

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

PRINTED: 01/29/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/15/2015
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NAME OF PROVIDER OR SUPPLIER  BRIDGE POINT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPOINT DRIVE FLORENCE, KY 41042
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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 000	INITIAL COMMENTS  A Recertification Survey was initiated on 01/13/15 and concluded on 01/15/15. Deficiencies were cited with the highest Scope and Severity of an "E".	F 000	<p>"This plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, Bridge Point Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency."</p> <p>F241</p> <p>1. It is the practice of this facility to 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>Residents in rooms 209, 212-A, 220-A and 221-B indwelling catheters bags were covered with dignity bags to ensure that the urinary drainage bags were not in full sight of other residents, visitors and family on 1/13/2015 by Unit Managers.</p>	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's "Resident Rights for the State of Kentucky", it was determined the facility failed to promote care for residents in a manner and environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality.  Observation during the initial tour of the facility revealed five (5) of the thirteen (13) residents having indwelling urinary catheters had their urine drainage bags uncovered and in full sight of other residents, visitors and family.  The findings include:  Review of the facility's "Resident Rights for the State of Kentucky" dated 01/01/14, revealed each resident would be treated with consideration respect, and full recognition of his or her dignity and individuality, including privacy in treatment and in care for his or her personal needs.	F 241		

3 - 9 2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chick Jones TITLE: Administrator (X6) DATE: 2-9-15

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

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F 241	Continued From page 1  Observation during the initial tour of the facility, on 01/13/15 at 11:00 AM, revealed residents in rooms 201-A, 209, 212-A, 220-A and 221-B to have indwelling urinary catheter drainage bags uncovered and in full sight of other residents, staff, visitors and family.  Interview with Certified Nursing Assistant (CNA) #3, on 01/15/15 at 6:05 PM, revealed the urinary catheter drainage bags should be covered in a blue privacy bag. Per interview, covering the drainage bags was done for the dignity of the resident.  Interview with Unit Manager (UM) #7, on 01/15/15 at 4:15 PM, revealed dignity/privacy bags for urinary drainage bags should be used to ensure the resident's dignity and privacy. Further interview revealed leg bags should be used when possible for residents who were out of their beds.  Interview with the Director of Nursing (DON), on 01/14/15 at 3:32 PM, revealed the facility did not have a policy specific to dignity of a resident requiring a catheter bag; however, her expectation would be for indwelling urinary catheter bags to be placed inside a privacy/dignity bag and not in full view of other residents, family and visitors.  Interview with the Administrator, on 01/15/15 at 7:15 PM, revealed the facility did not have a policy specific for urinary catheter bag coverage, however her expectation was for the urinary catheter bags to be placed in a dignity/privacy bag to preserve the resident's dignity and privacy.	F 241	2. All residents of the facility who have catheter bags have the potential to be affected. Audit Completed by the 100 hall, 200 hall and 300 hall Nurse Unit Managers on 1/13/2015 revealed no further privacy or dignity issues with residents who require use of a catheter bag.  3. All nurses and nursing assistants will be provided reeducation per the Director of Nursing, and the Nurse Practice Educator about dignity and respect of our residents including use of dignity bags over indwelling catheter bags at all times on or before 2/25/2015. A posttest will be provided to staff by Nurse Practice Educator validate understanding. Staff not available during this timeframe will be provided reeducation upon return to work by the Nurse Practice Educator or Director of Nursing.  The need for use of a dignity bag will be included on the "care cards" which each resident has in place to ensure all individualized needs are being met. The nursing assistants and nurses will utilize the care cards when providing care to be aware that residents who have an indwelling catheter need a dignity bag.		
F 253	483.15(h)(2) HOUSEKEEPING &				

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<p>F 253 SS=E</p>	<p>Continued From page 2 MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure housekeeping and maintenance services were provided to maintain a sanitary, orderly and comfortable interior. Observation of the facility's community shower rooms revealed: cracked, broken or missing tiles; one (1) toilet had a continuous flow of water to the toilet and a water-like substance leaking from the back of the toilet at the base; one (1) shower chair to have a brownish/black substance on the chair; one (1) full and overflowing trash bin; and one (1) full and overflowing uncovered linen bin. Observation revealed four (4) resident rooms had a dried brownish substance at the base of the toilets. Additionally, observation of the Chapel environment revealed nineteen (19) ceiling tiles with a brownish stain and the wall had a brownish vertical stain from the ceiling to floor.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Cleaning and Disinfecting", revised on 07/01/14, revealed cleaning and disinfecting of resident care items and environment should be cleaned of all foreign materials such as blood, feces, dust and dirt before disinfecting. Further review revealed multi-use equipment should be cleaned and disinfected between residents.</p>	<p>F241</p>	<p>Utilizing an audit tool the Nursing Managers of each unit will complete an audit of dignity bag use daily for two weeks, then three times a week for two weeks then two times a week for one month. Any concerns will be addressed immediately.</p> <p>4. A summary of findings will be submitted by the Director of Nursing to the monthly Performance Improvement Committee by the Director of Nursing consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager, and Dietary Supervisor for further review and recommendations.</p> <p>5. Completion Date 2/26/2015</p> <p>F253</p> <p>1. It is the practice of this facility to provide housekeeping and maintenance services necessary to maintain sanitary, orderly, and comfortable interior for our residents. The cracked, broken or missing tiles in the community shower rooms on the 100 and 300 halls will be repaired by maintenance staff by 2/25/2015. The toilet in the 100 shower room was fixed by the</p>	
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F 253	<p>Continued From page 3</p> <p>Review of the facility's policy titled, "Linen Handling", dated 09/01/04, revealed staff should maintain an appropriate and adequate system for containing soiled linen. Further review revealed the containers should be clean and disinfected, have lids in place and should not be over filled.</p> <p>Review of the facility's policy titled, "Waste Management", dated 09/01/04, revealed waste containers should be closable, puncture resistant and leak proof. Continued review revealed staff should remove waste for final disposition at least once daily.</p> <p>Observation of the community shower rooms during initial tour of the facility, on 01/13/15 at 11:00 AM, revealed the 100 and 300 Hall community shower rooms had cracked, broken or missing tiles. Observation in the 100 Hall community shower room revealed a toilet had a continuous water flow with a water-like substance leaking from the base of the toilet. Continued observation of the 100 Hall community shower room revealed it also contained one (1) uncovered full and overflowing trash bin and one (1) uncovered full and overflowing soiled linen bin. Observation of the 200 Hall community shower room revealed a resident shower chair with a brownish substance on the chair. Further observation during the initial tour revealed; resident rooms 201, 207, 208 and 210 had a dried brownish substance at the base of the toilets; the Chapel area had nineteen (19) ceiling tiles with a brown stain and a wall in the Chapel had a brownish vertical stain from ceiling to floor.</p> <p>Interview with Certified Nursing Assistant (CNA) #2 on 01/13/15 at 11:25 AM, revealed the</p>	F 253	<p>Maintenance Director on 1/14/2015. The shower chair in the 200 hall community shower room was cleaned by nursing on 1/13/2015; the trash bin was emptied and linen bins covered immediately, by nursing on 1/13/15. Resident rooms # 201, 207, 208, and 210 were deep 1/17/2015. The stains in the chapel are from roof related leaks, the facility received one bid on 2/2/15, and will receive a second bid on 2/12/2015. The facility will contract with one of the contractors, and will complete the repairs as quickly as possible. Upon completion of roof repairs, the facility will repair/replace the ceiling tiles and vertical wall stains.</p> <p>2. All residents of the facility have the potential to be affected. The Maintenance Director and Administrator will complete rounds by 2/25/2015 to observe for condition of shower rooms, for broken, missing tiles, cleanliness of shower chairs, trashcans covered and not overflowing, covered linen bins, toilets in resident rooms with corrective action if needed including a plan</p>	
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F 253	<p>Continued From page 4</p> <p>brownish/black substance should have been cleaned off the shower chair and the shower chair then disinfected. Further interview revealed housekeeping staff would disinfect the chairs or CNAs could use Clorox wipes. CNA #2 stated the brownish/black substance should not have been left on the shower chair.</p> <p>Interview with a Housekeeping Aide on 01/13/15 at 11:15 AM, revealed housekeeping staff cleaned and disinfected shower chairs when the shower room was cleaned daily or whenever a CNA asked them to disinfect the shower chairs. Per interview, housekeeping staff cleaned and mopped residents' rooms and bathrooms daily. Housekeeping Aide #1 stated there should not be a dried brownish substance at the base of the toilets in residents' bathrooms.</p> <p>Interview with CNA #1 on 01/15/15 at 2:30 PM, revealed shower chairs were to be rinsed off after each use and disinfected with Clorox wipes or housekeeping asked to disinfect the chairs. Per interview, this was not homelike and CNA #1 would not want to take a shower on a shower chair if it was not clean. Additional interview revealed the trash and linen containers were to have lids on them and they should not be overfilled and overflowing.</p> <p>Interview with CNA #3, on 01/15/15 at 6:05 PM, revealed the shower chair should have been cleaned and sanitized after each resident use. Per interview, the trash and soiled linen containers should have had lids on them, and the containers should be emptied after each shift. CNA #3 revealed this was not homelike for residents.</p>	F 253	<p>for repairs if indicated. The maintenance Director will complete audit of facility for roof leaks by 2/16/15 to ensure no additional roof stains with corrective action if indicated.</p> <p>3. The Director of Nursing, Nurse Practice Educator, and Housekeeping supervisor will reinservice all nurses, aides and housekeeping staff on the expectation of providing an interior environment that is sanitary, orderly, and comfortable for our residents' including completion of work orders if indicated by 2/25/15. A posttest will be provided to staff by Nurse Practice Educator to validate understanding to validate understanding. Staff not available during this timeframe will be provided reeducation upon return to work by the Nurse Practice Educator or Director of Nursing.</p> <p>Utilizing an audit tool, the housekeeping Manager, and 100 hall, 200 hall, and 300 hall Nurse managers across all shifts daily for two weeks, then three times a week for two</p>		

