

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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT GLENVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD. LOUISVILLE, KY 40222	
(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 initiated on 11/19/03 and concluded on 11/21/13 with deficiencies cited at the highest scope and severity of a "D". A Life Safety Code survey was initiated and concluded on 11/19/13 with deficiencies cited at the highest scope and severity of a "D".	F 000	The statements made on this plan or correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to ensure Intravenous (IV) poles which had held tube feeding were cleaned for two (2) of sixteen (16) sampled residents, Residents #1 and #2 and two (2) of six (6) unsampled residents, Unsampled Residents E and F. The findings include: Review of the facility's policy regarding Cleaning and Disinfection of Resident - Care Items and Equipment, revised 08/09, revealed reusable items were to be cleaned and disinfected or sterilized between residents (durable medical equipment). The facility did not provide a policy on the daily cleaning of the resident's medical equipment.	F 253	Resident #1 and resident #2 intravenous poles were immediately cleaned by housekeeping on 11/21/2013 An audit was conducted by unit managers on all intravenous poles in the facility to insure they were clean on 11/21/2013	

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

Charles A. Mayer

TITLE

Admin

(X6) DATE

12-13-13

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.

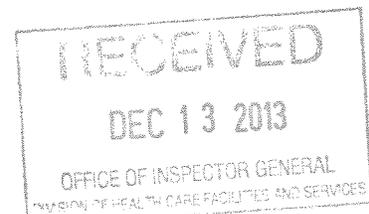
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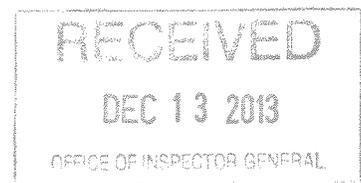
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F 253	<p>Continued From page 1</p> <p>Observation during tour, on 11/19/13 at 9:15 AM, revealed Resident #1's IV pole that held tube feeding bags had a light brown substance all along the base of the IV pole.</p> <p>Observation during environment tour, on 11/20/13 at 10:50 AM, revealed Resident #2 and Unsampld Resident F, were observed with IV poles with a brown substance on the base of each IV pole. Further observation 11:00 AM, revealed Unsampld Resident E's IV pole had a yellow substance at the base of the IV pole.</p> <p>Interview with Housekeeper #2, on 11/21/13 at 1:15 PM, revealed she had never had to clean an IV pole. Housekeeper #2 stated she tried to clean the base of the pole if she saw the IV pole was dirty. There was no schedule that stated the IV pole had to be cleaned. The Housekeeper stated she thought it was nursing's responsibility to clean the IV pole because she could dislodge the IV line or a tube feeding.</p> <p>Interview with Housekeeper #3, on 11/21/13 at 1:20 PM, revealed sometimes she cleaned the IV poles and sometimes she did not. Housekeeper #3 stated no one informed her that she was responsible for cleaning the IV poles.</p> <p>Interview with Registered Nurse (RN) #2, on 11/21/13 at 1:12 PM, revealed she thought it was housekeeping's responsibility to clean the IV poles. RN #2 stated she had cleaned an IV pole before when she was removing the IV pole from one resident room to another resident room. RN #2 stated she had not noticed the base of the IV poles being dirty.</p> <p>Interview with RN #3, on 11/21/13 at 1:21 PM,</p>	F 253	<p>Housekeeping, nursing and central supply will be educated by Staffing Development Coordinator (SDC) on checking intravenous poles for cleanliness. How and when to clean the IV poles by 12/20/13</p> <p>Housekeeping manager/ Assistant Director of Nursing (ADON)/ supervisor will conduct an audit twice a week for one month then weekly on all intravenous poles in the facility to check for cleanliness. The audit information will be discussed monthly in the QA meeting.</p> <p>Date of compliance 12-24-2013</p>	



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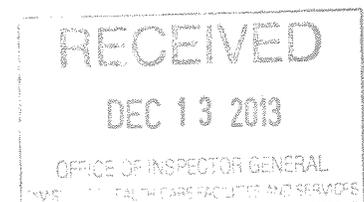
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F 253	Continued From page 2 revealed she thought it was housekeeping's responsibility to clean the IV poles. RN #3 stated if she saw the IV pole was dirty she would clean it with a bleach wipe. Sometimes the bottom was hard to clean with a bleach wipe and she would have to get a housekeeper to clean the bottom of the IV pole. Interview and observation of Housekeeper #2, on 11/21/13 at 1:30 PM, revealed she thought Unsampld Resident F's IV pole looked dirty. During the observation of Housekeeper #2 cleaning the pole revealed she stated the brown substance was hard to come off and that it was like taking off glue. Interview with the Housekeeping Manager, on 11/21/13 at 1:45 PM, revealed if the IV pole was in a resident room, it was the responsibility of the Housekeeping staff to clean the IV pole. If the IV pole was being removed from the room, then it was Central Supply's responsibility to clean the IV pole. The Housekeeping Manager stated if the IV poles were not cleaned then the chance of infection could occur. Interview with the Administrator, on 11/21/13 at 2:15 PM, revealed there was no one in Central Supply at the time and he was training someone for the Central Supply position. The Administrator stated it was the responsibility of Housekeeping to clean the base of the IV poles daily and when the IV poles came back to Central Supply, Central Supply was to clean the IV poles.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		



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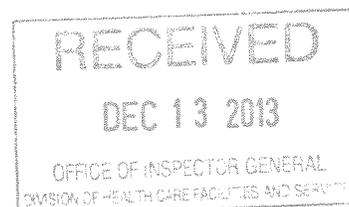
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F 279	<p>Continued From page 3</p> <p>to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to develop a comprehensive care plan for one (1) of sixteen (16) sampled residents, Resident #11 in regards to splints and one (1) of six (6) unsampled residents, Unsampled Resident A in regards to contact isolation.</p> <p>The findings include:</p> <p>1. Review of the facility's Care Plan Policy, effective December 2010, revealed the procedure for resident care plan was to initiate the care plan at the time of admission. General information from the new resident may include: clinical</p>	F 279	<p>F279</p> <p>The care plan of Resident #11 was updated on 11-21-13 by unit manager to reflect the use of splints. The care plan and physician order for un-sampled resident A was updated on 11-21-2013 by unit manager to include contact isolation. Certified Nursing Assistant (CNA) assignment sheet was immediately updated by unit managers on 11-21-2013 to show residents currently in isolation.</p> <p>An audit by Director of Nursing/Assistant Director of Nursing/Minimum Data Set Nurse/ Unit Managers of all resident physician orders, care plans and CNA assignment sheet will be completed by 12-20-2013 to insure appropriate orders, interventions and goals and updated accordingly. All new admissions will be reviewed by Director of Nursing/Assistant Director of Nursing/ Minimum Data Set Nurse in clinical meeting for accuracy of physician orders and care plans.</p>	



