

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

PRINTED: 01/10/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2011
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 FERN VALLEY ROAD LOUISVILLE, KY 40219	
(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 standard Health survey was conducted 12/20/11 through 12/22/11. A Life Safety Code Survey was conducted on 12/21/11. Deficiencies were cited, with the highest scope and severity of an "F" with the facility having the opportunity to correct deficiencies before remedies would be recommended for imposition.	F 000	The submission of this Plan of Correction does not indicate an admission by Franciscan Health Care Center that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Franciscan Health Care Center. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this Plan of Correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to revise the care	F 280		

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

X *Henry Adkins MD ED*

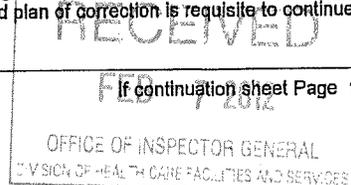
TITLE

X *Dir. Dir.* X

(X6) DATE

X *2-7-12*

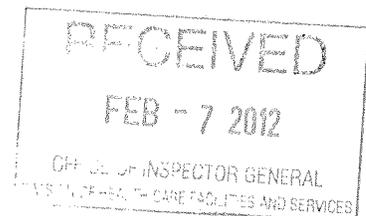
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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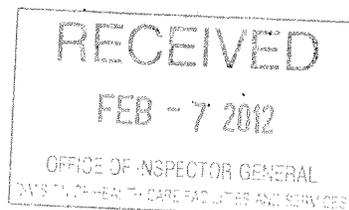
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F 280	<p>Continued From page 1</p> <p>plan for three (3) of seventeen (17) sampled residents. The facility developed an initial care plan that included interventions that were not appropriate for Resident #5's oral intake. The facility developed a Comprehensive Care Plan for Resident #9 that did not include the use of a bed/chair alarm. The facility developed a Comprehensive Care Plan for Resident #11's Activities of Daily Living that did not include interventions currently in use by the resident.</p> <p>The findings include:</p> <p>1. Review of the facility's policy Admission Nursing Assessment Purpose revealed to complete and document a comprehensive assessment...and implement a temporary plan of care to address problem areas.</p> <p>Review of the medical record for Resident #5 revealed the facility admitted the resident on 12/15/11 with diagnoses including Aspiration Pneumonia, Bronchiectasis, Esophageal Stricture, Diverticulum of Esophagus, s/p G-tube placement and Malnutrition. Review of the admission physician orders revealed, the resident was to have nothing by mouth (NPO) and Jevity 1.5 bolus feeding via G-tube four times a day.</p> <p>Observation, on 12/20/11 at 12:05 PM, revealed Resident #5 appeared well groomed and without odors. The resident had a Gastrostomy tube (G-tube) that was clamped. The resident was pleasant, cooperative and communicative.</p> <p>Review of the initial Care Plan for Resident #5 revealed the elimination deficit plan of care had the following checked: Encourage fluids; and</p>	F 280	<p>F280</p> <ol style="list-style-type: none"> Care plans for residents #5, #9 and #11 were updated to reflect current status. All resident care plans reviewed to insure that they reflect the residents current status. Any out of compliance were corrected. The interdisciplinary team as in-serviced by the Director of Health Services (DHS) on 01-13-2012 related to comprehensive care plans with emphasis on periodic review and revision. Ongoing compliance will be accomplished through morning CQI meeting where changes in condition in condition are reviewed daily. Care Plans will be revised based on results of daily CQI meeting. Care plans will also be reviewed quarterly by the IDT team and any changes will be addressed at that time as well. The unit manager will also update daily from the MD orders. 	2/3/2012



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F 280	<p>Continued From page 2 observe nutritional intake and types of food consumed.</p> <p>Interview, on 12/22/11 at 3:00 PM, with Registered Nurse (RN) #7 revealed Resident #5's initial care plan should not have been checked to encourage fluids and observe food consumed because the resident was to have nothing by mouth.</p> <p>2. Review of the facility's policy Resident First Meeting Guidelines revealed the purpose was to facilitate communication regarding the resident's plan of care; medical care;...to the caregiver within 3 days. Item #15 of the same policy stated to compare the care plan to the Minimum Data Set (MDS) and Nursing Assistant care form to make sure it all matched.</p> <p>Review of the medical record for Resident #9 revealed, the facility admitted the resident on 12/01/11 with diagnoses including Anemia, Atrial Fibrillation, Parkinson's Disease, and Chronic Obstructive Pulmonary Disease. Review of the Physician orders revealed, the facility wrote orders on 12/02/11 to include Pressure Sensor Alarm (PSA) to bed/chair.</p> <p>Observation, on 12/20/11 at 11:00 AM, revealed Resident #9 resting in bed. A PSA was in use on the bed.</p> <p>Review of the Comprehensive Care Plan for Resident #9 revealed a care plan for risk for falls. There was no intervention on the comprehensive care plan, dated 12/18/11, that included a PSA to chair or bed.</p>	F 280	