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F 253 Continued From page 5

Interview with Unit Manager (UM) #7, on 01/15/15 at 4:15 PM, revealed the CNA's were responsible for cleaning and disinfecting the shower chairs between resident use. UM #7 revealed the shower chair should have been cleaned and left ready for another resident's use. Continued interview revealed soiled linen and trash should be in a bag in a container with a lid and should not be overflowing. Further interview revealed this was not a home-like environment.

2. Review of the facility's policy titled, "Routine Maintenance" revised 06/01/07, revealed requests for routine maintenance would require a work order which would be picked up on a pre-determined schedule. The Policy revealed the work would be prioritized with completed work orders filed and maintained for one (1) year.

Interview with CNA #3, on 01/15/15 at 6:05 PM, revealed the damaged tiles in the shower rooms should have been reported to the supervisor for a work order to be placed for maintenance.

Continued interview with Unit Manager (UM) #7, on 01/15/15 at 4:15 PM, work orders were to be put on the clipboard for maintenance. UM #7 revealed for issues which required more timely service, the work order should be placed in the maintenance mailbox. Continued interview revealed the damaged or missing tiles should have been reported to maintenance for repair.

Interview with the Maintenance Director, on 01/15/15 at 10:40 AM, revealed the maintenance department made rounds six (6) days per week and picked up work orders during their rounds. Per interview, there was no work order request for the tiles to be replaced and he was not aware

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weeks then two times a week for one month then as determined by the monthly Performance Improvement Committee with corrective action upon discovery including completion of work orders if indicated.

4. A Summary of findings will be submitted by the housekeeping manager and unit managers to the monthly Performance Improvement committee consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager, and Dietary Supervisor for further review and recommendations.

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F 253	Continued From page 6 the tiles were missing or damaged in the shower rooms and Chapel area. Further interview revealed he did receive a work order for the toilet repair in the 100 Hall shower room on 01/14/15, and the toilet had been repaired.  Interview with the Director of Nursing (DON), on 01/15/15 at 4:00 PM, revealed the damaged tiles should have been reported to be repaired. Further interview revealed the trash and soiled linen containers should not have been overflowing and should have been covered with a lid. Further interview revealed the CNA's should clean the shower chairs after each resident use with bleach or sani-wipes. Continued interview revealed this was not a clean and homelike environment.	F 253			
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's policy and review of the Kentucky Board of Nursing (KBN) Advisory Opinion Statement (AOS), it was determined the facility failed to assure the administration of oral medication met professional standards of quality for five (5) unsampled residents (Unsampled Resident C, Unsampled Resident D, Unsampled Resident E, Unsampled Resident F and Unsampled Resident G) of the twenty-four (24) sampled and seven (7) unsampled residents.	F 281	F281 1. It is the practice of this facility to provide professional standards of quality. The LPN (#1) was reeducated by the Director of Nursing regarding the facility policy for oral medication administration and the expectation to observe the resident take the medication 1/14/2015. Upon interview 1/14/2015 by the Director of Nursing unsampled residents F, D, G, C, and E stated that they did take their medications when administered.		

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F 281	<p>Continued From page 7</p> <p>Observation during medication pass revealed Licensed Practical Nurse (LPN) #1 placed medication in medication cups, then took the medication in the cups to the residents' rooms placing the medication cups on the residents' bedside tables. LPN #1 left the residents' rooms without staying and observing the residents' take their medications to ensure the medication was taken.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Medication Administration: Oral", revised 01/02/14, revealed under Guideline #3 after giving the resident a medication the person administering the medication was to stay with the resident until the drug had been swallowed.</p> <p>Review of the KBN AOS #14 regarding Patient Care Orders, revised October 2010, revealed Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) were responsible for the administration of medication or treatment as authorized by a Physician, Physician Assistant, or Advanced Practice Registered Nurse (APRN). Review revealed components of medication administration included, but were not limited to, preparing and giving medication in the prescribed does, route and frequency.</p> <p>1. Observation on 01/14/15 at 4:00 PM, during the afternoon medication (med) pass on the 100 hallway, which was the Rehabilitation (Rehab) hallway, revealed LPN #1 placed two (2) scheduled oral medication tablets in a medication cup, took the medications in the cup to Unsampled Resident F's room where she put the cup on the bedside table. Continued observation</p>	F 281	<p>2. All residents of the facility have the potential to be affected. Audit completed by the Unit managers on 100 Hall, 200 Hall and 300 Hall and Nurse Practice Educator revealed no other residents had medications left at the bedside on 1/14/2015.</p> <p>3. The Director of Nursing, or Nurse Practice Educator will reeducate all nurses on the facilities policy for oral medication administration including observation of the resident taking the medication and a posttest will be given by the Nurse Practice Educator to validate understanding by 2/25/2014. Staff not available during this timeframe will be provided reeducation upon return to work by the Nurse Practice Educator or Director of Nursing.</p> <p>The 100 hall, 200 hall, and 300 hall Nurse Managers, Nurse Practice Educator or Director of Nurses will utilize an audit tool to monitor the nurse remains with the resident when administering medications daily across all shifts for two weeks, then three times a week for two weeks, then as determined by the monthly Performance Improvement Committee. Any concerns will be addressed immediately.</p>		