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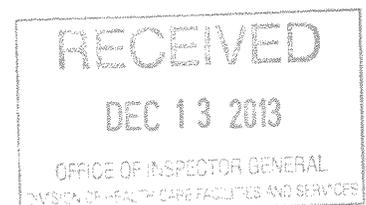
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F 279	<p>Continued From page 4</p> <p>conditions; activities of daily living; and personal habits. Supplementary information about the new resident may be obtained from: the interdisciplinary teams assessment; the physician orders; and the history and physical.</p> <p>Review of Resident #11's record revealed the facility admitted the resident on 11/27/12 with diagnoses of Cerebral Vascular Accident, Lack of Coordination, Abnormality of Gait and Left Sided Paralysis. Review of the Quarterly Assessment, dated 10/21/13, revealed the facility assessed Resident #11 with a BIM score of eleven (11), which identified Resident #11 as being interviewable.</p> <p>Review of Resident #11's physician orders, dated 11/01/13, revealed Resident #11 was to wear left upper extremity orthotic up to or equal to eight (8) hours daily.</p> <p>Observation of Resident #11, on 11/20/13 at 3:00 PM, 4:08 PM and 4:27 PM, revealed Resident #11 did not have any splints on his/her hands while laying in the bed.</p> <p>Interview with Resident #11, on 11/20/13 at 4:27 PM, revealed Resident #11 used to go to therapy and therapy would place splints on him/her. Resident #11 stated he/she had not had the splints on for a while and that no one ever put them on him/her.</p> <p>Review of Resident #11's Care Plan, revealed no plan of care for Resident #11's use of hand splints.</p> <p>Interview with Occupational Therapist (OT), on 11/21/13 at 2:48 PM, revealed she did not</p>	F 279	<p>All nursing staff educated on proper care planning processes, measureable goals and appropriate interventions by the Staff Development Coordinator. Educated therapy staff on the process of nursing completing care plans. On 12-16-2013 Regional MDS nurse educated MDS nurse on as part of the care plan process and new admission process that the residents were reviewed for splints and isolation if identified then a problem, goal and intervention that are appropriate for the resident was implemented. Education will be completed on 12-24-2013 <i>12-23-13 per C. Mayhew</i></p> <p>DON/ADON/MDS will monitor resident record review in clinical meeting to insure each resident has a comprehensive care plan that reflects resident physician orders. DON/Unit Manager will audit 10% of resident charts for compliance x 4 weeks then 10% x 2 months. This information will be discussed monthly in QA meeting. If resolved, then 10% of resident record reviews will be monitored monthly in clinical meeting.</p> <p>Date of compliance 12-24-2013 <i>by PB 12-18-13</i></p>	



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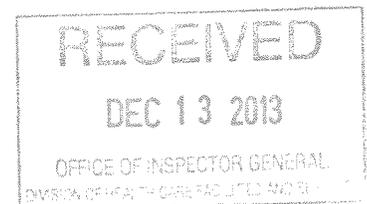
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F 279	<p>Continued From page 5</p> <p>complete care plans, she thought it was the nursing staff's responsibility to complete care plans on the splints. The OT stated she did come up with a plan but the plan was not apart of the comprehensive care plan.</p> <p>Interview with the Unit Manager, on 11/21/13 at 3:30 PM, revealed Resident #11 should have a splint care plan. The Unit Manager stated she would expect the staff to follow the care plan. If their was no plan of care the staff could not be expected to follow it.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator, on 11/21/13 at 3:47 PM, revealed she completed the comprehensive care plans and updated the care plans as needed. The MDS Coordinator stated she looked at nurses notes, therapy notes, psych notes and twenty-four (24) hour reports. The MDS Coordinator stated there should be a care plan for the use of splints and it was her responsibility to ensure the care plan was up-to-date. The MDS Coordinator stated the staff could not follow the splint care plan if one was not written.</p> <p>Interview with the Director of Nursing (DON), on 11/21/13 at 4:24 PM, revealed nursing and the MDS Coordinator could initiate the care plans. The DON stated she expected the nursing staff to follow the care plan and was not aware Resident #11 did not have a care plan for his/her splints.</p> <p>2) Review of Unsampled Resident A's clinical record revealed the facility admitted the resident on 11/13/13 with diagnoses of Vancomycin</p>	F 279		



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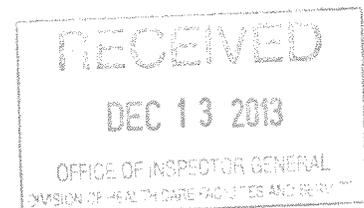
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F 279	<p>Continued From page 6</p> <p>Resistant Enterococci (VRE) Infection and Acute Renal Failure. Review of a Social Service note, dated 11/15/13, revealed the facility assessed Unsampld Resident A as having a cognition score of 13/15 on the Brief Interview for Mental Status (BIMS). Review of the initial nursing assessment and the nursing progress notes, dated 11/13/13-11/20/13 at 5:30 AM, revealed no mention of Unsampld Resident A being placed in contact isolation precautions for a VRE infection. However, review of the initial nursing plan of care, dated 11/13/13, revealed Contact Isolation Precautions as a goal due to the resident having VRE. Review of the physician orders prior to 10:30 AM on 11/20/13 revealed no order for Contact Isolation Precautions for Unsampld Resident A. Review of the comprehensive nursing care plan did not reveal a plan of care for the resident being in contact isolation precautions. Review of the CNA assignment sheet did not reveal any mention of the resident being in contact isolation precautions.</p> <p>Interview with Registered Nurse (RN) #1, on 11/20/13 at 4:30 PM, revealed Unsampld Resident A had been in contact isolation precautions since admission to the facility on 11/13/13 for a VRE infection. He stated there should have been a nursing care plan for contact isolation precautions as part of the comprehensive nursing care plan, a physician's order for the contact isolation precautions and contact isolation precautions should have been noted on the CNA assignment sheet.</p> <p>Interview with the Director of Nursing (DON), on 11/21/13 at 9:00 AM, revealed the facility nurses were trained to include all types of isolation precautions on the comprehensive nursing care</p>	F 279			



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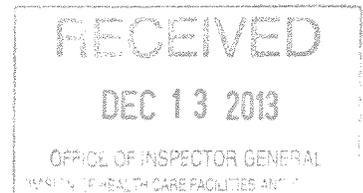
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F 279	Continued From page 7 plan, but not the CNA assignment sheet. She stated it was the facility's practice to get a physician's order when isolation precautions were required for any resident. She indicated she was not aware of why those things were not done. The DON further stated she realized the staff needed more training on infection control and isolation precautions and she recognized that information should be on the CNA assignment sheet.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to implement care plan approaches for two (2) of sixteen (16) sampled residents, Resident #9 and Resident #10. The comprehensive care plan failed to address assistance with setting up appointments with the VA as needed for a hearing test for Resident #10 and for floating the heels of Resident #9 while in bed to prevent pressure. The findings include: Review of the facility's care plan policy, (effective December 2010) revealed all residents were to have care plans which provided guidance to all staff caring for the residents and communicated those changes in care to all direct care staff. An	F 282	F282 Hearing test was set up on 12-3-2013 for resident #10 at the VA Hospital and care plan updated to reflect the need for assistance for setting up appointments with the VA for hearing test on 12-10-2013 Resident # 9 heels were immediately floated in bed on 11-21-2013 and care plan was updated by unit manager to reflect the need for floating resident's heels while in bed to prevent pressure.	



