.</p> <p>Multidisciplinary committee will continue to meet monthly to assess compliance and quality of care plans. The multidisciplinary committee, composed of the TCU DON, TCU/Rehab Director, VP of Clinical Services, the TCU Social Worker, Occupational Therapy (OT), Physical Therapy (PT), Recreational Therapy, Respiratory Therapy</p>	<p>07/02/2010</p>
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<p>F 281</p>	<p>Continued from page 7</p> <p>Observation of the resident on 05/19/10 at 5:12 PM revealed the resident was lying in the bed with oxygen per nasal cannula.</p> <p>Review of the Initial Plan of Care dated 05/12/10 revealed there was no Plan of Care for the resident related to managing the Chronic Obstructive Pulmonary Disease, or use of oxygen.</p> <p>Interview on 05/19/10 at 11:45 AM and 05/20/10 at 9:00 AM with the Director of Nursing (DON) revealed the Initial Care Plan was to be completed by the admitting nurse. She further stated the night shift nurses were to review and revise the Care Plans every night. Continued interview, revealed Care Plans should have been initiated for Continued From page 6</p> <p>Resident #2 related to anticoagulant therapy and Diabetes, Resident #4 related to anti-coagulant therapy and Resident #3 related to anticoagulant therapy and Diabetes. She further stated she had recognized there was a problem with Initial Care Plans and revising Care Plans and had talked to the nurses about it in the last unit meeting.</p> <p>Review of the facility's Plan of Care policy and procedure, revealed the individualized Care Plan will be used to provide interdisciplinary plan of care for patients according to their history, diagnosis and assessed needs.</p> <p>4. Review of Resident #3's Physicians Orders revealed an order written on 05/13/10 for Novolog insulin per sliding scale schedule #2, a Cat Scan (CT) scan of the pelvis and abdomen and also laboratory orders for a Complete Blood Count (CBC) and Comprehensive Metabolic Panel (CMP).</p> <p>Review of the 05/10 Medication Administration Record (MAR), revealed there was no evidence the order for the Novolog Insulin had been transcribed to the MAR, and no evidence the resident had received the Insulin. According to the sliding scale schedule #2, the resident should have received Novolog Insulin (anti-diabetic agent) per sliding scale</p>	<p>F 281</p>	<p>(RT), Patient Safety Specialist, TCU charge nurse, Dietician, will formerly round on TCU to review patient plans of care, and tour the facility quarterly. This team will assess TCU environment, observe patient care processes, and patient record to ensure professional standards of care maintained in accordance with State requirements.</p> <p>Care plan audits will be completed weekly by the DON to assure completeness. Compliance goal set at 100%. Results to be added to the quality dashboard and presented in the monthly quality meeting.</p> <p>Regarding resident #3, On 5/19/10, the charge nurse called the physician caring for the resident and informed him of the missed orders. The physician came later that day and gave orders at that time of the tests he wanted done presently.</p> <p>Every care plan will be audited every week by the nurse who attends the regularly scheduled care plan meeting. Each patient's plan of care is reviewed a minimum of once per week during this meeting. Weekly audits will also be done by the DON. The care plan audits will consist of reviewing the care plan to ensure that it reflects: diagnosis, current problem list, patient's progress, and current physician orders. The DON will randomly audit 2 charts each week. The weekly auditing by the DON will continue for 6 months. As an on-going Performance Improvement (PI) project, the care plan audits will continue until 100% compliance achieved for 4 consecutive months. The audits by the</p>	<p>07/02/2010</p>
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<p>F281</p>	<p>Continued from page 8</p> <p>eleven (11) times from 4:45 PM on 05/13/10 to 6:06 AM on 05/19/10. Review of the Radiology Reports and Laboratory Data revealed no evidence the CT scan was performed or laboratory specimens obtained.</p> <p>Further interview with the DON on 05/19/10 at 11:45 AM and 05/20/10 10:00 AM, revealed she verified the Physician's Order written on 05/13/10 was missed. She stated each shift the nurse was to check the medical records for Physician's Orders and initial the orders to denote the Orders had been transcribed to the Medication Administration Record (MAR) and scanned to Pharmacy and the Laboratory. Continued interview, revealed at the end of the shift the nurses were to perform a "chart check" to ensure all orders were transcribed on their shift. She stated Registered Nurse #2 was the nurse who was responsible for transcribing the 05/13/10 Physician's Order. She further stated, "All I can say is it is a medication error".</p> <p>Telephone Interview on 05/20/10 at 1:23 PM with RN #2, revealed nurses were to input Physician's Orders to the computer and scan the Orders to pharmacy and the Laboratory. She stated once the Orders were verified in the computer system, the Orders would show up on the MAR. Continued interview revealed witch nurse was to perform twelve hour chart reviews to ensure all Physicians' Order were addressed. RN #2 stated, she did not see the order and did not know how she missed it.</p> <p>Interview with the Physician on 05/20/10 at 9:40 AM revealed he would expect the nurses to follow Physician's Orders.</p> <p>Review of the facility "Receiving/Processing Physician's Orders" Policy, revealed upon receipt of written orders the Registered Nurse/Licensed Practical Nurse or unit secretary should enter all orders into a computerized clinical information system, placing an order number and initials by each order, enter all consults to pharmacy onto the revision screen, and scan//fax all orders to pharmacy, indicating date and time done followed by initials.</p>	<p>F281</p>	<p>nurse who attends the care plan meetings will be continued permanently, as part of the standard procedure.</p> <p>The DON initiated the DWP process for the three (3) nurses directly involved with this omission of physician orders. A Reminder One (1) was given on 06/25/2010 to the LPN assigned to the direct care of the resident the day the omission occurred.</p> <p>On 05/27/2010, a Reminder One (1) was given to the RN who was the charge nurse the day the omission occurred. The physician's orders had not been checked for omissions that day. The DON discussed with the charge nurse the fact that the resident had missed eleven doses of sliding scale insulin; furthermore the resident missed a CBC (lab test) and a CT (Cat scan) of the abdomen. All of these had been ordered by the physician as a necessary part of the resident's care.</p> <p>On 05/28/2010 a Reminder One (1) was given to the LPN assigned to the resident that day. Part of this LPN's responsibility before she left the unit was to check the charts on her assigned residents to assure that all physician orders had been carried out and noted. The DON discussed with the charge nurse the fact that the resident had missed eleven doses of sliding scale insulin; furthermore the resident missed a CBC and a CT of the abdomen. All of these had been ordered by the physician as a necessary part of the resident's care.</p> <p>On 05/29/2010, a Reminder One (1) was given to the LPN</p>	<p>07/02/2010</p>