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F 281	<p>Continued From page 8</p> <p>revealed LPN #1 left the resident's room and did not stay to observe Unsampld Resident F take his/her medication. LPN #1 was observed to return to the medication cart and document the medication as administered even though she had not observed Unsampld Resident F take the medication.</p> <p>2. Observation on 01/14/15 at 4:05 PM, during the afternoon med pass on the 100 hallway, revealed LPN #1 placed one (1) scheduled medication tablet for Unsampld Resident D in a medication cup, took the medication cup to the resident's room and placed the cup on the bedside table. Continued observation revealed LPN #1 left the resident's room and did not stay to observe Unsampld Resident D take his/her medication. LPN #1 was observed to return to the medication cart and document the medication as administered even though she had not observed Unsampld Resident D take the medication.</p> <p>3. Observation on 01/14/15 at 4:12 PM, during the afternoon med pass on the 100 hallway, revealed LPN #1 placed one (1) scheduled medication tablet for Unsampld Resident G in a medication cup, took the medication cup to the resident's room and placed the cup on the bedside table. Continued observation revealed LPN #1 left the resident's room and did not stay to observe Unsampld Resident G take his/her medication. LPN #1 was observed to return to the medication cart and document the medication as administered even though she had not observed Unsampld Resident G take the medication.</p> <p>4. Observation on 01/14/15 at 4:20 PM, during</p>	F 281	<p>4. A summary of findings will be submitted by the unit managers to the monthly Performance Improvement Committee consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager, and Dietary Supervisor for further review and recommendations.</p> <p>5. Completion date: 2/26/2015</p>		

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F 281	Continued From page 9 the afternoon med pass on the 100 hallway, revealed LPN #1 placed one (1) scheduled medication tablet for Unsampled Resident C in a medication cup, took the medication cup to the resident's room and placed the cup on the bedside table. Continued observation revealed LPN #1 left the resident's room and did not stay to observe Unsampled Resident C take his/her medication. LPN #1 was observed to return to the medication cart and document the medication as administered even though she had not observed Unsampled Resident C take the medication.  5. Observation on 01/14/15 at 4:30 PM, during the afternoon med pass on the 100 hallway, revealed LPN #1 placed three (3) scheduled medication tablets for Unsampled Resident E in a medication cup, took the medication cup to the resident's room and placed the cup on the bedside table. Continued observation revealed LPN #1 left the resident's room and did not stay to observe Unsampled Resident E take his/her medication. LPN #1 was observed to return to the medication cart and document the medication as administered even though she had not observed Unsampled Resident E take the medication.  Interview with LPN #1 on 01/14/15 at 5:30 PM, revealed she was aware of the facility's medication administration policy for oral medication and the need to observe the resident take their medication. However, she stated she was "not aware" she wasn't doing that. Per interview, she would make sure she didn't "do it again", in reference to leaving medications at residents bedsides and not watching them take the medications.	F 281			

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F 281	Continued From page 10  Interview with RN #1 on 01/15/15 at 3:20 PM, revealed it was her expectation for all nurses to remain present in a resident's room during the administration of oral medication. RN #1 stated she by doing so the nurse was observing and ensuring the resident swallowed the medication and the medication administration was successful.  Interview with the Director of Nursing (DON) on 01/15/15 at 6:30 PM, revealed it was her expectation for all of her nurses to observe residents swallowing their medications during the med pass. According to the DON, it would be a concern if medications were left unattended in a resident's room and a confused resident wandered into that resident's room. She stated the Staff Development Nurse (SDN) checked nursing staff off on medication administration during orientation, and reviewed this information during the facility's yearly in-services.	F 281			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's Manufacturer Safety Data Sheets	F 323	F323 1. It is the practice of this facility to 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.  The disposable razor was removed from the 300 hall shower by the unit manager on 1/13/2015. The two containers of anti-fungal cream and the two bottles of shampoo products were removed from the unlock cabinet by the unit manager on 1/13/2015. 2. All residents of the facility have the potential to be affected. Audit for razors, anti-fungal creams and shampoos to ensure appropriate storage was completed on 1/14/2015 by the Nurse Practice		

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F 323	<p>Continued From page 11</p> <p>and policy, it was determined the facility failed to ensure the environment was as free from accident hazards as possible for facility residents. Observation revealed disposable razors in the 300 Hall shower room on top of a paper towel dispenser and in a resident's room on the sink counter and in an unlocked plastic container. Additionally, anti-fungal medications and shampoos were observed on the 300 Hall in an unlocked cabinet accessible to residents.</p> <p>The findings include:</p> <p>1. Observation during the initial tour of the facility on 01/13/15 at 11:00 AM, revealed an unlocked cabinet in the 300 Hall shower room which contained two (2) containers of anti-fungal cream and two (2) bottles of shampoo products accessible to residents.</p> <p>Review of the facility's MSDS for Remedy Antifungal Powder, dated 11/08/12, revealed combustion of this product might produce carbon monoxide and or carbon dioxide. Continued review revealed the product could be an inhalation hazard, and if ingested to seek medical attention. Review revealed if contact with eyes occurred flush eyes with plenty of water for at least fifteen (15) minutes and seek immediate medical attention.</p> <p>Review of the facility's MSDS for Suave Shampoo, dated 07/10/07, revealed the product was incompatible with strong oxidizers, acids or bases. Further review revealed it might cause redness or irritation to the eyes, redness to the skin and if ingested might cause nausea, vomiting and diarrhea.</p>	F 323	<p>Educator and unit managers on 100 hall, 200 hall, and 300 hall. No further areas of concern were noted.</p> <p>3. All Nursing staff will be reeducated by the Director of Nursing or Nurse Educator regarding proper storage of potentially hazardous items by 2/25/2015. A posttest will be provided to staff by Nurse Practice Educator to validate understanding. Staff not available during this timeframe will be provided reeducation upon return to work by the Nurse Practice Educator or Director of Nursing.</p> <p>Utilizing an audit tool, the 100 hall, 200 hall and 300 hall Nursing Managers/or designee will monitor resident rooms, and shower rooms for potentially hazardous items daily for two weeks, then three times a week for two weeks, then two times a week for one month. Any concerns will be addressed immediately.</p>		