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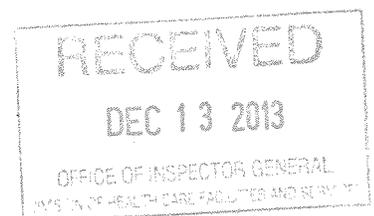
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F 282	<p>Continued From page 8</p> <p>interdisciplinary approach was used to identify problems and develop solutions and goals providing individualization and coordination of resident care.</p> <p>Review of the clinical record for Resident #10 revealed the facility admitted the resident on 03/05/11 with diagnoses of Heart Failure, Atrial Fibrillation, Hypertension, Peripheral Vascular Disease, Diabetes Mellitus, with Neuropathy. Review of the Annual Assessment, dated 07/26/13, revealed the facility assessed the resident's hearing without his/her hearing aids and was found to have moderate difficulty and required the speaker to increase volume and speak distinctly. The resident was also found to have good mental recall of information, and orientation to year, month, and day. The Brief Interview for Mental Status (BIMS) score was 15 of 15.</p> <p>Review of the Resident #10's care plan, dated 03/05/11, revealed the resident's long term goal was to maintain their highest level of self-function related to his/her hearing loss. The facility's approach, dated 04/24/12, included: assistance with setting up appointments with the VA as needed for hearing test; encourage and remind the resident to report changes in hearing; observe daily for changes in hearing; and encourage the resident to wear his/her hearing aids.</p> <p>Observation of Resident #10, on 11/19/13 at 9:40 AM, revealed the resident was not wearing hearing aids and was sitting in his/her wheel chair in the main dining room. The resident asked why it was taking so long to get an appointment for new hearing aids. Communication with Resident #10 required an elevated speaking volume, slowly</p>	F 282	<p>An audit will be completed by Director of Nursing/ Assistant Director of Nursing/ Minimum Data Set Nurse (MDS) and Unit Managers of all resident physician orders/ care plans and CNA care records by 12-20-2013 to insure all interventions are in place as ordered.</p> <p>Staff Development Coordinator will educate nursing staff on the care of hearing aids, educated staff on how to properly float heels in bed as ordered by 12-24-2013. All nursing staff educated on how to read and follow a care plan and CNA care records by Staff Development Coordinator by 12-24-2013-12-23-13 pncm 12-18-13</p>		



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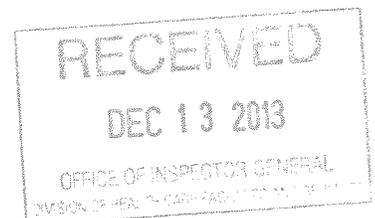
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F 282	<p>Continued From page 9 and directly into the resident's ear. Continued observation of Resident #10 sitting in his wheel chair at the nurses' station, on 11/19/13 at 3:35 PM, revealed the resident was agitated and verbalizing the need for an appointment with the VA.</p> <p>Interview with Resident #10, on 11/19/13 at 3:35 PM, revealed he/she was hard of hearing, and he had hearing aids, but they did not work right and wanted to go back to the VA for an appointment about getting some new hearing aids.</p> <p>Interview with the Unit Manager, Licensed Practical Nurse #5, on 11/19/13 at 4:10 PM, revealed Resident #10 had been to the VA about a year ago, and further stated the resident refused to wear the current hearing aids.</p> <p>Review of the facility's appointment book for outside appointments, on 11/20/13 at 9:50 AM, revealed no appointments for auditory services for Resident #10 for the whole year of 2013, including the last few weeks of this year.</p> <p>Interview with Certified Nursing Assistant (CNA) #5, on 11/21/13 at 8:20 AM, revealed Resident #10 had two (2) hearing aids, and she would assist him with getting them in the resident's ears. The CNA stated she saw them last about a month ago.</p> <p>Observation and Interview with Registered Nurse (RN) #3, on 11/21/13 at 8:45 AM, at the medication cart for the North Unit revealed in the top drawer two cases labeled with Resident #10's name, one contained batteries for hearing aids and the other contained only a small brush and cloth for cleaning hearing aids. RN #5 stated she</p>	F 282	<p>Director of Nursing/Assistant Director of Nursing/Minimum Data Set Nurse will monitor resident record review in clinical meeting to insure each resident has a comprehensive care plan that reflects resident physician orders. DON/Unit Manager will audit 10% of resident charts for compliance x 4 weeks then random x 2 months. This information will be discussed monthly in QA meeting. If resolved, then 10% of resident record reviews will be monitored monthly in clinical meeting.</p> <p>Date of compliance 12-24-2013</p>		



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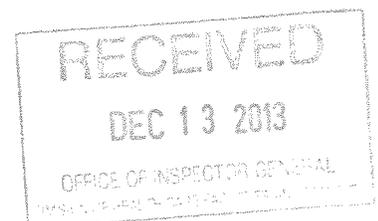
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F 282	<p>Continued From page 10</p> <p>was not aware Resident #10 had hearing aids and denied ever assisting the resident with inserting hearing aids. RN #3 further stated she had known Resident #10 to make verbal request since Summer 2013 for an appointment to the VA for his hearing and had made a verbal inquiring to Social Services, but did not know the outcome.</p> <p>Interview with RN #3, on 11/21/13 at 9:30 AM, revealed she was not aware of Resident #10's care plan that addressed his/her hearing needs.</p> <p>Interview with Quality of Life Director, on 11/20/13 at 10:25 AM, revealed he did not know Resident #10 had bilateral hearing aids despite attending multidisciplinary care plan meetings and completing two (2) quarterly assessments on 07/26/13 and 10/24/13. The Director further revealed he was not aware of any VA benefits for Resident #10 to utilize.</p> <p>Interview with Director of Nursing (DON), on 11/21/13 at 3:45 PM, revealed Resident #10 should have had a follow up appointment to the VA per his/her request about his/her hearing aids and hearing loss. The DON stated the Unit Manager should have made the residents appointment.</p> <p>2. Review of Resident #9's clinical record, revealed Resident #9 was admitted on 06/07/08, with diagnoses of Altered Mental Status, Lack of Coordination, Difficulty Walking and Cerebrovascular Accident.</p> <p>Review of Resident #9's Quarterly Assessment of the Minimum Data Set (MDS), dated 09/12/13, revealed Resident #9 had a BIM score of 00</p>	F 282	