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F281	Continued from page 9	F281	<p>assigned to this resident on the shift following the one with the omission. This LPN had checked the physician orders for all orders to be carried out and noted, and she had not discovered the omission. The DON discussed with the charge nurse the fact that the resident had missed eleven doses of sliding scale insulin; furthermore the resident missed a CBC and a CT of the abdomen. All of these had been ordered by the physician as a necessary part of the resident's care.</p> <p>On 5/20/2010, the charge nurse checked all the current charts to ensure that all the orders had been noted and completed. No other physician order omissions were found.</p> <p>On 06/01/2010 and 06/03/2010, during TCU unit meetings, the DON informed the nurses that, starting immediately, the chart checks for assurance that all physicians orders have been completed and noted, were to be done during the change of shift. The oncoming and off-going nurses will check the physician orders together to ensure they were implemented. They will document the time and date the chart check took place and will include the names of both nurses participating in the process.</p> <p>The DON will do weekly chart audits to assure that all physician orders are complete. One day a week, randomly selected, the DON will check all the charts, looking for completion of all physician orders. Compliance goal is set at 100%. In the event of non-compliance, the DON will initiate DWP process for the assigned care giver and charge nurse if any patient's record reveals physician orders that were not</p>	07/02/2010
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F281	Continued from page 10	F281	<p>carried out and noted. This process was started the week of 06/07/2010. This process will continue for the remainder of the calendar year.</p> <p>During the TCU unit meetings, scheduled 06/29/2010 and 07/01/2010, both at 7:00 AM, the DON educated 100% of all current TCU nurses on the process to ensure that all physician orders were implemented on every resident. This process includes checking the charts every 12 hours, at change of shift, the off-going nurse will review all physician orders on each resident with the on-coming nurse during their change-of-shift report/hand-off communication. This double-check system will ensure that all physician orders have been completed. Education on this required process was included in the orientation packet that is required for all new hires and agency nurses and provided by their designated preceptors. This will be added to the competency validations for all new hires and agency nurses, and must be completed before their 90 day evaluation.</p>	07/02/2010
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<p>F 323 SS=E</p>	<p>Continued from page 11</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure adequate supervision to prevent accidents for one (1) of five (5) sampled residents (Resident #4). In addition, the facility failed to ensure a safe environment related to items left unattended with could pose a danger to residents.</p> <p>The findings include: 1. Review of Resident #4's medical record revealed diagnoses which included Chronic Obstructive Pulmonary Disease and Lower Extremity Weakness. Review of the Admission Minimum Data Set (MDS) Assessment dated 04/30/10 revealed the facility assessed the resident as having no short or long term memory loss and as having no problems with cognitive skills for decision making. The MDS revealed the facility assessed the resident to be independent with eating, required limited assistance with transfers/ambulation, and required extensive assistance with hygiene/bathing.</p> <p>Review of the Plan of Care dated 05/16/10 revealed the resident had impaired functional status related to Debility and hospitalization. The interventions included breaking Activities of Daily Living into subtasks.</p> <p>During Group Interview on 05/18/10 at 3:00 PM, Resident #4 complained of spilling hot coffee on self and burning self while in the bed earlier that morning. The resident stated the coffee spilled on her/his gown and residents roommate's family notified the nurse.</p> <p>Interview on 05/18/10 at 4:15 PM with Registered Nurse (RN) #2 who was assigned to the Resident #4, revealed she made coffee for Resident #4, every morning from the coffee machine in the</p>	<p>F 323</p>	<p>Resident #4 was checked by the charge nurse for burns; there was no redness on the resident's skin, nor any sign of a burn. The coffee maker was temporarily disconnected until decision was made how to ensure patient safety when drinking hot coffee.</p> <p>After discussion between the TCU director, the DON, and the Foodservice director, the decision was made that the Transitional Care Unit will purchase lids for the hot cups used on the unit, and any hot liquid given to residents from the coffee maker in the nourishment room will have "sippy" lids on them to prevent spillage, yet the residents will be able to drink from them. The unit started using these lids on 06/07/2010.</p> <p>On 05/21/2010 the DON, with the charge nurse reviewed all the residents on the unit and decided that there are none at that time that needed the extra protection. As of 06/07/2010, all new residents will be assessed initially by the admitting nurse for shakiness, or any indication that the extra protection is needed for the lids. In addition to that, the Occupational Therapist (OTR) who conducts the initial OT assessment will incorporate into the assessment the need for extra protection to prevent spilling, and alert the charge nurse, who will in turn assure that all this is put on the dietary screen and include this safety precaution in the patient's plan of care. Dietary will, in turn, apply lids to all hot drinks coming from the cafeteria for all those residents.</p> <p>Protecting the safety of the residents was discussed in the unit meetings held on 06/01/2010 and 06/03/2010. The nurses were instructed by</p>	<p>06/26/2010</p>