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F 323	<p>Continued From page 12</p> <p>Continued interview with the Director of Nursing (DON), on 01/15/15 at 5:52 PM, revealed she would have to research to ascertain if the facility had a policy specific for safe chemical storage; however, her expectation for shampoo products and anti-fungal products was for them to be stored in a locked area and not accessible to residents. Further interview revealed the anti-fungal product and shampoo products could be a potential hazard for some of the facility's residents if they gained access to them.</p> <p>2. A policy was requested for safe sharps storage and handling and a facility policy titled, "Needle Handling and Sharps Injury Prevention", revised 03/01/12, was received. However, review of the policy revealed it did not address safe storage of sharps.</p> <p>Continued observation during the initial tour of the facility, on 01/13/15 at 11:00 AM, revealed a bag of ten (10) disposable razors lying unsecured on top of a paper towel dispenser in the 300 Hall shower room accessible to residents. Continued observation revealed disposable razors in resident room 211, unsecured with one (1) lying on the sink counter and one (1) visible stored in an unlocked clear plastic container.</p> <p>Interview with the Director of Nursing (DON), on 01/15/15 at 5:52 PM, revealed the facility did not have a specific policy related to storage of disposable razors; however, her expectation was for disposable razors be kept locked in a storage closet and not accessible to residents. Further interview revealed the razors could be a potential hazard for some of the facility's residents if they gained access to them.</p>	F 323	<p>4. A summary of findings will be submitted by the unit managers to the monthly Performance Improvement Committee consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager, and Dietary Supervisor for further review and recommendations.</p> <p>5. Completed on: 2/26/2015</p>	

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F 323 Continued From page 13  
Interview with the Administrator, on 01/15/15 at 7:15 PM, revealed the disposable razors should not have been accessible to residents. Further interview revealed disposable razors should be stored in a locked environment and secured away from residents for resident safety. Per interview, the razors should be used with staff supervision and disposed of properly after use.

F 323

F 366  
SS=D 483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE

F 366

Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.

F366  
1. It is the practice of this facility to ensure each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. All residents' likes and dislikes are determined within 48 hours of admission and updated quarterly or upon request.

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 offer food substitutions for one (1) of twenty-four (24) sampled residents and one (1) unsampled resident (Unsampled Resident A). Observation during a lunch meal service revealed a vegetable listed as a dislike for Unsampled Resident A was served to the resident without regard to his/her pre-established food preferences.

Unsampled resident A's dislikes were reviewed by the Dietary supervisor with the dietary staff on duty on 1/13/2015 regarding need to follow the residents preferences listed on the tray card when preparing tray.

The findings include:  
Review of the facility's policy titled, "3.4 Food Preferences" revised 06/05/13, revealed the Food Service Director or designee would visit residents within forty-eight (48) hours of admission to the facility to determine his/her food preferences. The Policy revealed food preferences would be updated at a minimum of

2. All residents of the facility have the potential to be affected. An audit of tray cards by the Dietary Supervisor to ensure all tray cards are updated for current likes/dislikes will be completed by 2/25/2015 with corrective action if indicated.

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F 366	Continued From page 14 quarterly. Continued review revealed food preferences would be accommodated whenever possible regarding individual residents eating habits, cultural and religious preferences. Per the Policy, Food and Nutrition Service staff would carefully read tray tickets during meal service with preferences served and substitutions provided for residents disliked items.  Observation during the lunch meal service, on 01/13/15 at 12:17 PM, revealed Unsampld Resident A to have Brussels sprouts present on his/her tray. Continued observation revealed Unsampld Resident A consumed almost one hundred percent of his or her meal, with the exception of the serving of Brussels sprouts. Review of Unsampld Resident A's meal card at the time of observation which was delivered with the resident's lunch meal, revealed under dislikes Brussels sprouts was included.  Interview with Unsampld Resident A, on 01/13/15 at 12:17 PM, at the time of observation, revealed he/she did not like Brussels sprouts and had informed the facility of this information. However, Unsampld Resident A stated "it happens all the time" in regards to receiving disliked food.  Interview with the Dietary Manager, on 01/13/15 at 12:23 PM, revealed the facility did pre-establish a resident's likes and dislikes upon admission, and these should be honored. Continued interview revealed Unsampld Resident A should not have been served the Brussels sprouts as it was noted to be a dislike. Further interview revealed Unsampld Resident A should have received the cucumber salad as a substitution or the resident asked for his/her preference	F 366	3.The dietary supervisor will rein-service all food service workers regarding the facilities policy on food preferences to include offering of substitutes for residents' disliked items by 2/25/2015. A posttest will be given by Dietary Supervisor to validate understanding.  Utilizing an audit tool, the dietary supervisor or dietician will monitor for tray accuracy by comparing the pre-established food preferences with the completed tray. The audit will also include monitoring for substitutions being offered when residents dislike items. The audit will be completed daily for two weeks, then three times a week for two weeks, and then as determined by the monthly Performance Improvement Committee Any concerns will be addressed immediately. 4. A summary of findings will be submitted The Dietary Supervisor to the monthly Performance Improvement Committee consisting of Ad-ministrator, Director of Nursing, Maintenance Director, Business Of- fice Manager, and Dietary Supervi- sor for further review and Recommendations 5. Completion date: 2/26/2015		

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F 366	Continued From page 15 regarding a substitution.	F 366		
F 371 SS=F	<p>Interview with the Administrator, on 01/15/15 at 7:15 PM, revealed food preferences should be honored with residents not served a pre-established disliked food. Per interview, substitutions should be made.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy and audit tools, it was determined the facility failed to ensure dietary staff adhered to proper sanitation practices during food preparation.</p> <p>Observation of a sanitation bucket sanitizing solution test revealed the test strip was left in the sanitizing solution for three (3) seconds instead of the manufacturer's recommended ten (10) seconds, and the strip did not change color to indicate the solution was within the recommended level. Additionally, testing of another sanitizing bucket solution revealed the sanitizing solution to be below the recommended level.</p>	F 371	<p>F371</p> <p>1. It is the practice of this facility to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and to store, prepare, distribute and serve food under sanitary conditions.</p> <p>On 1/13/2015 the dietary supervisor immediately initiated steps to ensure dietary staff adherence to proper sanitation practices during food preparation, and prepared a new sanitation bucket with sanitizing solution which tested within the recommended levels. This bucket was used while cleaning the kitchen until close of service.</p> <p>2. All residents of the facility who consume food prepared from the kitchen have the potential to be affected. The Dietary Manager observed dietary employees process for testing sanitizing solution with corrective action if indicated on January 16, 2015.</p>	

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F 371	Continued From page 16  The findings include:  Interview with the Dietary Manager (DM), on 01/15/15 at 3:30 PM, revealed the facility did not have a policy regarding testing of the sanitizing solution in the sanitation buckets.  Review of the facility's policy titled, "Manual Warewashing and Sanitizing", revised 10/01/10, revealed the purpose of the policy was to "ensure all food preparation equipment and serviceware" were cleaned and "sanitized". The Policy revealed if the facility was using a quaternary product (a chemical sanitizing solution) a two (2) inch test strip was to be held in the sanitizing solution for (10) seconds and the strip color was to be checked against the strip container. Per the Policy, the color of the strip should darken to a range of 150 to 400 parts per million (ppm) for proper sanitizing solution strength. Continued review revealed corrections were to be made prior to using the sanitizing solution if the test strip did not turn the appropriate color indicating the solution was within the recommended range.  Observation on 01/13/15 at 11:15 AM the sanitizing solution in the sanitation buckets used in the front food preparation (prep) area and the back food prep area of the kitchen, revealed the sanitizing solution in the sanitation buckets to be clear. Continued observation revealed when the DM checked the sanitizing solution in the two (2) sanitation buckets revealed the test strips did not change color to indicate the solution was within the recommended range. Observation revealed the DM did not leave the test strips in the sanitizing solution for the manufacture's recommended ten (10) when she performed the	F 371	3. On 1/13/15 the dietary supervisor immediately began reeducation of all dietary staff regarding the facility's policy and the expectation to adhere to proper sanitation practices to be completed by 2/25/2015. A posttest will be given to validate understanding by the dietary supervisor.  A log is being utilized which requires that the sanitized water be changed and tested after each meal and as needed throughout the day. The log will be kept for proper documentation. Any concerns will be addressed immediately.  The dietary supervisor will conduct an audit daily for two weeks, three times a week for two weeks, then weekly for a month then as determined by the monthly Performance		