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F 280	<p>Continued From page 3</p> <p>Interview with Registered Nurse #3, on 12/22/11 at 2:00 PM, revealed she was providing care for Resident #9 on this day and the resident did have a PSA in use, in the bed and chair, as the resident was a high risk for falls. RN #3 stated the nurses care plan any new orders on the admission care plan. She went on to say, the nurses who complete the admission Minimum Data Set (MDS) will carry over any applicable intervention from the initial care plan to the comprehensive care plan. RN #3 acknowledged the PSA was in use for Resident #9, but it was not on the comprehensive care plan.</p> <p>3. Review of the medical record for Resident #11 revealed the facility admitted the resident on 11/18/11 with diagnoses including, Right Femoral Popliteal Graft Infection, Coronary Artery Disease and Congestive Heart Failure. Review of the Physician orders revealed, an order dated 11/22/11 for pressure relief boots to both feet.</p> <p>Observation, on 12/22/11 at 8:20 AM, 9:45 AM, 10:30 AM and 12:30 PM, revealed Resident #11 laying in bed on a low air loss mattress. Heel boots were noted to bilateral heels.</p> <p>Review of the Comprehensive Care Plan for Resident #11, dated 11/30/11, revealed no intervention on any care plan reflecting the use of heel boots to both feet.</p> <p>Interview with Registered Nurse (RN) #2 and #7, on 12/22/11 at 3:00 PM, revealed they are responsible for completing the MDS and any assessments. They both stated, all new orders are duplicated and the Director of Nursing and Assistant Director of Nursing collect them every</p>	F 280		
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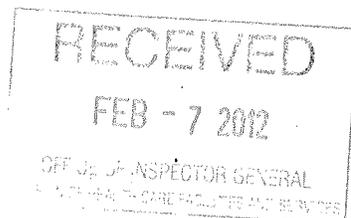
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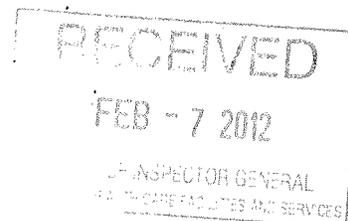
F 280	Continued From page 4 morning and bring the orders to a morning meeting where anything pertinent should be added to the Care plan by the MDS Nurses, and the Director of Nursing. Both acknowledged the interventions for Resident #5 and #11 were not added to the care plan. They stated, we just missed it.	F 280		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's food labeling policy; Leftover Food Storage; cleaning schedule; and dietary meeting minutes, it was determined the facility failed to store, serve, and prepare food in a sanitary manner as evidenced by a soiled mixer stored ready for use, and improperly stored food items. The findings include: Review of the facility's policy titled, Food Labeling, revealed refrigerated, ready-to-eat, potentially hazardous food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container	F 371	F371 1. All residents had the potential to be effected by the cited deficiency. No residents showed any signs of food related illness, therefore no residents identified being effected by cited deficiency. 2. All items that were found opened and/or not dated in the kitchen were thrown away. The mixer was cleaned immediately. 3. Dietary staff will be in serviced 01-31-2012, using our new guidelines/ protocols titled: The Handling of leftover food, (We changed to this policy/guidelines because this does include all instructions needed for proper sealing, and wrapping and dating of food/leftovers). In servicing will be completed by the Dietary Manager (DM) on the proper procedures for storing food and the cleaning of the mixer. Cleaning schedules are posted for staff and DM or assistant DM will complete an audit of the freezer, walk in	2/1/2012