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<p>F 323</p>	<p>Continued from page 12</p> <p>nourishment room. She further stated, the resident was "shaky" this morning and she warned the resident the coffee was hot when she left the coffee on the resident's bedside table. Continued interview, revealed the resident's roommate's family yelled at the nurse, to inform her the resident had spilled coffee. The RN stated, the resident had spilled coffee on her/his gown on the chest area and she quickly removed the resident's gown. RN #2 was not sure if anyone monitored the coffee temperatures from the coffee machine in the nourishment room. She further stated, the nourishment room coffee was for residents and visitors. However, Resident #4 was the only resident to drink coffee from the nourishment room machine and one other resident used the machine for hot water for tea. Continued interview revealed the coffee from the nourishment room was not served with a lid. She further stated, the Recreational Therapist monitored the temperature of the food and fluids on the trays with came to the unit from the kitchen.</p> <p>Observation of a skin assessment on 05/18/10 at 4:20 PM revealed the resident had no redness or evidence of a burn.</p> <p>Interview on 05/18/10 at 4:20 PM and 5:00 PM with the Recreational Therapist, revealed she took temperatures of test trays in the facility; however, she stated she did not test the temperature of the coffee from the nourishment room machine. Observation of the temperature of the coffee from the nourishment room coffee machine taken by the Recreational Therapist, on 05/18/10 at 4:20 PM, revealed a temperature of 175 degrees.</p> <p>Interview on 05/18/10 at 4:50 PM with the Director, revealed there was no system in place to monitor the temperature of the hot water or coffee from the machine in the nourishment room and no system in place to monitor the resident's ability to handle hot liquids. He further stated, "hot liquids can cause burns".</p> <p>1. Observation on initial tour on 05/18/10 at 12:40 PM, revealed items sitting on a shelf in the general bathroom including spray bottles of Buckeye Sanicare Quat-64 Disinfectant Liquid, Cavicide Disinfectant/Decontaminate Cleaner, and Oxivir Five. Review of the Material Safety Data</p>	<p>F 323</p>	<p>the DON to assess the residents initially and on an ongoing basis for shakiness, and to add sippy lids to hot drinks to the dietary screen every time deemed necessary. Also, as previously stated, sippy lids will be placed on the cups of all hot liquids given to the residents from the nourishment room. This information was incorporated into the TCU unit specific education, validations, and orientation packet which is required for all new hires and agency staff, and provided by their designated preceptors. This validation process must be completed before their 90 day evaluation.</p> <p>To ensure this process is sustained for all residents, beginning 06/25/2010, charts are monitored daily by the charge nurse to ensure spill assessment completed and safety measures included in care plan if applicable. The DON will audit 2 charts each week to assess for compliance with process. The audit per DON will continue for 6 months. If 100% compliance achieved times 4 consecutive months, the audits by the DON will cease. If compliance goal is not achieved, this will become an ongoing PI project and will continue until compliance for 4 consecutive months achieved.</p> <p>Regarding the items left in the general bath/shower room. The spray bottles of Buckeye Sanicare Quat 64 Disinfectant Liquid, Cavicide disinfectant/decontaminant cleaner, and Oxivir-5 were all removed from the general bathroom. All toiletry items were placed in a caddy on rollers and stored in the supply room across the hallway from the general bathroom. The staff was instructed to roll the caddy to the bathroom when needed, and to return them to the</p>	<p>06/26/2010</p>
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<p>F 323</p>	<p>Continued from page 13</p> <p>Sheet (MSDS), revealed Buckey Sanicare Quat-64, revealed; corrosive, causes irreversible eye damage and skin burns, harmful if swallowed, call a poison control center or doctor immediately for treatment advice. For inhalation, move person to fresh air, if person is not breathing, call 911. Keep out of reach of children. Wear safety glasses or chemical splash goggles, rubber gloves or imperious gloves and protective clothing.</p> <p>Review of the Cavicide MSDS Sheet, revealed contact with eyes could cause reversible damage, low or mild irritation if inhaled, may be harmful if swallowed. Keep out of reach of children.</p> <p>Review of the Oxivier MSDS Sheet, revealed handle in accordance with good industrial hygiene and safety practice, keep out of reach of children.</p> <p>Other items found in an unlocked cabinet in the general bathroom included; Johnson's Baby Shampoo, containing a label which state, Keep out of reach of children, Aloe Vesta Cleanser, containing a label which stated, warning: for external use only, Shave Cream, with a label which stated, avoid spraying in eyes, and keep out of reach of children, and Scope Mouthwash, with a label which stated, in case of accidental ingestion, seek professional assistance or contact a poison control center immediately, keep out of reach of children.</p> <p>Interview on 05/20/10 at 8:30 AM with the Director of Nursing (DON), revealed nursing or occupational therapy cleaned the bathroom using the cleansers in between residents. She further stated, cleaning supplies should not be left in the shower rooms. Continued interview, revealed as far as she knew, toiletries could be left in the shower room; however, sometimes residents did go in the shower room alone.</p>	<p>F 323</p>	<p>locked supply room when not using them.</p> <p>Discussion by the DON in the unit meetings on 06/01/2010 and 06/03/2010 included direction to team that no chemicals, cleaning agents, or toiletries are to be left in the general bathroom. Personal toiletries will be stored in each resident's cabinet or bedside table and all chemicals and cleaning agents will be stored in the secure utility room and housekeeping closet as appropriate. The duty of making sure all chemicals and toiletries are stored in their proper places will be assigned, every shift to a staff member. The proper storage requirements of toiletries and chemicals was added to the orientation /validation packet that must be completed by all new hires and agency nurses. This validation process must be completed before the completion of their 90 day evaluation.</p> <p>Compliance with storage requirements will be audited and recorded by the DON a minimum of 20 times per month. In the event of non-compliance, the assigned staff member will be held accountable using the DWP process: first offense will result in a performance improvement conversation. Second offense will result in Reminder 1. Second offense will result in Reminder 2. Third offense shall result in decision making leave and possible termination. In the event the duty is not assigned, the charge nurse will be held accountable, by the same DWP process.</p>	<p>06/26/2010</p>
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Continued from page 14