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F 371	Continued From page 17 testing. The DM and dietary staff were not able to locate the test strip container to compare the tested strip against the strip container. Further observation on 01/13/15, at 6:30 PM, of a check of the sanitizing solution of the front food prep sanitation bucket, revealed the sanitizing solution was clear, and the test strip results were 0 ppm when compared to the test strip container which had been located.  On 01/13/15, after the performance of the 6:30 PM test strip check of the front food pre area sanitation bucket, review of the test strip documentation log for the morning test on 01/13/15, untimed, revealed Dietary Aide (DA) #1 had recorded the results as 150 ppm, the minimum recommendation. Further review of the log revealed no documented evidence the sanitizing solution in the sanitation buckets had been tested at "noon" and "evening" which were also areas on the log.  Interview with DA #1 on 01/13/15 at 11:20 AM, revealed she was aware the test strip for the sanitizing solution should be left in the solution for ten (10) seconds and needed to indicate at least 150 ppm. She stated after performing the checks of the sanitation buckets that morning, she had put the test strip container on the sink and she didn't know where the container was now. Per interview, the DM found a strip container in her office desk, and the sanitation buckets were filled with fresh sanitizing solution and re-tested, with the test strips indicating the solution was barely 150 ppm, per the color of the test strip.  Interview with Cook #1, on 01/13/15, at 6:35 PM, revealed he had come in approximately 12:30 PM that day, and one of his duties when he arrived	F 371	Improvement Committee with corrective action upon discovery.  4. A summary of findings the Dietary Supervisor will be submitted to the monthly Performance Improvement Committee consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager, and Dietary Supervisor for further review and recommendations.  5. Completion date: February 26, 2015	
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F 371	<p>Continued From page 18</p> <p>for his shift was to change and test the sanitation bucket solution. Continued interview revealed he was also supposed to change and test the sanitation bucket solution before supper meal service started. He stated however, he had not changed the sanitation bucket solution at all on 01/13/15. Cook #1 indicated it could be a cross contamination issue if the proper sanitation level was not followed.</p> <p>Interview with the DM, on 01/15/15, at 4:02 PM, revealed the first sanitization buckets were prepared about 5:30 AM, after the day shift person came in. The DM stated the sanitizing bucket solution was then changed again around the lunch and supper meal services. Per interview, she liked the sanitizing solution to be changed every four (4) hours; however the log did not provide for every (4) hour testing and documentation. The DM revealed the facility did not have a policy addressing the testing/documentation process for the sanitizing solution in the sanitation buckets. She stated after reviewing the log, staff probably was "not being honest" in the documentation of the sanitation bucket test results on the log.</p> <p>Continued interview revealed she provided sanitation education for staff, but was unable to locate the education documentation. Further interview revealed she did not go behind staff to check to make sure they were doing their jobs as they were supposed to, and indicated she did not do audits of any kind. According to the DM, the issue with the sanitation bucket testing/documentation was an "eye opener" for her.</p> <p>Interview with the RD, on 01/15/15 at 4:56 PM, revealed she did perform dietary audits of the</p>	F 371		

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F 371	Continued From page 19  dietary department which included checking the efficacy of the sanitation buckets. Per interview, the RD utilized a facility audit tool when performing the audits of the dietary department. Review of the "Food Safety and Sanitation Audit", revised 05/2014, utilized of by the RD, revealed sanitation solutions were to be available and in use throughout the day for cleaning work counters and surfaces. However, further review revealed testing the level of sanitizer in the sanitation buckets was not an area listed on the audit tool.  Interview with the Administrator, on 01/15/15 at 4:51 PM, revealed the facility's expectation was for the Registered Dietician (RD) to do dietary audits of the dietary area. She stated it was her expectation for dietary staff to follow the facility's policy, and if a concern surfaced inservicing and additional audits would be conducted.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	F431  1. It is the policy of this facility to ensure drugs and biological are stored in accordance with currently accepted profession principles; The vial of influenza vaccine was discarded by the unit manager on 1/13/2015.  2. All residents of the facility have the potential to be affected. All refrigerators were audited by the unit managers to ensure there were no other expired vials/medications on 1/13/2015. No other issues were found.	

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F 431	<p>Continued From page 20</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's medication storage policy, it was determined the facility failed to ensure drugs and biologicals were stored in accordance with currently accepted profession principles. Observation on 01/13/15 at 12:55 PM, in a medication refrigerator in a medication room on the 200 hallway revealed one (1) vial of influenza (flu) vaccine opened and dated 12/11/14.</p> <p>The findings include: Review of the facility's policy titled, "5.3 Storage and Expiration Dating of Drugs, Biologicals, Syringes, and Needles", revised 05/16/11, revealed drugs, biologicals, syringes, and needles were to be stored under proper conditions with regard to sanitation, temperature, light, moisture,</p>	F 431	<p>3. The Director of Nursing or Nurse Educator will reeducate all nurses on facility policy of discarding expired drugs/biological by 2/25/2015. A posttest will be given to validate understanding by the Nurse Practice Educator or Director of Nurses. Staff not available during this timeframe will be provided reeducation upon return to work by the Nurse Practice Educator or Director of Nursing.</p> <p>4. The Nurse Managers on 100 hall, 200 hall and 300 hall will utilize an audit tool to monitor for expired medications in the refrigerator or medication carts daily times two weeks then three times weekly for two weeks then as determined by the monthly Performance Improvement Committee with corrective action upon discovery. The pharmacist will monitor for expired medications during visits. Any concerns will be addressed immediately.</p>	
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F 431 Continued From page 21  
ventilation, segregation, safety, security, and expiration date as directed by state and federal regulations and manufacturer/supplier guidelines. The Policy revealed the purpose of this was to ensure the stability and quality of drugs, biological, syringes, and needles and prevent contamination. Further review of the Policy revealed once any drug or biological package was opened, staff were to follow the manufacturer/supplier guidelines for expiration dating.

Observation, on 01/13/15 at 12:55 PM, of the medication room on the 200 hallway revealed one (1) vial of flu vaccine stored in a medication refrigerator. Further observation revealed the flu vaccine vial had been opened and was dated 12/11/14.

Interview with Licensed Practical Nurse (LPN) #2 on 01/15/15 at 6:15 PM, revealed if she saw a medication, injectable, or eye drops which had been opened for more than thirty (30) days she would immediately discard it and order new medication, or if it was a vaccine, order a new vial from the Pharmacy.