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F 371	<p>Continued-From page 5</p> <p>is opened in a food establishment and if the food is held for more then 24 hours, to indicate the date or day by which the food shall be consumed on the premises.</p> <p>Review of the facility's Leftover Food Storage policies and procedures, not dated, revealed proper sealing, covering, and wrapping of food items was not discussed in the policy. Review of the facility's kitchen cleaning schedule revealed reach-ins including freezers are checked daily for labeling and expired products, mixer was to be cleaned after each use and covered with a garbage bag</p> <p>Observation during initial tour of the kitchen, on 12/20/11 at 8:25 AM, revealed a jar of half emptied Basil Pesto sauce in the reach-in refrigerator that was opened and not dated. The walk-in freezer contained a box of ocean perch, crunchy cod, and catfish all opened with food product exposed and not resealed. The reach-in cooler contained a clear plastic container of tuna fish salad, opened with plastic wrap, crumpled up and pushed towards the back of the container leaving the salad exposed. The mixer was sitting covered and ready for use, inspection of the mixer revealed a white and brown splattered dried substance on the grate and the blades cover shield.</p> <p>Interview with Dietary Aide #1, on 12/22/11 at 2:15 PM, revealed she had been trained on the proper procedure for storage and labeling of food items. However, the Dietary Aide revealed food items are used quickly and she had noticed items being stored uncovered or not dated.</p>	F 371	<p>and reach in refrigerator weekly for items not properly stored or dated. They will also complete an audit of the mixer for cleanliness weekly.</p> <p>4. Ongoing compliance will be achieved by biannual in services for the dietary staff and by continued weekly audits by the DM or DM assistant.</p>	



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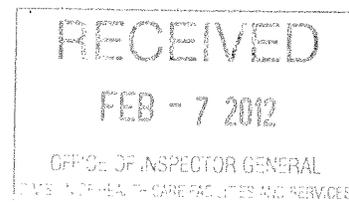
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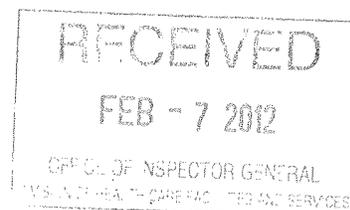
F 371	Continued From page 6 Interview with Dietary Cook #1, on 12/22/11 at 2:25 PM, revealed she had been trained with the health department on proper storage and labeling of food items. The Dietary Cook revealed she covered and dated food items if she found improperly stored items. The Dietary Cook revealed improperly stored and undated food items could potentially pose a risk to food borne illness. Interview with the Dietary Manager (DM), on 12/22/11 on 2:10 PM, revealed the mixer should be cleaned after every use, which is usually done by the chef on duty. The DM revealed he personally routinely checked the mixer and it was deep cleaned weekly due to the small parts and screws. The DM revealed the mixer was last inspected on 12/18/11. The DM revealed a potential for cross contamination and sanitation issues could occur by not properly cleaning the mixer. The DM revealed everyone was responsible to cover and date any food item when it was opened for use. The DM revealed he monitored daily and inspected more thoroughly on Mondays and Thursdays. The DM revealed a potential for cross contamination or freezer burn if food items or not properly sealed and dated.	F 371		
F 441 SS=F	Review of the Dietary Meeting topics and outline, dated 06/15/2011, revealed storage and dating of food items was not listed. 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	F 441		



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F 441	Continued From page 7 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 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's policy, and review of the manufacturer's	F 441	1. Resident, #12 had no negative outcomes related to dressing change completed during survey. All expired wipes were removed and new wipes were substituted. All supplies were checked for expiration dates. No other issues were identified. 2. Infection rates for 2011 were compared to the previous year before wipes were expired. There was no significant difference in the rates. No residents were effected by the cited deficiency related to the expired wipes or improper hand washing. Residents with orders for dressing changes were reviewed to ensure proper hand washing was being carried out. 3. Nurses were in serviced by the Director of Health Services (DHS) and the In service Director on 12-21-2011. Education was related to storage of drugs and biologicals with emphasis on checking for expiration dates. Treatment nurse was coached and counseled by the DHS on 1-13-2012 related to hand washing. This nurse is also scheduled to attend formal training on 01/27/2012.	2/4/2012