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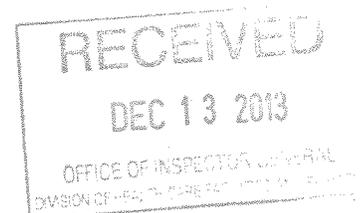
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F 282	<p>Continued From page 11 which meant Resident #9 was not interviewable.</p> <p>Review of Resident #9's Routine Care Needs, revealed the staff was to elevate the resident's heels off the bed at all times while in bed. Review of Resident #9's Physician Orders, revealed Resident #9 was to have his/her heels elevated at all times while in bed to prevent pressure.</p> <p>Observation of Resident #9, on 11/19/13 at 4:13 PM and 4:57 PM and 11/20/13 at 4:09 PM, revealed Resident #9 laying in bed with his/her feet directly on the bed.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 11/20/13 at 4:30 PM, revealed she was not aware Resident #9 was suppose to have his/her feet floating while in the bed. CNA #3 stated normally floating means that she would put on feet floaters and she did not see any in the residents room at the time.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 11/20/13 at 5:12 PM, revealed he was not aware Resident #9's feet were not elevated so as to float them while in the bed. LPN #3 stated he should have probably checked to ensure that when the CNA laid Resident #9 down that his/her feet were floating off the bed.</p> <p>Observation with LPN #3 of Resident #9's heels, on 11/20/13 at 5:12 PM, revealed no skin concerns.</p> <p>Interview with the Unit Manager, on 11/21/13 at 3:30 PM, revealed she was not aware of any skin concerns to the bottom of Resident #9's heels. The Unit Manager stated she was aware the staff was to float the resident's heels to prevent</p>	F 282			



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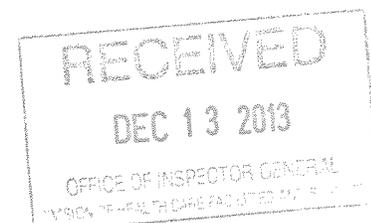
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F 282	Continued From page 12 pressure and she expected the staff to follow the care plan as directed. Interview with the Director of Nursing (DON), on 11/21/13 at 4:24 PM, revealed she expected the nursing staff to follow the care plan. The DON stated she was not aware if Resident #9 had any reddened heels or if the staff was to float the resident's heels. The DON stated she expected the staff to follow the care plan and do what the care plan stated.	F 282		
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure one (1) of sixteen (16) sampled residents, Resident #10 received proper treatment to obtain hearing devices to maintain his/her auditory function to enhance the resident's hearing. The findings include: Review of the facility's policy regarding Care of Hearing Aids, dated June 2007, revealed the staff	F 313	F313 Hearing test was set up on 12-3-2013 for resident #10 at the VA and care plan updated to reflect the need for assistance for setting up appointments with the VA for hearing test on 12-10-2013 An audit was conducted by Unit Managers on all residents with hearing difficulties including the need for hearing aides by 12-20-2013 and any concerns found were addressed by 12-24-2013	



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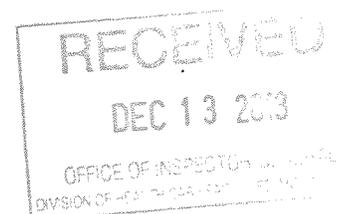
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F 313	<p>Continued From page 13</p> <p>was to consult the resident's care plan concerning the use of hearing aids. The policy included issues or concern and possible causes related to behavior related to hearing loss. This policy did not offer any monitoring and/or communication of the issues and concerns listed in the policy.</p> <p>Review of the clinical record for Resident #10 revealed the facility admitted the resident on 03/05/11 with diagnoses of Heart Failure, Atrial Fibrillation, Hypertension, Peripheral Vascular Disease, and Diabetes Mellitus with Neuropathy. Review of the Admission Minimum Data Set Assessment (MDS) Annual Assessment, dated 07/26/13, revealed the facility assessed the resident's hearing without using his/her hearing aids and was found to have moderate difficulty and required the speaker to increase the volume and speak distinctly.</p> <p>Review of the Resident #10's care plan, dated 03/05/11, revealed the resident's long term goal was to maintain their highest level of self-function related to hearing loss. The facilities approach, dated 04/24/12, included assistance with setting up appointments with the VA as needed for hearing test, to encourage and remind the resident to report changes in hearing, to observe daily for changes in hearing, and encourage the resident to wear his/her hearing aids.</p> <p>Observations of Resident #10, on 11/19/13 at 8:40 AM, 9:40 AM, and 3:35 PM, revealed the resident was not wearing hearing aids.</p> <p>Interview with Resident #10, on 11/19/13 at 3:35 PM, revealed he/she was hard of hearing, and had hearing aids, but they did not work right,</p>	F 313	<p>Staffing Development Coordinator will educate all nursing staff on identifying residents with hearing impairments to notify unit manager and social services to set up appropriate services for the resident and education on care of hearing aids by 12-24-2013. <i>12-23-13 per CM by PJ 12-18-13</i></p> <p>Social services will audit weekly x 4 weeks the monthly x 2 months for resident complaints of hearing issues and appointments. Social Services will follow up with Unit Managers every week x 3 months to insure residents who are requesting hearing services have an appointment to be seen. This information will be discussed monthly in QA meeting. If resolved, then Unit Managers will follow up with Social Services monthly.</p> <p>Date of compliance 12-24-2013</p>	



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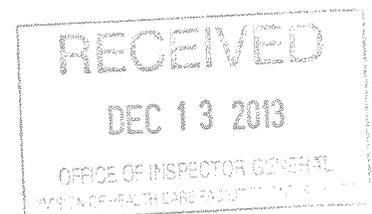
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F 313	<p>Continued From page 14</p> <p>therefore the resident was not wearing them, but wanted to go back to the VA for an appointment about getting some new hearing aids.</p> <p>Interview with Unit Manager, Licensed Practical Nurse (LPN) #5, on 11/19/13 at 4:10 PM, revealed Resident #10 had refused to wear the hearing aids. LPN #5 further stated it had been over a year since Resident #10's last appointment to the VA for hearing.</p> <p>Interview with Certified Nursing Assistant (CNA) #5, on 11/21/13 at 8:20 AM, revealed Resident #10 had two (2) hearing aids, and she would assist him with the use of those aids. The CNA further stated the resident would complain the hearing aids did not work well and would take them out.</p> <p>Interview with Registered Nurse (RN) #3, on 11/21/13 at 8:45 AM, revealed she was not aware Resident #10 had hearing aids and denied ever assisting the resident with inserting hearing aids. RN #3 further stated she had known Resident #10 to make verbal request since Summer 2013 for an appointment to the VA about getting new hearing aids. The nurse was not able to locate Resident #10's hearing aids, only the empty case was locked up on the medication cart.</p> <p>Interview with the Quality of Life Director, on 11/20/13 at 10:25 AM, revealed he did not know Resident #10 had bilateral hearing aids despite attending multidisciplinary care plan meetings and completing two (2) quarterly assessments on 07/26/13 and 10/24/13. The Director further revealed he was not aware of any VA benefits for Resident #10 to utilize. The Quality of Life Director was interviewed again, on 11/21/13 at</p>	F 313			