Interview with Registered Nurse (RN) #2 on 01/15/15 at 6:00 PM, revealed if a vaccine had been opened and was dated over thirty (30) days previously, it should immediately be discarded and removed from potential use. RN #2 stated the facility did not presently have a policy or procedure for checking drugs and biological routinely for expiration dates.

Interview with the Director of Nursing (DON) on 1/15/15 at 6:30 PM, revealed it was the facility's policy if a medication of any kind had been

F 431  
4. A summary of findings will be submitted the unit managers to the monthly Performance Improvement Committee consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager, and Dietary Supervisor for further review and recommendations.  
5. Completion date: February 26, 2015

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F 431	Continued From page 22 opened it should be discarded after it had been opened for thirty (30) days. Per interview, the flu vaccine should have been discarded as it was over thirty (30) days since it had been opened.	F 431			
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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	F 441	F441 1. It is the practice of this facility 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.  All unlabeled bedpans/urinals bath basins/graduates/toothbrushes in rooms 201, 208, 216, 210, 222, 305, and 309 were discarded and replaced with new individually labeled items by nursing staff on 1/14/2015. Items were covered, and stored properly. The Nurse who administered the dropped pill to unsampled resident H was reeducated by the Director of Nursing on 1/15/2015.  Dietary aide #2 was reeducated on proper handling of ice from an ice		

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F 441	<p>Continued From page 23</p> <p>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 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.</p> <p>Observation during initial tour of the facility revealed soiled urine graduates, soiled bedpans, soiled urinals and soiled bath basins sitting on the floor in residents' bathrooms without labels or stored covered. Continued observation revealed unlabeled toothbrushes lying uncovered in resident rooms.</p> <p>Observation during a medication (med) pass revealed medication was dropped in the lap of a resident (Unsampled Resident H), retrieved by person administering the medication, and then administered to the resident.</p> <p>Additionally during a dining observation, staff was utilizing a cup without a handle to scoop ice from the ice bucket into the beverage cup and leaving the cup stored in the ice bucket.</p> <p>The findings include:</p> <p>1. Interview with the Director of Nursing (DON), on 01/14/15 at 3:32 PM, revealed the storage of</p>	F 441	<p>bucket by the dietary supervisor on 1/13/2015.</p> <p>2. All residents of the facility have the potential to be affected. Audit for infection control i.e. bedpans, urinals, and tooth brushes stored appropriately was completed on 1/14/2015 by the unit managers on 100 hall, 200 hall, and 300 hall, and Nurse Educator to ensure a safe sanitary comfortable environment to prevent the development and transmission of disease and infection standards were met. No further areas of concern were identified.</p> <p>Medication pass observations were conducted by the Unit Mangers on 1/15/2015 with nurses to ensure medications that were spit out by the resident or dropped by the nurse were discarded with no concerns identified.</p>	
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F 441	<p>Continued From page 24</p> <p>bedpans, urinals, urine graduates and bath basins was a standard of practice, and the facility did not have a specific policy addressing storage of these items.</p> <p>Review of the facility's policy titled, "Cleaning and Disinfecting" revised 07/01/14, revealed cleaning and disinfecting of resident care items and environment was to be conducted based on the risk of infection involved. The Policy revealed the purpose was to prevent infectious spread from items or environment to residents and/or staff. Continued review revealed single resident care equipment should be cleaned and disinfected with appropriate disinfectant before use by the resident.</p> <p>Observation during initial tour of the facility, on 01/13/15 at 11:00 AM, revealed: resident rooms 201, 208 and 216 contained unlabeled and uncovered soiled bedpans lying on the floor of the bathroom, in room 201 there was also an unlabeled and unbagged urine graduate; resident room 210's bathroom had two (2) unlabeled and uncovered soiled wash basins lying on the floor; in resident room 222's bathroom there was one (1) unlabeled and uncovered urinal. Continued observation revealed in resident room 305 an unlabeled and uncovered toothbrush lying on top of a cabinet, and resident room 309 an unlabeled and uncovered toothbrush lying on the sink were lying unlabeled and uncovered.</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on 01/15/15 at 2:30 PM, revealed bedpans and urinals should be labeled with the resident's name and room number and dated and they should be placed in a plastic bag and not sitting on the toilet. Further interview revealed this was</p>	F 441	<p>Observations were conducted 1/15/2015 by Dietary Manager and unit managers on 100 hall, 200 hall, and 300 hall during meal times and ice pass to ensure the ice scoop with handles were used and stored appropriately with no additional findings.</p> <p>3. The Director of Nursing, or the Nurse Educator will reeducate the nursing department staff regarding storage of bedpans, urinals, bath basins, graduates, toothbrushes, handling of medications spit out by the resident or dropped by the nurse by 2/25/2015. The Dietary Manager will reeducate dietary staff regarding use of the ice scoop with handles and appropriate storage of ice scoops by 2/25/2015. A posttest will be given to validate understanding. Staff not available during this timeframe will be provided reeducation upon return to work by the Nurse Practice Educator or Director of Nursing.</p>		

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F 441	<p>Continued From page 25</p> <p>cross-contamination issue.</p> <p>Interview with CNA #3 on 01/15/15 at 6:05 PM, revealed when the bedpans and urinals were dirty they needed to be discarded. Per interview, those items were to be labeled with the resident's name and dated. Additional interview revealed they were then to be covered with a plastic bag and stored in the resident's closet. CNA #3 stated if the bedpans and urinals were dirty and not covered it would be cross-contamination issue.</p> <p>Interview with Unit Manager (UM) #7 on 01/15/15 at 4:15 PM, revealed her expectation was for residents' bedpans/urinals to be labeled with their names and stored covered in plastic bags. Further interview revealed the bedpans/urinals should not have been lying uncovered, as that was an infection control issue.</p> <p>Interview with the Infection Control Nurse (ICN), on 01/15/15 at 6:42 PM, revealed the facility did not have a policy specific to the storage of soiled bedpans, urinals, urine graduates, bath basins or toothbrushes. However, she stated the soiled bedpans, urinals, urine graduates and bath basins should be labeled and stored in a plastic bag in the bottom drawer of the resident's nightstand. The ICN revealed resident toothbrushes should be labeled and stored covered in a toothbrush holder. Continued interview revealed if these items were left unlabeled and uncovered it could be an infection control issue or risk for cross contamination.</p> <p>Interview with the Director of Nursing (DON), on 01/14/15 at 3:32 PM, revealed the storage of bedpans, urinals, urine graduates and bath basins was a standard of practice and the facility</p>	F 441	<p>Utilizing audit tools, the 100 hall, 200 hall, and 300 hall Nurse managers will monitor for proper infection control measures including storage of bedpans, urinals, bath basins, graduates, toothbrushes, and handling of medications spit out by the resident or dropped by the nurse daily for two weeks, then three times a week for two weeks then as determined by the monthly Performance Improvement Committee. The Dietary Manager and unit managers will monitor for ice scoop with handles were used and stored appropriately daily times two weeks, then three times per week times two weeks then as determined by the monthly Performance Improvement Committee. Any concerns will be addressed immediately.</p> <p>4. A summary of findings will be submitted by the Director of Nursing and the Dietary Supervisor to the monthly Performance Improvement Committee consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager, and Dietary supervisor for further review and recommendations.</p> <p>5. Completion date: February 26, 2015</p>