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F 441	<p>Continued From page 8</p> <p>recommendations, it was determined the facility failed to ensure infection control practices were followed as evidenced by disinfection wipes with an expiration date of April 2011 that were in use for six (6) of six (6) Glucometer testing machines and two (2) of two (2) Prottime testing machines. In addition, the facility failed to follow infection control guidelines related to dressing changes for one (1) of seventeen (17) sampled residents, Resident #12.</p> <p>The findings include:</p> <p>1. Review of the facility policy specific medication administration (Med-Pass) procedures one (1) B. indicated to check expiration dates on package/containers.</p> <p>Review of the Glucometer Cleaning Guidelines, undated, revealed if glucometers are used from one resident to another ...clean and disinfect after each use. The policy continued to state, the exterior surfaces should be cleaned following the manufacturer's recommendation's/directions using ... (Note: the Sani-cloth bleach wipe by PDI ordered through our clinical medical supplier). Continued review of the policy revealed, no indication that the disinfection wipes should be checked for an expiration date.</p> <p>Observation, on 12/21/11 at 11:00 AM, revealed Registered Nurse (RN) #4 cleaned the Glucometer with a disinfection wipe (Gluco-Chlor) prior to completing blood sampling for unsampled Resident #A. Upon further observation, it was discovered, the disinfection wipes had an expiration date of 04/11.</p> <p>Interview with RN #4, on 12/22/11 at 11:30 AM</p>	F 441	<p>4. Ongoing compliance will be achieved by annual needed competency checkoffs for hand washing and Infection Control technique. All employees are trained on Infection Control upon hire and then annually as required by regulation. DHS will randomly audit three dressing changes two times monthly for three months, then monthly for two months and randomly one treatment per week to ensure proper infection control technique is used. Central supply coordinator will monitor medical supplies weekly by checking for expiration dates. If any expired dates are found the supplies will be thrown out and not used. She will also always rotate supplies, putting the newest supplies ordered in the back of the older ones already on the shelves.</p> <p>Infection rates are reviewed monthly during Quality Assurance (QA) Meeting. If rates are above company standards of 5 %, then an action plan (AP) will be required until compliance is achieved. If rates are above the AP will include interventions not limited to education, hands on demonstration, and observation. The rates will be continually monitored until compliance is achieved. QA will monitor through monthly meetings.</p>	
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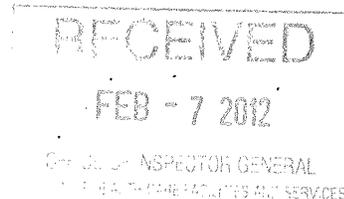
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F 441	<p>Continued From page 9</p> <p>and 3:10 PM, revealed she had worked at the facility for thirteen (13) years. She stated, staff were educated on infection control at least yearly and did not know the disinfection wipes had an expiration date. She did not remember being told to check the disinfection wipes. She believed they had started using the current disinfection wipes about three (3) years ago.</p> <p>Observation, on 12/21/11 from 11:00 AM to 11:45 AM, revealed all six (6) glucometers and two (2) Prottime machines, in use at the facility. The facility was stocked with disinfectant wipes with an expiration date of 04/11. At the time of discovery there were 143 disinfectant wipes expired in the facility. Continued observation of the disinfectant wipe revealed, a four (4) inch by three (3) package with the expiration date imprinted on the top, back side. Each box of disinfectant wipes contained 100 packages. The box contained the words "Expiration Date: 0411". The expiration date was inked on the front of the boxes in ¼ inch numbers.</p> <p>Interview with the President of Medrol Manufacturing, (manufacturer of the disinfectant wipes), on 11/21/11 at 12:45 PM, revealed the wipes had a one (1) year shelf-life from the date of manufacture and this was mandated by the Environmental Protection Agency (EPA). He stated, the wipes were no longer effective after the expiration date and should not be used.</p> <p>Interviews conducted, on 12/21/11 with RN #5 at 3:25 PM, RN #2 at 3:30 PM, Licensed Practical Nurse (LPN) #9 at 3:45 PM, LPN #6 at 3:50 PM, RN #6 at 3:55 PM and on 12/22/11 with RN #3 at 8:30 AM, revealed they had been trained on</p>	F 441		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2011
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NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE ... 3625 FERN VALLEY ROAD LOUISVILLE, KY 40219
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F 441	<p>Continued From page 10.</p> <p>infection control related to cleaning of the Glucometer and Prottime machines at least yearly, but did not recall being told to check the expiration dates on the disinfectant wipes.</p> <p>Interview with Staff Development, on 12/21/11 at 4:15 PM, revealed he had worked at the facility for fifteen (15) months. He stated he was responsible for new employee orientation and setting up other in-services the Director of Nursing wanted to be conducted. He stated, in-services on infection control was completed from 12/07-12/11/2011 with all staff. He went on to say, he did know the wipes had an expiration date because he assumed everything had an expiration date.</p> <p>Interview with LPN #8, on 12/22/11 at 8:40 AM; revealed she was responsible for Central Supply and had been in that position for about one (1) year. She stated she was trained on how to order supplies, monitor for expiration dates, and storage of supplies. She stated, she did not have a list of products used in the facility, and assumed everything had an expiration date. She stated, it was just an over site on her part. She went on to say, Nursing should have been checking for expiration dates on products used in the facility. LPN #8 stated she did not have a system in place to monitor products used or checking for expired products. She stated the last order for the disinfectant wipes was 06/25/10 from the previous Central supply clerk. LPN #8 acknowledged the disinfectant wipes lose their potency if they are expired.</p> <p>Interview with the Medical Director, on 12/22/11 at 12:15 PM, revealed she believed the disinfectant</p>	F 441		
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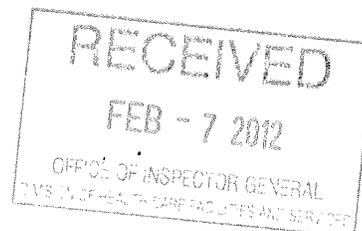
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INSPECTOR GENERAL
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 11</p> <p>wipes were "probably still effective" and the residents were at a low risk for infective illnesses, and she knows sometimes things get overlooked for no good reason.</p> <p>Interview with the Executive Director and Director of Nursing on 12/22/11 at 1:30 PM, in conjunction with a review of admissions, diagnoses, and infection control logs for 2010 and 2011 revealed only one (1) resident had a diagnosis of a Blood Borne Pathogen since 04/01/11 and the resident was not a diabetic. Review of the census on 12/21/11 revealed there were eighteen (18) diabetic residents in the facility and zero (0) were in isolation. Review of the infection log revealed from April 2010 to December 2010 there were forty-three (43) facility acquired infections in diabetic residents. From April 2011 to December 2011 there were twenty-seven (27) facility acquired infection among diabetic residents. There was no indication of a cluster of infections for any particular-month or unit. Continued interview with the Executive Director revealed she was a Registered Nurse and had a hard time believing staff did not know the disinfectant wipes had an expiration date, as that is standard practice.</p> <p>2. Review of the facility's policy titled Guidelines for Disposal of Soiled Dressings, dated 11/2010, revealed in the procedure to remove gloves, wash hands, and don clean gloves before continuing the dressing change.</p> <p>Review of the facility's policy titled Guidelines for Handwashing, dated 10/2004, revealed health care workers shall wash hands after removing gloves, worn per standard precautions for direct</p>	F 441		