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F 313	Continued From page 15 3:10 PM, and revealed Resident #10 had asked him about making appointments to the VA everyday, but no appointments were made for the resident. The Director further stated he spoke with Resident #10 on 11/19/13 in the PM about getting new hearing aids. Interview with Director of Nursing (DON), on 11/21/13 at 3:45 PM, revealed Resident #10 should have had a follow up appointment to the VA per his request about his/her hearing aids and hearing loss. The DON also revealed Resident #10 had hearing aids at one time, but refused to wear because they were too loud. She continued to say she did not know when that happened because hearing aids are not tracked on the medication or treatment record.	F 313			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to ensure one (1) of sixteen (16) sampled residents, Resident #11 received restorative services as ordered. The findings include:	F 318	F318 Restorative services were implemented as ordered immediately for resident #11 on 11-21-2013 An audit will be conducted by 12-24-2013 by the restorative nurse on all residents to insure all restorative orders are in place as ordered. Restorative nurse and therapy educated by Director of Nursing/ Assistant Director of Nursing on the referral process for restorative nursing services on 12-18-2013.	12-23-13 pm Cm by PB 12-18-13	



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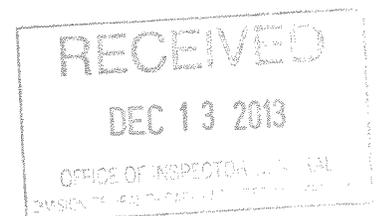
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F 318	Continued From page 16 Review of the facility's Introduction to Restorative Nursing Process policy, dated July 2010, revealed the goal at all levels, was to restore the resident's functionality whenever possible, improve the ability for self-care and maintain independence as long as possible. Review of Resident #11's record revealed the facility admitted the resident on 11/27/12 with diagnoses of Cerebral Vascular Accident, Lack of Coordination, Abnormality of Gait and Left Sided Paralysis. Review of Resident #11's Quarterly Assessment, dated 10/21/13, revealed the facility assessed Resident #11 with a BIMs score of eleven (11), which identified Resident #11 as being interviewable. Review of Resident #11's Admission Assessment, dated 01/08/13, revealed the resident and direct care staff believed Resident #11 was capable of increased independence in at least some activities of daily living (ADL's). Review of Resident #11's physician orders, dated 10/24/13 (late entry), revealed on 10/18/13 Resident #11 was discharged from skilled Occupational Therapy Services secondary to non-compliance with plan of care. Review of Resident #11's physician orders, dated 11/01/13, revealed Resident #11 was to wear a left upper extremity orthotic up to or equal to eight (8) hours daily. Review of the Restorative Care Program, revealed therapy discharged Resident #11 on 10/18/13 and was to begin restorative program on 10/19/13. The goal was to maintain range of	F 318	Director of Nursing/ Assistant Director of Nursing will receive copies of all restorative referrals daily and will be reviewed and audited in clinical meeting. Results will be discussed at QA meeting monthly. Date of compliance 12-24-2013		

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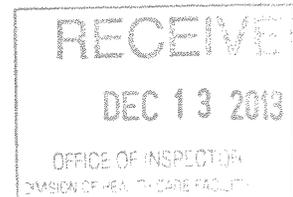
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F 318	<p>Continued From page 17</p> <p>motion in both arms and legs and was to tolerate the left hand orthotic six (6) to eight (8) hours with out signs and symptoms of pain or discomfort.</p> <p>Observation of Resident #11, on 11/20/13 at 3:00 PM, 4:08 PM and 4:27 PM, revealed Resident #11 did not have any splints on his/her hands while laying in the bed.</p> <p>Interview with Resident #11, on 11/20/13 at 4:27 PM, revealed Resident #11 used to go to therapy and therapy would place splints on him/her. Resident #11 stated he/she had not had the splints on for a while and that no one ever put them on. Resident #11 wanted to wear the splints because it helped with keeping his/her hands open.</p> <p>Interview with Certified Nursing Assistant (CNA) #4, on 11/21/13 at 3:21 PM, revealed she had not noticed Resident #11 refusing care and had seen restorative putting splints on Resident #11. CNA #4 stated she felt Resident #11 was interviewable and Resident #11's contractures had not gotten worse, but were about the same.</p> <p>Interview with the Restorative Nurse, on 11/21/13 at 2:28 PM, revealed Resident #11 was discontinued from Restorative and placed back into Occupational Therapy's (OT) Service because she had noticed the splints were too tight. The Restorative Nurse stated she did not have a referral from the Therapy Department to start restorative services for Resident #11. She stated she could not work with residents while they were receiving therapy services. The Restorative Nurse stated she was not aware Resident #11 was not getting his/her splints like</p>	F 318			



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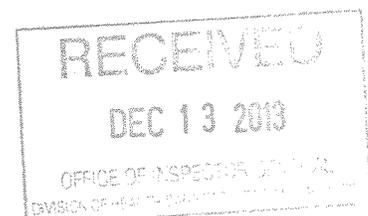
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F 318	<p>Continued From page 18</p> <p>he/she was suppose to. The Restorative Nurse stated she documented in the restorative book the restorative therapy that was provided daily. She also completed weekly notes and at the end of the month re-evaluated the residents. The Restorative Nurse stated she did not document in the computer, but that the restorative notes were her notes for each resident receiving services.</p> <p>Review of the Restorative Binder, revealed Resident #11 did not have any documentation of Restorative therapy that was received since 09/30/13, when Resident #11 was referred back to therapy.</p> <p>Further interview with the Restorative Nurse, on 11/21/13 at 2:28 PM, revealed Resident #11 was a good candidate for restorative services. The Restorative Nurse stated she had not worked with Resident #11, but was sure the restorative aid had been working with Resident #11.</p> <p>Interview with the Occupational Therapist (OT), on 11/21/13 at 2:48 PM, revealed she informed the Restorative Department when they were to start a resident on restorative. The OT stated Resident #11 was a good candidate for the restorative program to ensure the contractures did not become worse.</p> <p>Interview with Rehabilitation Services Manager, on 11/21/13 at 2:55 PM, revealed she made a restorative plan of action and recommendations and gave the information to the Restorative Nurse. The Rehab Services Manager stated she informed the Restorative Nurse on 10/16/13 to start Resident #11 on restorative services.</p> <p>Review of the Restorative Care Program sheet</p>	F 318			