F 333  
SS=D

483.25 (m) (2) RESIDENTS FREE OF  
SIGNIFICANT MED ERRORS

The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review it was determined the facility failed to ensure residents were free of significant medication errors for one (1) of five (5) sampled residents (Resident #3).

The findings include:

Review of the clinical record for Resident #3 revealed a Physician's Order dated 05/13/10 for Novolog insulin per Sliding Scale (SS) schedule #2 (<150 = 0 units, 151-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350 = 8 units,> 350 = 10 units). Further record review revealed no evidence the resident received any insulin even though, per the SS schedule, eleven doses should have been administered from 4:45 PM on 05/13/10 to 6:06 AM on 05/19/10.

According to the Fingerstick Blood Sugars, the Novolog Insulin should have been administered per sliding scale as follows: 2 units on 05/12/10 at 10:52 AM for a Blood Sugar (BS) of 186 and 2 units at 8:28 PM for a BS of 189; 2 units on 05/13/10 at 4:45 PM for a BS of 186; 2 units on 05/15/10 at 5:01 PM for a BS of 178 and 2 units at 9:45 PM for a BS of 174; 2 units on 05/16/10 at 4:01 PM for a BS of 179 and 2 units at 9:45 PM for a BS of 185; 4 units on 05/17/10 at 12:08 PM for a BS of 233 and 4 units at 9:10 PM for a BS of 220; 2 units on 05/18/10 at 5:05 PM for a BS of 194 and 2 units at 8:38 PM for a BS of 181; and 2 units on 05/19/10 at 6:06 AM for a BS of 180.

Interview with the Director of Nursing on 05/20/10 at 9:00 AM revealed the resident should have received the Novolog, "all I can say is, it is a medication error" and "by looking at the Glucoscans, the resident should have received insulin many times since it was ordered". She further stated, she felt it was a significant medication error due to "Keeping blood sugars under control is a significant part of taking care of diabetics".

F 333

The charge nurse called the physician caring for the resident and informed him of the missed orders. The physician came later that day and gave orders at that time regarding sliding scale insulin.

On 05/19/2010, the charge nurse and the DON checked all the physician orders on all the current charts for errors and omissions, and none were found.

The DON initiated the DWP process on 3 nurses directly involved with this omission of physician orders.