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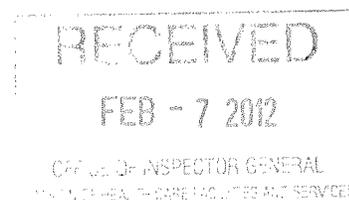
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NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3626 FERN VALLEY ROAD LOUISVILLE, KY 40219
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F 441	<p>Continued From page 12</p> <p>contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc..</p> <p>Review of the facility's policy titled Standard Precautions, dated 10/2004, revealed to wash hands after removing gloves.</p> <p>Review of the CDC Guideline for Hand Hygiene in Health-Care Setting, dated 10/25/02, revealed the following indications for handwashing and hand antisepsis: Decontaminate hands after contact with body fluids or excretions, mucous membranes, nonintact skin, and wound dressings; Change gloves during patient care if moving from a contaminated body site to a clean body site; Decontaminate hands after removing gloves.</p> <p>Review of Resident #12's clinical record revealed the facility admitted the resident on 12/11/11 with the following diagnoses: End Stage Renal Disease requiring hemodialysis three times a week, Atrial Fibrillation, Coronary Artery disease, Hypertension, Diabetes, and a recent fall at home that resulted in a Right Hip Fracture and required a hip replacement.</p> <p>Observation of a dressing change for Resident #12 with the Wound Care Certified Nurse (WCCN), on 12/21/11 at 4:10 PM, revealed the dressing change/supply field was set up on the heating/cooling unit under the window. The WCCN removed the resident's soiled dressing from the resident's left buttock. With the same pair of gloves, the WCCN cleaned the wound with normal saline, then opened a package of Aquacel, picked up the dressing and cut a section</p>	F 441		
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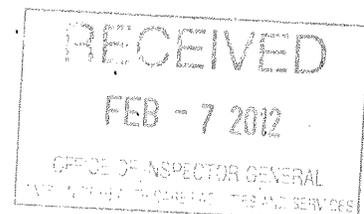
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F 441	<p>Continued From page 13</p> <p>to the appropriate size. The remainder of the Aquacel was stored back in the package. Continuing with the same soiled gloves, the WCCN placed the Aquacel dressing into the wound and covered the area with an ABD pad. The WCCN, then removed the soiled gloves and applied another pair of gloves without washing her hands. The WCCN removed the resident's brief to clean a sheared area of the scrotum with normal saline and applied nutrashield cream. Again with the same pair of soiled gloves the nurse continued with a skin assessment including removal of the dressing covering the resident's right hip incision.</p> <p>Interview with the WCCN, on 12/22/11 at 2:45 PM, revealed she did not realize she did not change gloves or wash her hands. She stated she felt nervous and wished she had set her field up differently, however, after discussing the dressing change she remembered she did not change her gloves or wash her hands. The WCCN revealed she did not know the facility's policy regarding hand washing and disposing of soiled dressings. However, the WCCN revealed she did know to wash her hands between glove changes but had forgotten to do so. The WCCN revealed she did not know when the last training had occurred for hand washing because someone else did them. The WCCN recalled having a clinical checkoff on dressing changes a year ago. The WCCN revealed there was an increase for cross contamination and infections within the facility as a result of staff 's improper hand washing</p> <p>Interview with the Staff Development and Education Coordinator, on 12/22/11 at 2:55 PM,</p>	F 441		