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F 441	Continued From page 26 did not have a specific policy. Per interview, her expectation was for soiled bedpans, urinals, urine graduates and bath basins to be labeled with the resident's name and stored in a plastic bag in the resident's closet or drawer for infection control purposes and to reduce the risk for cross contamination. Further interview revealed toothbrushes should also be labeled with the resident's name and covered for infection control and cross contamination risks.  Interview with the Administrator, on 01/15/15 at 7:15 PM, revealed soiled bedpans, urinals, urine graduates and bath basins should be labeled and stored covered or bagged due to infection control and cross contamination issues. Additionally, the Administrator stated residents' toothbrushes should be labeled with their names, and stored covered to prevent infection control and cross contamination issues.  2. Review of the facility's policy titled, "8.2 Disposal/Destruction of Refused, Discontinued, and Expired Medication", revised 03/01/11, revealed if a resident's medication was dropped the person administering the medication was to immediately dispose of the medication.  Observation during a med pass on 01/14/15 at 11:20 AM, revealed Licensed Practical Nurse (LPN) #1 was observed to attempt administering three (3) medication tablets to Unsampled Resident H. However, observation revealed Unsampled Resident H accidentally spit two (2) of the medications out of his/her mouth during the administration of the medication. Continued observation revealed one of the tablets landed on the seat of the wheelchair, and the second one landed on the resident's left pant leg. LPN #1	F 441		
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F 441	Continued From page 27 was observed to pick up both of the tablets and then administer the medication to Unsampled Resident H.  Interview with LPN #1 on 01/15/15 at 3:05 PM, revealed she was aware of the facility's medication administration policy for administering oral medication and the need to discard a medication if it had be dropped and become contaminated. LPN #1 stated she knew she should not have picked the medication up and administered it. However, she stated Unsampled Resident H would have started screaming if he/she had not gotten his/her medication "right away".  Interview with Registered Nurse (RN) #1, on 01/15/15 at 3:20 PM, revealed it was her expectation of all nurses administering medications to discard medication which had been dropped and became contaminated. RN #1 revealed dropped, contaminated medication should not be administered.  Interview with the DON, on 01/15/15 at 6:30 PM, revealed it was her expectation if a resident spit out or dropped their medication, the medication should be discarded. Per interview, the person administering medication should then obtain a new medication for the resident.  Interview with the ICN, on 01/15/15 at 6:42 PM, revealed any medication dropped should have been discarded and a new medication dispensed due to infection control issues and risk for cross contamination.  Interview with the Administrator, on 01/15/15 at 7:15 PM, revealed dropped medications should	F 441		
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F 441	<p>Continued From page 28</p> <p>have been wasted and a new pill given. Further interview revealed the medication was potentially contaminated and was an infection control issue.</p> <p>3. Review of the facility's policy titled, "Ice Chests", revised 11/24/14, revealed the procedure for obtaining ice from the ice chest included holding the scoop by the handle only and not touching the bowl area of the scoop. The Policy revealed the bowl area of the scoop should be covered when it was not in use, and ice should not be obtained with one's hands. Per the Policy, staff should not leave the ice scoop stored in the ice chest.</p> <p>Observation on 01/13/15 at 12:11 PM, during the lunch meal, and at approximately 5:30 PM, during the dinner meal revealed Dietary Aide (DA) #2 serving beverages. Observation revealed DA #2 utilizing a small glass without a handle to scoop ice into residents' beverage glasses. Further observation revealed DA #2 used her bare hand to handle the cup and left the cup stored in the ice between serving residents.</p> <p>Interview with DA #2, on 01/13/15 at 6:30 PM, revealed she used a cup to serve the ice due to the scoop being "too big". Further interview revealed she was unaware of the facility's policy to utilize a scoop and to not leave the scoop stored in the ice.</p> <p>Interview with the Director Manager (DM), on 01/15/15 at 4:02 PM, revealed she was unaware staff used a cup to scoop the ice out of the ice container. Continued interview revealed this could be an infection control issue. Further interview revealed the dietary department had smaller scoops for staff to utilize.</p>	F 441		

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F 441	Continued From page 29  Interview with the ICN, on 01/15/15 at 6:42 PM, revealed the ice scoop should not be stored in the ice, and should be stored outside the ice container. Continued interview revealed the scoop should have a handle so as to not touch the ice due to infection control and cross contamination. The ICN revealed a cup should not be utilized to obtain the ice.  Interview with the Administrator, on 01/15/15 at 7:15 PM, revealed staff should use a scoop with a handle to obtain ice which should be stored in a separate holder outside the ice container due to possible infection control issues and risk for cross contamination.	F 441		
F 492 SS=E	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD  The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.  This REQUIREMENT is not met as evidenced by: Based on interview and review the facility's safety inspection documentation, it was determined the facility failed to ensure the operation and provided services were in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles which apply to professionals providing services in	F 492	F492 1. It is the practice of this facility to operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and princi-	

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

PRINTED: 01/29/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/15/2015
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NAME OF PROVIDER OR SUPPLIER  BRIDGE POINT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPOINT DRIVE FLORENCE, KY 41042
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F 492 Continued From page 30

such a facility. Review of the facility's safety inspection documentation revealed the facility failed to ensure the resident transportation vehicle was inspected annually for safety as per State Law.

The findings include:

Review of the Kentucky Administrative Regulations (KAR), 603 KAR 5:072, Mandatory annual bus inspection, revealed buses should undergo a safety inspection at least once each year.

However, review of the facility's vehicle safety inspection documentation, revealed the facility's resident transportation bus was last inspected by Commercial Vehicle Enforcement on 11/01/12. Continued review revealed no documented evidence of the required annual inspections of the facility's transportation bus for the years of 2013 or 2014.

Interview with the Maintenance Director, who was from one (1) of the facility's "sister" facilities, on 01/15/15 at approximately 6:00 PM, revealed he was responsible for the routine maintenance and inspections of the facility's vehicle. The Maintenance Director revealed the resident transportation vehicle had not been inspected by the appropriate authorities since 2012; however, the vehicle should have been inspected in 2013 and 2014 as required. Further interview revealed the facility's resident transportation vehicle was inspected on 01/14/15, after State Surveyor requests were made for the current inspection documentation.

Interview with the Administrator, on 01/15/15 at

F 492

ples that apply to professionals providing services in such a facility. -

The resident transportation bus was inspected by the State on 1/14/2015 with no negative findings or necessary repairs needed.

2. All residents of the facility have the potential to be affected. There are no other facility owned vehicles.

3. The facility Administrator reeducated both the maintenance director from the "sister" facility responsible for van maintenance and center's Maintenance Director on 1/14/2015.

The Maintenance Director has added the annual vehicle inspection to the automated "TELS" system to ensure each annual inspection is completed. Report will be provided to the Administrator when the inspection is completed. Any concerns will be addressed immediately.