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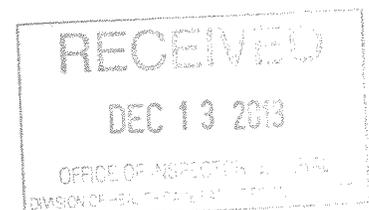
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT GLENVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD. LOUISVILLE, KY 40222		
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F 318	Continued From page 19 signed 10/16/13 by the Restorative Nurse, revealed Resident #11 was to be discharged from therapy on 10/18/13 and begin a restorative program on 10/19/13. Interview with the Restorative Nurse, on 11/21/13 at 2:28 PM, revealed she did not remember signing the Restorative Care Program, but stated it was her signature on the form. The Restorative Nurse stated if a resident did not receive restorative services like they should, the resident could become worse. Interview with the Director of Nursing (DON), on 11/21/13 at 4:24 PM, revealed she was not aware Resident #11 was not getting his/her restorative services. She usually monitored the discharge orders from therapy and that was how she found out when a resident would be put on restorative services. The DON stated they must have missed the orders for Resident #11. The DON stated Resident #11 contractures had not declined and if a resident did not receive restorative as they should the resident could become worse.	F 318			
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	F 431	F431 The medication cart containing loose no labeled medication was immediately cleaned on 11-21-2013. Audit completed by Unit Managers of all medication and treatment carts to insure no loose non-labeled medications were located in the medication carts by 12-20-2013.		



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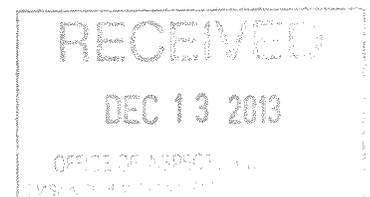
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F 431	<p>Continued From page 20</p> <p>professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all 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 policy Medication Administration-Storage, it was determined the facility failed to appropriately store resident medications in one (1) of the five (5) facility medication carts. A total of twenty-seven (27) pills were found laying on the bottom of the medication cart drawer, loose and not labeled to indicate the name, dosage, and to whom the medication belonged.</p> <p>The findings include: Review of the facility's policy Medication</p>	F 431	<p>Staffing Development Coordinator educated all nurses on proper storage of medications and cleaning schedule on medication and treatment carts. Education completed by 12-24-2013. 12-23-13 <i>mu 201</i></p> <p>Five times a week x 4 weeks auditing of medication and treatment cart will be completed by Unit Managers and Supervisor starting on 12-10-13 then weekly to insure the carts do not contain loose unlabeled medications. Director of Nursing will review audits with the Unit Managers weekly to insure compliance and results will be discussed at QA meeting monthly.</p> <p>Date of compliance 12-24-2013.</p>		



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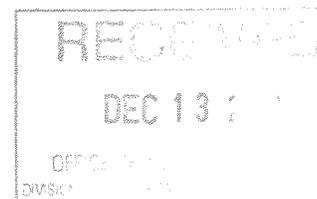
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F 431	<p>Continued From page 21</p> <p>Administration-Storage, dated December 2010, revealed the provider pharmacy dispenses medications in containers that meet legal requirements, including requirements of good manufacturing practices. Medications are kept in these containers.</p> <p>Observation of the South Unit front hall medication cart, on 11/21/13 at 10:15 AM, revealed twenty-seven (27) pills of various types laying loose on the bottom of the medication cart drawers.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 11/21/13 at 10:20 AM, revealed the pills fall out of the bubble pack in which they are supplied, stating the bubble packs are easily compromised when the carts are very full. The LPN revealed she did not know what the pills were or to whom they belonged. The LPN revealed night shift was responsible to clean the medication carts, which she stated was last completed on 11/18/13.</p> <p>Interview with LPN #4, on 11/21/13 at 2:50 PM, revealed medication carts were cleaned at least every two (2) weeks and monitored weekly to ensure the carts were in proper condition. The LPN revealed she had been the Unit Manager for the South Hall, but resigned two (2) weeks prior and did not know if the carts were still being monitored. The LPN revealed the Managers monitored the carts for their perspective Units.</p> <p>Interview with the Director of Nursing (DON), on 11/21/13 at 4:15 PM, revealed all the medication carts were cleaned and organized on 11/18/13. The DON revealed medication carts were assigned for cleaning every week; however, every nurse using a medication cart should be</p>	F 431			



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F 431	Continued From page 22 monitoring for loose medications.	F 431			
F 441 SS=D	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 Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F441 Housekeeper #1, CNA #1 and #2 were immediately educated by Staff Development Coordinator on infection control and what type of PPE is required for different types of isolation on 11-20-2013 Audit conducted by Unit Managers on 11-20-2013 to insure isolation for a resident is care planned and noted on the CNA assignment sheet. All staff educated by the Staff Development Coordinator on infection control, different types of isolation and wearing the correct Personal Protective Equipment (PPE). Education completed on 12-10-13 EMS services educated by Director of Nursing on facility infection control procedures. Director of Nursing and Unit Mangers will monitor infection control practices including wearing correct PPE for isolation to insure compliance is met 5 times a week x 2 weeks, then weekly. Results will be		



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F 441	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to ensure the staff infection control practices were consistent with current infection control principles for one (1) of six (6) Unsampled Residents, Unsampled Resident A. Housekeeper #1, Certified Nursing Assistant (CNA) #1 and #2 and an Emergency Services (EMS) worker were observed in the resident's room without the appropriate personal protective equipment (PPE) for contact isolation. The findings include: Review of the facility's policy Isolation-Categories of Transmission-Based Precautions, dated August 2012, revealed staff should wear gloves and a disposable gown upon entering the contact precaution room. Observation of Unsampled Resident A's room (Room 20), on 11/19/13 at 10:30 AM, revealed Housekeeper #1 was in the room without any PPE on and with her clothing touching the bed. Further observation of the room revealed an isolation sign on the door of the room and a cart containing PPE outside the door. Observation of Room 20, on 11/19/13 at 3:50 PM, revealed an Emergency Services (EMS) worker in the room without PPE on, and adjusting the overbed television screen for Unsampled Resident A with his clothing touching the bed.	F 441	discussed monthly in QA meeting. Date of compliance 12-24-2013	