A Reminder 1 was given on 05/25/2010 to the LPN assigned to the direct care of the resident the day the omission first occurred.

On 05/27/2010, a reminder 1 was given to the RN who was charge nurse the day the omission occurred. The physician's orders had not been checked for omissions that day. The DON discussed with the charge nurse the fact that the resident had missed eleven doses of sliding scale insulin; which could have caused a significant health care risk to the resident.

On 05/28/2010 a reminder 1 was given to the LPN assigned to the resident that day. Part of this LPN's responsibility before she left the unit was to check the charts on her assigned residents to assure that all physician orders had been carried out and noted. . The DON discussed with the charge nurse the fact that the resident had missed eleven doses of sliding scale insulin; which could have caused a significant health care risk to the resident.

07/02/2010

<p>F 333</p>	<p>Continued from page 15</p> <p>Interview on 05/20/10 at 9:40 AM with the Physician, revealed he would expect the nurses to follow the Physician's Orders.</p>	<p>F 333</p>	<p>On 05/29/2010, a reminder 1 was given to the LPN assigned to this resident on the shift following the shift when the omission occurred. This LPN had checked the physician orders for all orders to be carried out and noted, and she had not discovered the omission. The DON discussed with the charge nurse the fact that the resident had missed eleven doses of sliding scale insulin; which could have caused a significant health care risk to the resident.</p> <p>To reduce the risk of medication errors, KDMC requires medication safety education and competency validations for all new hires during orientation and for all current nurses annually. TCU nurses and new hires and agency nurses are required to complete the KDMC Medication Safety annual competency validations. To ensure medication errors do not occur, TCU will follow KDMC protocol and will require nurses to check physician's orders every 12 hours during change of shift to ensure that each medication order is implemented. The chart check process for physician orders was included in the discussion by the DON in the TCU unit meetings on 06/29/2010 and 07/01/2010 and included in the annual TCU competency validations and is included in the orientation packet for all TCU new hires and agency nurses. This orientation packet/validation will be completed before the end of the 90 day evaluation.</p> <p>On 06/01/2010 and 06/03/2010, during TCU unit meetings, the DON informed the nurses that, starting immediately, the chart checks for assurance that all physician's orders have been</p>	<p>07/02/2010</p>
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F 333	Continued from page 16	F 333	<p>completed and noted, were to be done during the change of shift. The oncoming and off-going nurses will check these orders, and both will sign on the order sheet, date and time that the chart check was completed.</p> <p>During the unit meeting on 06/29/2010 and 07/01/2010, the DON will go over the hospital policy, already in place, to ensure medication errors do not occur: The nurse will scan down the original order to the pharmacy. The pharmacy will enter the medication order on the MAR. A nurse will verify the original order with the order entered by the pharmacist on the verification tab. If there is a discrepancy with the order, the nurse will open the electronic intervention and document the details of the discrepancy to initiate verification by the pharmacy. If there is any question regarding a drug prescribed, dose or strength, administration frequency, or dosage interval, a nurse or pharmacist will contact the physician and clarify the questionable orders prior to administering the medication. All medications are administered via the epic system. The residents' arm bands are scanned to assure the resident's name matches with the medication on the MAR. The system will not allow the scanning of any medication that has not been entered by the pharmacy to be administered to the resident. All insulin administration is verified by a second nurse. Any medication error will be reported via SAFE report, to help identify trends and prevent recurring medication orders. The prevention of medication errors will also be incorporated into the unit specific orientation and validations for new hires and agency nurses. This orientation packet/validation</p>	07/02/2010
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F 333	Continued from page 17	F 333	will be completed before the end of the 90 day evaluation.	07/02/2010
F 371 SS=F	<p>483.35 (I) FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY The facility must –</p> <ol style="list-style-type: none"> <li>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</li> <li>(2) (2) Store, prepare, distribute and serve food under sanitary conditions</li> </ol> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to store, prepare, and serve food under sanitary conditions.</p> <p>The findings include:</p> <p>Initial tour of the kitchen on 05/18/10 at 1:00 PM revealed a container of tuna salad in the refrigerator was outdated with a date of 05/14/10, the stainless steel refrigerators and freezers were visibly soiled on the outside with fingerprint smudges and spills, the kitchen walls were soiled throughout the kitchen, two utensil drawers had utensils with handles not facing the same direction, and two staff were noted with hair nets not adequately covering their hair.</p>	F 371	<p>Immediate actions included: On 05/18/2010 Tuna salad was discarded immediately. On 05/18/2010 Refrigerators, freezers, and walls visibly soiled were cleaned immediately. On 05/18/2010 Utensils were re-washed/sanitized and stored properly. On 05/18//2010 Team members were verbally instructed on proper use of hair nets/restraints</p> <p>Actions implemented following survey: 06/09/2010 In-servicing of all Food Service staff by Food Services director included: proper storage of utensils, proper use of hair net/restraint, proper storage of prepared foods, cleaning of soiled walls, freezers, and refrigerators. Master cleaning schedule revised and implemented on 06/09/2010.</p> <p>Dietary sanitation requirements education is a component of the Food Services orientation checklist. All new Food Services staff</p>	06/12/2010