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F 492	Continued From page 31 7:15 PM, revealed the resident transportation bus was shared with two (2) other "sister" facilities. The Administrator revealed a maintenance staff person at one (1) of the "sister" facilities was responsible for service and inspection of the vehicle. Further interview revealed the resident transportation vehicle should have been inspected annually for resident safety.	F 492	4. A summary of findings will be submitted the Maintenance Director to the monthly Performance Improvement Committee consisting of Administrator, Director of Nursing, Maintenance Director, Business Office Manager, and Dietary Supervisor for further review and recommendations.		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure the clinical record was accurate and complete for each resident for five (5) unsampled residents (Unsampled Resident F, Unsampled Resident D, Unsampled Resident G, Unsampled Resident C, and Unsampled Resident E) out of twenty-four (24) sampled and	F 514	5. Completion date: February 26, 2015		

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F 514	Continued From page 32 seven (7) unsampled residents.  Observation revealed Licensed Practical Nurse (LPN) #2 placed medication in medication cups and left them in residents' rooms without staying to observe the residents take the medication. However, even though she had not witnessed the residents taking the medication, LPN #2 documented the medication as administered on the residents Medication Administration Records (MARs).  The findings include:  Interview with the Director of Nursing (DON), on 01/15/15 at 2:55 PM, revealed the facility did not have a policy related to ensuring residents' medical records were complete and accurate.  Review of the facility's policy titled, "Medication Administration: Oral", revised 01/02/14, revealed after administering and observing medications taken, the medication administration person should document the administration including any side effects, irritation or adverse reactions.  Observation, on 01/14/15 beginning at 4:00 PM and ending at 4:30 PM, during an afternoon medication (med) pass on the 100 hallway, revealed LPN #2 was observed to prepare and take medication into five (5) unsampled residents' rooms, Unsampled Resident C, D, E, F and G. Continued observation during this timeframe revealed LPN #2 would leave the medication in the residents' rooms without observing and ensuring the residents took the medication. Further observation revealed LPN #2 returned to the med cart and documented the residents' medications as administered, even though she	F 514	F514  1. It is the practice of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized.  The LPN (#1) was reeducated by the Director of Nursing regarding the facility policy for oral medication administration and the expectation to observe the resident take the medication 1/14/2015. Upon interview 1/14/2015 by the Director of Nursing unsampled residents F, D, G, C, and E stated that they did take their medications when administered.  2. All residents of facility have the potential to be affected. Audit completed by the Unit managers on 100 Hall, 200 Hall and 300 Hall and Nurse Practice Educator revealed no other residents had medications left at the bedside on 1/14/2015.		

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F 514	Continued From page 33 had not witnessed this.  Interview with LPN #2, on 01/14/15 at 5:30 PM, revealed she was aware of the facility's medication administration policy and the need to observe residents take their medication and then document the successful administration on the residents' MARs.  Interview with the Director of Nursing (DON) on 01/15/15 at 6:30 PM, revealed licensed nurses should only document a medication had been administered when the medication had been observed to be administered. Per interview, then the successful medication administration should be documented on the resident's MAR. Per interview, the facility's expectation was for residents' medical records to be complete and accurate.	F 514	3. The Director of Nursing, or Nurse Practice Educator will reeducated all nurses on the facilities policy for oral medication administration including observation of the resident taking the medication and a posttest will be given by the Nurse Practice Educator to validate understanding by 2/25/2014. Staff not available during this timeframe will be provided reeducation upon return to work by the Nurse Practice Educator or Director of Nursing.  The 100 hall, 200 hall, and 300 hall Nurse Managers, Nurse Practice Educator or Director of Nurses will utilize an audit tool to monitor the nurse remains with the resident when administering medications daily across all shifts for two weeks, then three times a week for two weeks, then as determined by the monthly Performance Improvement Committee. Any concerns will be addressed immediately.  4. A summary of findings will be submitted the unit managers to the		

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: Construction Date 06/10/69</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) Story, Type III (000) Unprotected</p> <p>SMOKE COMPARTMENTS: Nine (9) smoke compartments.</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (Dry SYSTEM)</p> <p>EMERGENCY POWER: Type II Diesel Generator.</p> <p>A Life Safety Code Survey was conducted on 01/15/15. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation in Medicare and Medicaid. The facility is licensed for one hundred and fifty-one (151) beds and the census was one hundred and forty-five (145) the day of the survey.</p>	K 000	<p>"This plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, Bridge Point Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency."</p>	
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1-9-2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Debra Jones</i>	TITLE Administrator	(X6) DATE 2-9-12
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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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K 000	Continued From page 1 Deficiencies were cited with the highest deficiency identified at a "D" level.	K 000	K062	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation interview and review of the facility's sprinkler contractor's documentation, it was determined the facility failed to ensure the automatic fire sprinkler system was inspected and maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of nine (9) smoke compartments, forty-eight (48) residents, staff and visitors.  The findings include:  Observation, on 01/15/2015 at 10:21 AM, with the Maintenance Director revealed the quick opening device (accelerator) for the sprinkler system valve was closed and the gauge showed a reading of 0 Pound Square Inch (PSI). Interview, with the Maintenance Director during the observation, revealed he was not aware the quick opening device (accelerator) valve was closed and the gauge was indicating 0 PSI. Further interview, revealed the sprinkler contractor was in the facility on 01/02/15 to provide maintenance on the system.	K 062	1. It is the practice of this facility to continuously maintain our automatic sprinkler system in reliable operating condition and to inspect and test periodically. The quick opening device (accelerator) valve was serviced by the sprinkler contractor on 1/02/2015. On 2/9/2015 the sprinkler is scheduled for repair and is functioning safely. The sprinkler contractor has been informed by the Administrator on 1/16/2015 that during all future sprinkler inspections, any abnormalities of our sprinkler system must be immediately reported to the maintenance director both orally and re-	

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K 062	<p>Continued From page 2</p> <p>Review of the documentation left for the facility on 01/02/15 by the sprinkler contractor did not reveal any problems with the quick opening device (accelerator).</p> <p>Telephone interview, on 01/15/15, with the facility's sprinkler contractor revealed the sprinkler contractor had discovered the quick opening device (accelerator) was not functioning properly on 01/02/15, and the part would have to be replaced. The sprinkler contractor indicated to the facility he had been "too busy" to document this in the paperwork left at the facility on 01/02/15.</p> <p>Reference: NFPA 25 (1998 Edition)</p> <p>9-4.4.1.2 Gauges shall be inspected weekly.</p> <p>(a) The gauge on the supply side of the dry pipe valve shall indicate that the normal supply water pressure is being maintained.</p> <p>(b) The gauge on the system side of the dry pipe valve shall indicate that the proper ratio of air or nitrogen pressure to water supply pressure is being maintained in accordance with the manufacturer's instructions.</p> <p>(c)* The gauge on the quick-opening device, if provided, shall indicate the same pressure as the gauge on the system side of the dry pipe valve. Exception: Systems equipped with low air or nitrogen pressure alarms shall be inspected monthly.</p>	K 062	<p>flected properly on the documentation upon discovery.</p> <p>2. All residents of the facility have the potential to be affected. Audit of the Sprinkler system by the Maintenance Director on 1/15/2015 revealed there were no further issues related to the proper functioning of the Sprinkler system</p> <p>3. The administrator provided reeducation with the maintenance director on 1/16/2015 regarding need to ensure that any concerns identified during the sprinkler inspection are reported immediately by the contractor and regarding the need for the weekly gauge inspection</p>		

The facility will conduct weekly inspection of the gages by the Maintenance Director and after any sprinkler system maintenance completed by the facility's contractor to ensure that the gages read at the proper PSI.

The Maintenance Director will utilize an audit tool to monitor and document that this solution is sustained.

4. A summary of the findings will be submitted by the Maintenance

*Ant. Jones* Administrator 2/9/15