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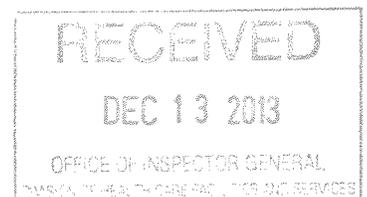
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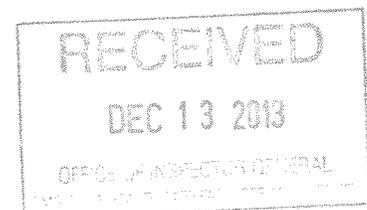
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F 441	<p>Continued From page 24</p> <p>Observation of Room 20, on 11/20/13 at 10:30 AM, revealed Certified Nursing Assistant (CNA) #1 and #2 in the room without PPE on and touching the bed linens.</p> <p>Review of Unsampled Resident A's clinical record revealed the facility admitted the resident on 11/13/13 with diagnoses of Vancomycin Resistant Enterococci (VRE) infection and Acute Renal Failure. Review of a Social Service note, dated 11/15/13, revealed the facility assessed Unsampled Resident A as having a cognition score of 13/15 on the Brief Interview for Mental Status (BIMS). Review of the initial nursing assessment and the nursing progress notes, dated 11/13/13-11/20/13 at 5:30 AM, revealed no mention of Unsampled Resident A being placed on contact isolation precautions for a VRE infection. However, review of the initial nursing plan of care, dated 11/13/13, revealed Contact Isolation Precautions was a goal due to the resident having VRE. Review of the physician orders prior to 10:30 AM on 11/20/13 revealed no order for Contact Isolation Precautions for Unsampled Resident A. Review of the comprehensive nursing care plan did not reveal a plan of care for the resident being in contact isolation precautions. Review of the CNA assignment sheet did not reveal any mention of the resident being in contact isolation precautions.</p> <p>Interview with Housekeeper #1, on 11/19/13 at 10:35 AM, revealed she saw Unsampled Resident A being taken from the room to go to the hospital and she thought she would take the opportunity to clean the room. She stated she knew it was a contact isolation room, but she failed to remember to don any PPE. She</p>	F 441			



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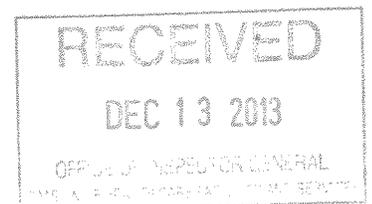
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F 441	<p>Continued From page 25</p> <p>indicated she had been trained by the facility to wear a gown and gloves when in a contact isolation room and touching the bed/linens or any other potentially contaminated objects in the room. Housekeeper #1 stated she knew she could pass on the infection to other residents in the facility if she failed to wear the appropriate PPE.</p> <p>Interview with Registered Nurse (RN) #1, on 11/19/13 at 4:00 PM, revealed he saw the EMS worker come out of Room 20 without PPE on at the same time as the surveyor and he realized the worker should have had on PPE. RN #1 stated the EMS workers did not always report to the facility nurse before taking residents into their rooms, but they should heed the signage on the room doors for precautions and should wear the appropriate PPE in order not to spread infections.</p> <p>Interview with CNA #1, on 11/20/13 at 9:00 AM, revealed she had been trained by the facility on isolation precautions, but she was unsure of when to wear the appropriate PPE. She stated she knew the resident in room 20 was on precautions, but she did not know what for and did not know which PPE she should wear in the room. CNA #1's assignment sheet did not have contact isolation precautions listed for Unsampled Resident A. She further stated she forgot to wear the PPE in Room 20 that morning.</p> <p>Interview with CNA #2, on 11/20/13 at 9:15 AM, revealed she had been trained by the facility on infection control and on isolation precautions. She stated she did not remember to don gloves that morning when she delivered the resident's tray and she did touch the bed linens with her clothing.</p>	F 441			



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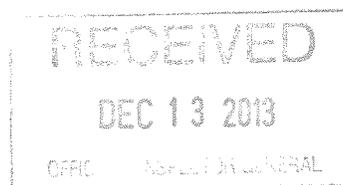
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F 441	Continued From page 26 Interview with the Housekeeping Manager, on 11/21/13 at 8:30 AM revealed it was her job to train the housekeepers on infection control, different types of isolation precautions and PPE. She stated she was not sure what type of isolation one of the residents was on and she also stated Housekeeper #1 should have had on PPE when she cleaned Room 20 the morning of 11/19/13. Interview with the Director of Nursing (DON), on 11/21/13 at 9:00 AM, revealed the facility had a new infection control nurse for the past five (5) months and she and the Housekeeping Manager were both doing some infection control training. She stated it was now clear to her the staff were not knowledgeable about different types of isolation precautions for the residents and which PPE to wear for different infections. She further stated isolation precautions should be on the comprehensive nursing care plan and on the CNA assignment sheets.	F 441			
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure laboratory collection tubes were not expired to ensure quality and accuracy of the results. There were eight blood culture bottles found expired in one	F 502	F502 Expired laboratory supplies were immediately disposed of on 11-21-2013 Audit was conducted on 11-21-2013 by Unit Managers to insure no expired laboratory supplies were in facility		



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F 502	Continued From page 27 (1) of the two (2) facility medication rooms. The findings include: The facility did not provide a policy on monitoring of laboratory supplies, the quality of laboratory specimens and the accuracy of the results. Observation of the South Unit medication room, on 11/21/13 at 10:15 AM, revealed three (3) aerobic blood culture bottles that expired 07/12/13, three (3) anaerobic blood culture bottles that expired 08/30/13, one (1) aerobic blood culture bottle that expired 05/31/13, and one (1) anaerobic blood culture bottle that expired 05/18/13. Interview with Licensed Practical Nurse (LPN) #1, on 11/21/13 at 10:15 AM, revealed expired laboratory specimen bottles could alter results and cause inaccurate readings. The LPN revealed she thought the Unit Manager was responsible to monitor the lab supplies, but was not sure. Interview with LPN #4, on 11/21/13 at 2:50 PM, revealed she was the former South Unit Manager but resigned from the position. The LPN revealed she assumed the responsibility of monitoring the lab supplies while Unit Manager. However, the LPN revealed two (2) nurses had been sharing the task as interim unit manager and was not sure if this was still being done. Interview with the Director of Nursing (DON), on 11/21/13 at 4:15 PM, revealed the Unit Managers were responsible to monitor the lab supplies. However, the DON revealed she did not tell the interim manager and felt she probably did not	F 502	Educated unit managers and nurses by Staff Development Coordinator to check dates on laboratory supplies and dis-guard if expired. Education completed by 12-24-2013 <i>12-23-13 pncm by p312-1873</i> Unit managers will audit laboratory supplies weekly and discuss results with DON. These results will be discussed monthly at QA meeting. Date of compliance 12-24-2013		

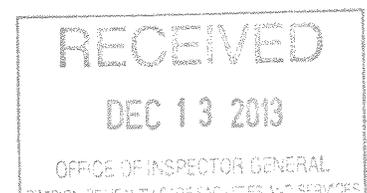


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F 502 F 514 SS=D	Continued From page 28 know it was her responsibility to monitor. 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards 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 record review, it was determined the facility failed to maintain clinical records in accordance with accepted professional standards and practices which were complete and accurately documented for six (6) of sixteen (16) Sampled and six (6) Unsampled Residents, Resident #1, #14, #15, #16 and Unsampled Resident A and B. The Medication Administration Record (MAR) had no nursing signatures on the signature legends for Resident #1, #14, #15, #16 and Unsampled Resident A and the MAR for Unsampled Resident B had an order documented as "duplicate" with no duplicate order found on the MAR. The findings include:	F 502 F 514	F514 The nurses working with residents #1,#14, #15, #16 and un-sampled resident A immediately signed the legend on the MAR and TAR. Resident un-sampled Bilateral eye drops order was clarified with MD. Audit will be conducted by Unit Managers on MARS and TARS for nurse signatures on MAR and TAR legends on All physician orders were compared to MARs and TARS for accuracy on 12-13-2013. Staff Development Coordinator educated all nurses to sign the master signature log located in the front of the MAR and TAR. Education completed by 12-23-13. Unit managers were educated on 12-13-2013 by Staff Development Coordinator to check MARs and TARs daily to insure physician orders have been transcribed properly.		