<p>F 371</p>	<p>Continued from Page 18</p> <p>Continued tour of the kitchen on 05/19/10 at 4:45 PM revealed four (4) cooks were observed to be cooking with their bangs not covered by their hair net and the Server was observed to be scooping food with her hair net not covering her bangs.</p> <p>Interview with the Food Service Director on 05/19/10 at 4:45 PM and on 05/20/10 at 1:00 PM, revealed the tuna salad dated 05/14/10 was outdated, and food was only to be kept for three (3) days after it was prepared. He stated the utensils in the drawers were to be facing the same direction to prevent contaminating the utensils when picking them up. Further interview revealed the outside of the refrigerators and freezers were to be cleaned daily and shined weekly; however, he did not think this was being done. Continued interview revealed the kitchen walls were to be washed down daily around the trash cans and were to be power sprayed weekly. He further stated he did not have any logs to refer to in order to ensure these tasks were completed.</p>	<p>F 371</p>	<p>receives the dietary sanitation education from the Food Services Supervisor during the Food Service's department-specific orientation.</p> <p>Plan to ensure violations do not reoccur: Weekly audit to be completed by Production Manager and/or Retail Supervisor, and recorded, to check for outdated items in the refrigerator. A summary of the audit results will be sent to the director of Accreditation and to the TCU DON at the end of each month.</p> <p>Master cleaning schedule to be checked by the Production Supervisor weekly to ensure areas/equipment are cleaned appropriately and signed off by position number. Cleaning schedule developed 05/25 /2010 and implemented 06/11/2010. A summary of the audit results will be sent to the director of Accreditation and to the TCU DON at the end of each month.</p> <p>Weekly audit to be completed by P.M. Patient Services Supervisor and recorded to ensure utensils are stored properly.</p> <p>Daily audit to completed by A.M. Patient Services Supervisor, and recorded, to ensure food handlers have all hair restrained. Development of Audit sheet completed 06/10/2010. A summary of the audit results will be sent to the director of Accreditation and to the TCU DON at the end of each month.</p>	<p>06/12/2010</p>
<p>F 441 SS=D</p>	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the</p>	<p>F 441</p>	<p>The lack of Contact isolation on resident's door was noted on 5/18/2010. DWP by Reminder 1 was implemented to the admitting nurse and to the nurse assigned to that</p>	<p>07/03/2010</p>