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F 441	<p>Continued From page 14</p> <p>revealed infection control practices during dressing changes had not been discussed during an in-service. However, handwashing and standard infection control practice were covered during inservice training in March, 2011.</p> <p>Review of the inservice, dated 03/29/11, revealed infection control and handwashing were covered and attended by the WCCN.</p> <p>Interview with the Director of Health Services (DHS), on 12/22/11 on 3:02 PM, revealed all staff are expected to use the general procedure of using clean gloves when applying a dressing. She revealed the facility had provided inservicing on infection control and revealed the WCCN had provided training to the facility staff on wound care. The DHS revealed improper technique may cause cross contamination and infection. The DHS revealed she did assist the staff with dressing changes once or twice a week, but did not monitor or audit dressing changes in regards to infection control practice and technique. The DHS further revealed competency checkoffs had not been done at the facility since June 2010.</p>	F 441		



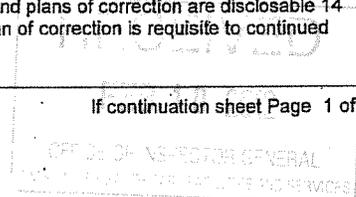
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1964, 1975, 2001</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V protected.</p> <p>FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier.</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors, upgraded in 1975.</p> <p>SPRINKLER SYSTEM: Complete automatic (wet/dry) sprinkler system, upgraded in 1975.</p> <p>GENERATOR: Two (2) Type II generators. One (1) Fuel source is diesel. One (1) Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was conducted on 12/21/11. Franciscan Health Care Center was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for eighty-five (85) beds and the census was eighty-four (84) on the day of the survey.</p>	K 000	<p>1. No residents were affected by this cited deficiency.</p> <p>2. The door to the dry storage located in the kitchen was repaired on 12-23-11. A self closing device was installed on the door. The door now latches when it closes. All doors potentially being effected were checked also.</p> <p>3. Director of Plant Operations, Executive Director and the Administrator were educated by Home Office Plant Operations Support on 12-23-11 related to NFPA requirement that doors must be self closing. Director of Plant Operations (DPO) or assistant DPO will check all facility doors monthly to ensure they all are equipped with a functioning self closing device and that the doors latch when closed. This systemic change will prevent recurrence of this deficient practice. Any doors found not self closing will be corrected immediately.</p>	01-15-2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X *Murray Adkins, W, ED* TITLE: X *Exec. Dir.* (X6) DATE: X *2-10-12*

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	K 000		
K 029 SS=D	<p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p> <p>Deficiencies were cited with the highest deficiency identified at D level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards, per NFPA Standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility is licensed for eighty-five (85) beds and the census was eighty-four (84) on the day of the survey.</p> <p>The findings include:</p>	K 029	4. DPO will report the findings of the door checks monthly in QAA. DPO will also report door check findings in the daily CQI meetings. Any non compliance with the doors will be corrected.	



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K 029	Continued From page 2 Observation, on 12/21/11 at 11:00 AM, with the Executive Director, the Administrator and the Maintenance Director revealed the door to the Dry Storage Room located in the Kitchen, did not have a self closing device installed on the door, nor would it latch when closed. Interview, on 12/21/11 at 11:00 AM, with the Executive Director, the Administrator and the Maintenance Director revealed they were not aware the Dry Storage Room was considered a hazardous storage area and the door was required to be equipped with a self closing device and latch when closed. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops	K 029		



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K 029	Continued From page 3 (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		