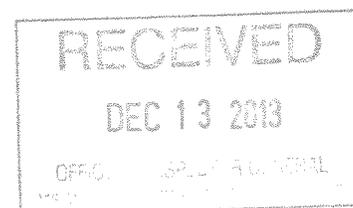
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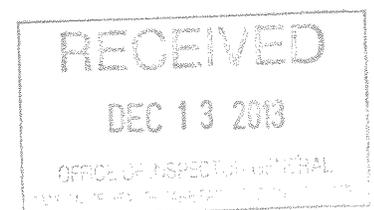
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F 514	<p>Continued From page 29</p> <p>The facility did not provide a policy regarding proper documentation on the MAR.</p> <p>Review of the MAR for Resident #1, #14, #15, #16 and Unsampled Resident A revealed no nurses' signatures on a legend to signify whose name was attached to the initials documented in a space to indicate a nurse had administered a medication at a specific time as ordered.</p> <p>Interview with Registered Nurse (RN) #1, on 11/20/13 at 4:00 PM, revealed it was not the facility's practice for nurses to sign a legend on the MAR to identify their initials documented on the MAR. He stated it was part of his responsibility to review records, but he did not know the legends were to be signed. He stated he was a new nurse and he had never signed his signature to a MAR at the facility.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 11/20/13 at 4:10 PM, revealed it was the facility's practice for nurses to sign each medication given with their initials, but the legend on the MAR was not signed with the nurses' signatures. She stated she thought the facility had a master legend of the nurses' signatures.</p> <p>Interview with the Director of Nursing (DON), on 11/20/13 at 4:20 PM, revealed the facility was owned by a different corporation within the past year and the other corporation practice was to keep a master legend of the nurses' signatures who administered medications. She indicated she did not have a master legend for the nurses' signatures and the nurses were not in the habit of signing the legends on the MAR's. She further indicated it was standard practice for nurses to sign the legend on the MAR or for the facility to</p>	F 514	<p>Unit managers will audit MARs and TARs 5 x a week for 4 weeks then weekly to insure orders are transcribed properly. These results will be discussed with Director of Nursing daily and results will be monitored at QA meeting monthly.</p> <p>Unit Manager/Assistant Director of Nursing will audit master signature log weekly to insure all nurses have signed. These results will be reviewed by the Director of Nursing with the Unit Managers weekly and results will be discussed at QA meeting monthly.</p> <p>Date of compliance 12-24-2013</p>	12-24-2013	



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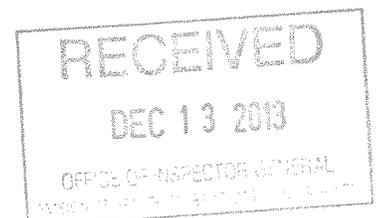
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F 514	<p>Continued From page 30</p> <p>have a master signature legend. The DON stated it was standard and best practice for a nurse to have his/her signature listed to identify his/her initials on a medication administration record.</p> <p>Review of the facility's policy regarding Physician Orders at a Glance, not dated, revealed all Medication Administration Records (MAR) to be audited daily by the Director of Nursing or designee.</p> <p>Observation of the medication pass for Unsampled Resident B, on 11/20/13 at 8:25 AM, revealed Registered Nurse (RN) #1 administered Artificial tears to the left eye and Isopto tears to both eyes.</p> <p>Review of Unsampled Resident B's Physician orders for reconciliation of medications after observation of the medication pass, revealed an order, dated 11/08/13 for Artificial tears one (1) drop to the left eye four (4) times a day and Isopto Tears 0.5% one (1) drop to both eyes four (4) times a day, dated 09/22/13.</p> <p>Review of Unsampled Resident B's MAR revealed the Isopto Tears 0.5% were marked as "duplicate" on 11/12/13. However, review of MAR revealed the medication was neither written anywhere else on the MAR or initialed that it was given during the medication pass on 11/20/13.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 11/21/13 at 2:50 PM, revealed copies of orders go to the morning meeting for review, but</p>	F 514			



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F 514	<p>Continued From page 31</p> <p>stated the MAR's are not brought to the meeting to ensure correct transcription of order. The LPN revealed the duplicate error was written three (3) days after the order transcription, so mistakes may not have been corrected until the end of the month when new MAR's were checked for accuracy. However, the LPN revealed nurses were responsible to ensure they were giving the correct medication and should have noticed the duplicate error written on the MAR to prevent the medication from not being administered.</p> <p>Interview with the Director of Nursing (DON), on 11/21/13 at 4:15 PM, revealed the Unit Managers were responsible to review the MAR daily to ensure there were no errors or variances. The DON revealed the South Unit had an interim manager who was aware of this responsibility. However, the DON revealed the interim manager was new to that position and the MAR's were probably not checked for accuracy. The DON revealed she completed a random audit to ensure this was being done.</p> <p>Interview with LPN #1, on 11/21/13 at 4:25 PM, revealed she had been interim manager for one (1) week and knew she was to check MAR's daily. However, The LPN revealed this was not done.</p>	F 514		

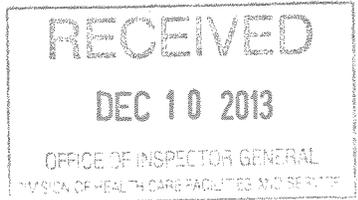


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K 000	Continued From page 1 Fire).	K 000		
K 130 SS=D	Deficiencies were cited with the highest deficiency identified at D level. NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a means of egress, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, approximately twenty-five (25) residents, staff and visitors. The facility has one-hundred and twenty (120) certified beds and the census was seventy-seven (77) on the day of the survey. The findings include: Observation, on 11/19/13 at 9:37 AM, with the Maintenance Director revealed an unapproved lock [pad lock type] was installed on the egress side of the door to Room 31, to the exit access corridor. The room was being used to store resident furniture. Interview, on 11/19/13 at 9:37 AM, with the Maintenance Director revealed he was unaware the pad lock was prohibited and agreed that a pad lock could be a deterrent to exiting the room in the event of an emergency.	K 130 K130	The lock in question was immediately removed by staff on November 18, 2013. In-service of all staff will be completed by Director of Maintenance before December 15, 2013. Audits will be performed by Maintenance Director weekly to ensure compliance and results reported to Quality Assurance Committee monthly for three months. Completion Date 12-15-13	



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K 130	Continued From page 2 Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130			

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