<p>F 441</p>	<p>Continued from page 19</p> <p>development and transmission of disease and infection.</p> <p>(a) Infection Control program The facility must establish an Infection Control Program under which it – (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions</p> <p>Continued from page 15</p> <p>from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to maintain an infection control program in order to prevent the development and transmission of disease and infection within the facility.</p> <p>The findings include:</p> <p>Review of Resident #2's medical record revealed diagnoses which included Methicillin Resistant Staph Aureus (MRSA) of the nares.</p> <p>Review of the Physician's Orders dated 05/17/10 revealed Orders to swab the nares for Staph Aureus. If MRSA positive,</p>	<p>F 441</p>	<p>resident on the following shift (night shift). The resident was admitted on 5/17/2010. The isolation equipment was on the door, and the sign was applied as soon as the nurse discovered it was absent. Contact isolation sign placed on the door 05/18/2010 as soon it was noted that it was not on the door as required.</p> <p>On 5/18/2010, all doors were checked by the charge nurse against physician orders for isolation precautions signage. There were no other residents who required isolation precautions without a sign on their door.</p> <p>During the 06/01/2010 and 06/03/2010 unit meetings, Isolation precautions were discussed at length. The DON informed the nursing staff of the surveyor's findings and of her intention to improve compliance with the isolation measures on the unit. Improvements include: The DON met with the infection control nurse on 06/29/2010 at 10:00 AM, to assure the DON has a good understanding of the CDC guidelines for infection control. The DON will audit and record 100% of isolation residents to assure that all isolation guidelines are being followed.</p> <p>During further discussion on 06/09/2010 the KDMC quality director, coordinated with the infection control department to present an official infection control in-service to the TCU staff.</p> <p>Correct observation of Isolation precautions was added to the unit specific competency validations. This will include a mandatory completion of multi drug resistant organisms (MDRO) presentation on KDMC-U, KDMC's online education program. Each staff nurse will complete the program and the post test and present the completion certificate to the DON on or before 06/23/2010.</p>	<p>07/03/2010</p>
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<p>F 441</p>	<p>Continued from page 20</p> <p>initiate contact isolation precautions and begin intranasal</p> <p>Mupirocin to each nostril twice daily for five days.</p> <p>Review of the Plan of Care dated 05/17/10 revealed the resident had an actual infectious process related to MRSA. The interventions included; provide isolation if indicated, maintain good hand washing technique, and educate resident/family on hand hygiene.</p> <p>Observation on tour on 05/18/10 at 12:40 PM revealed there were no gowns and gloves on the front of Resident #2's door, however, there was no signage on the door related to precautions.</p> <p>Observation of Resident #2's door on 05/18/10 at 2:15 PM revealed a sign on the door stating "contact precautions".</p> <p>Interview with Licensed Practical Nurse (LPN) #2 who was assigned to the resident on 05/18/10 at 3:40 PM, revealed Continued from Page 16</p> <p>she had placed a contact precautions sign on the resident's door a few hours ago after noticing there was no signage. She further stated, the resident was on contact precautions for MRSA of the nares.</p> <p>Continued interview revealed anyone entering the room would need to wear gloves and a gown if touching the resident or if touching objects in the room.</p> <p>Further observation on 05/18/10 at 2:15 PM and on 05/19/10 at 2:45 PM revealed Resident #2 was in the bed and was talking with his/her daughter who was sitting in chair next to the resident's bed. The daughter was not observed to be wearing any gown or gloves.</p> <p>Further interview with LPN #2 on 05/18/10 at 3:40 PM, revealed the resident was admitted on 05/17/10 in the evening and she had not educated the resident's daughter related to contact precautions. The LPN was unsure if anyone had educated the daughter on the contact precautions needed.</p> <p>Interview on 05/19/10 at 2:45 PM with the resident's daughter revealed she had not</p>	<p>F 441</p>	<p>Also included in the competency validations are basic isolation techniques, which will also include a post test and verbalization to the valuators regarding the types of isolation, procedure followed, and rationale. The competency validations were completed on 07/01/2010 with 100% compliance.</p> <p>Verbal teaching and provision of written materials for all residents and their family regarding isolation precautions will be initiated on the day of admission, or on the day the need for isolation is determined. There is an isolation letter to patients and family in the Infection Control Manual, section 4 that will be given to isolation residents and/or families. Follow-up teaching will be specific to the organism and type of isolation the resident is in. This information will be obtained from the infection control department.</p> <p>Verbal teaching will be documented in the nurse's notes by the individual nurses. The DON will audit the records of all isolation residents. The goal will be 100% compliance; and the DWP process will be initiated for non-compliance.</p> <p>Beginning 06/14/2010 the Infection Control Department will spend a minimum of 4 hours per week on the TCU for observation and teaching. This is to assure that all isolation precautions are understood and followed.</p> <p>Official infection control in-services were conducted by the Infection Control Nurse. on 06/23/2010 and completed 07/02/2010. These in-services were provided by an infection control nurse, and included teaching the residents and families about isolation precautions. The admitting nurse will explain the rationale for the isolation, and give them a letter from</p>	<p>07/03/2010</p>
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<p>F 441</p>	<p>Continued from page 21</p> <p>been given any instructions related to precautions needed when in</p> <p>the resident's room. She stated she was aware the resident had MRSA of the nare, however, she was unaware she needed to take any precautions.</p> <p>Continued observation on 05/18/10 at 2:45 PM revealed LPN #2 removed Resident #2's indwelling Foley catheter, emptied the urine from the urinary drainage bag into the toilet and discarded the urinary drainage bag. The LPN then removed her gown and gloves and placed them in the hamper in the resident's room, opened the resident's door, and went down the hall and into the soiled utility room. There was no evidence the LPN washed her hands prior to leaving the resident's room or after exiting the resident's room and prior to entering the utility room.</p> <p>Interview on 05/18/10 at 3:00 PM with LPN #2 revealed she thought she had sanitized using the sanitizer on the wall in the hallway across from Resident #2's room. Further interview revealed she should have washed or sanitized her hands after removing the gown and gloves and before leaving the resident's room.</p> <p>Observation of the Director of Nursing on 05/19/10 at 11:45 AM, revealed she removed her gown and gloves while in Resident #2's room, exited the room and entered her office to work on the computer. There was no evidence the DON washed her hands or sanitized after removing the gown and gloves prior to leaving the resident's room or after leaving the resident's room.</p> <p>Interview on 05/19/10 at 11:45 AM with the DON, revealed she should have washed her hands after removing the gown and gloves, but must have forgotten.</p> <p>Continued interview with the DON on 05/20/10 at 9:00 AM revealed she had noticed once in the past a door did not have proper signage, but was unaware Resident #2 did not have proper signage on the door on 05/18/10 related to contact precautions. Continued interview revealed the nurses should have been educating the family on an ongoing basis related to</p>	<p>F 441</p>	<p>KDMC infection control policy, further explaining it. A nurse from IC department is spending a minimum of 4 hours a week on TCU, and doing individual teaching to all TCU department members. She is providing written material, verbal teaching, and observing each team member individually for compliance with isolation measures, teaching and coaching as needed, and providing a post test, with 100% passage required. The deadline for completion by all TCU staff members of this isolation education is set for July 1, 2010. Isolation education completed by 7-1-10. Those team members who have not yet completed this part of their competency validations will not be permitted to work until this is completed. The IC department will continue to spend a minimum of 4 hours a week on TCU for at least the rest of the calendar year, and beyond if deemed necessary, for observation, coaching, mentoring, and teaching. The IC department is putting together a packet for new hires and agency nurses, to be included with orientation and unit specific validation. This packet will include all the necessary isolation requirements and precautions, as well as patient and family teaching, and will be given to all new hires and agency nurses by their preceptors. This requirement will need to be completed during the 90 day evaluation period of the new hires, and with the orientation of agency nurses.</p> <p>The DON or a designee will audit and record 100% of the isolation residents on a weekly basis. This audit will continue until 100% compliance is achieved for 4 consecutive months. Thus audit will include appropriate isolation sign on door, isolation kit on door, staff observed following isolation precautions, Isolation</p>	<p>07/03/2010</p>
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Continued from page 22

precautions needed when entering resident rooms. She stated the nurses should have made Residents #2's family aware of the need to use a gown and gloves when visiting.

The DON further stated, the facility had an annual competency related to infection control and handwashing and an audit was done each month for observation of hand washing. She stated she had not identified any concerns related to handwashing.

Review of the facility's Isolation Policy and Procedure, revealed for Contact Precautions; masks were indicated for Continued from page 26

those who came close to the patient, gowns were indicated if soiling was likely, gloves were indicated for touching infective material, and hands must be washed after touching the patient or potentially contaminated articles and before taking care of another patient.

F 441

precautions ordered by the physician and on EPIC, Isolation precautions appropriately care planned, daily documentation in epic on isolation precautions, and documentation of appropriate teaching on the medical records. The IC department will continue to spend a minimum of 4 hours a week, for observation and teaching, on TCU for at least the rest of the calendar year, and beyond if deemed necessary, for observation, coaching, mentoring, and teaching.

07/03/2010

STATEMENT OF DEFICIENCIES AND PLAN OF ACTION		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION G. BUILDING _____ H. WING _____	(X3) DATE SURVEY COMPLETED 05/20/2010
NAME OF PROVIDER OR SUPPLIER <b>KING'S DAUGHTERS MEDICAL CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2201 LEXINGTON AVE. ASHLAND, KY. 41101</b>	
(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
K 000	INITIAL COMMENTS  A Life Safety Code survey was initiated and concluded on 05/20/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a "F".	K 000		
K155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8  The STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure a documented record of a fire watch was in place according to NFPA standards, when the fire alarm system was out of service for more than four hours in a twenty-four hour period.  The findings include:  On 05/20/2010 at 10:42 AM during record review, the Plant Operations Manager was unable to provide a documented record for evacuation of the facility or setting up an approved fire watch on 03/08/10 through 04/12/10 when the fire alarm system was out of service for more than four hours in a 24-hour period.	K 155	KDMC's Interim Life Safety Policy does include provisions for providing alternate protection when the fire alarm or sprinkler system is out of service for more than 4 hours in a 24-hour period. The most common practice is to establish a fire watch, in areas that are without these life safety systems and notification of the local fire department of the extended outage.  KDMC follows the intent of this policy as well as the NFPA 101 Life Safety Code. The fact that notification of the fire watch was in place on 5/20/10 was verified with Security and the Switchboard, however written documentation was insufficient to support hourly rounding. In response to this issue, the following plan of correction will be implemented:  •1 Additional education for the completion of the time line on the fire alarm isolation log initiated 06/07/2010.	06/08/2010
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		DATE
<i>Lynn Ann Boushka RN, CIC, Director of Accreditation &amp; Regulatory Affairs</i>				07/07/2010

**RECEIVED**  
JUL \* 7 2010

STATEMENT OF DEFICIENCIES AND PLAN OF ACTION		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION I. BUILDING _____ J. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER <b>KING'S DAUGHTERS MEDICAL CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2201 LEXINGTON AVE. ASHLAND, KY. 41101</b>		
(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
K 155	<p>Continued From page 1</p> <p>An interview with the Plant Operations Manager on 05/20/10 at 10:42 AM revealed the facility had a policy for fire watch if the fire alarm system was down for more than four hours in a 24-hour period, but that he could not show documented proof for how long the fire watch was performed. The Plant Operations Manager agreed with the findings and stated that changes would be made in the way fire watch was documented.</p> <p>Reference: NFPA 101 (2000edition) 9.6.1.8*</p> <p>Where a required fire alarm system is out of service for more than 4 hours in a 24- hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.</p>	K 155	<ul style="list-style-type: none"> <li>●2 All fire watches will be documented on the revised "Fire watch Rounding Log" including hourly rounding.</li> <li>●3 Review of the process for the required testing of the Fire Alarm system initiated 05/20/2010 to improve documentation of areas of testing, time frames and notifications of authorities.</li> </ul> <p>Audits, per Plant Operations Department, of this process will be conducted monthly and reviewed by the Life Safety Officer to gauge effectiveness.</p>	06/08/2010