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

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RECEIVED
JUN 15 2015
Division of Health Care
Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	185330	B. WING	05/21/2015

NAME OF PROVIDER OR SUPPLIER
CAMPBELLSVILLE NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1580 OLD GREENSBURG ROAD
CAMPBELLSVILLE, KY 42718

(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	F 000		
	A standard health survey was conducted on 05/19-21/15. Deficient practice was identified with the highest scope and severity at "F" level.		"Submission of this Plan of Correction is neither an admission to nor an agreement with the Deficient Practices noted below, but provided as required under the Conditions of Participation."	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		
	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, record review, and facility policy review, it was determined the facility failed to ensure services were provided in accordance with each resident's written plan of care for one (1) of fifteen (15) sampled residents (Resident #8). A review of the comprehensive plan of care for Resident #8 revealed staff would provide catheter care every shift and would secure the urinary catheter with a leg strap. Observation of catheter care for Resident #8 revealed the indwelling catheter was not secured to the resident's leg. The findings include: Review of the facility policy titled "Care Plan Policy Statement," undated, revealed the resident's care plan identified the needs of the resident and would be developed by the interdisciplinary team in coordination with the resident and family. The policy stated the care plan would aid in preventing and reducing declines in the resident's functional status and/or		1. Resident # 8 urinary catheter has been secured with leg strap as directed by resident care plan, observation 06/09/15. 2. 100% audit/observation completed on 06/11/15 by facility D.O.N. and A.D.O.N confirmed residents with urinary catheters were provided. Secured via leg strap. Supra Pubic Catheter secured with adhesive patch and/or as indicated by residents plan of care.	06/23/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Neda Beard
TITLE: Administrator
(X6) DATE: 6-19-15

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

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F 282	Continued From page 1 functional levels. The policy did not address when and how often staff was required to review the plan of care. Review of the medical record for Resident #8 revealed the facility admitted Resident #8 on 05/15/13 with diagnoses that included Alzheimer's Disease and Neurogenic Bladder. Review of the physician's orders for Resident #8 revealed an order dated 11/01/13, for Resident #8 to have an indwelling urinary catheter due to a diagnosis of Neurogenic Bladder. Review of the plan of care for Resident #8 with a revision date of 11/22/13 revealed an Intervention had been added to secure Resident #8's urinary catheter to the resident's leg with a leg strap. Review of a quarterly Minimum Data Set (MDS) assessment dated 02/21/15 revealed Resident #8 had been assessed by the facility to have severely impaired cognition. The MDS also revealed the resident required the extensive assistance of two staff persons for toileting, was frequently incontinent of bowel, and required an indwelling urinary catheter. Observation of catheter care for Resident #8 by State Registered Nursing Assistant (SRNA) #1 and SRNA #2 on 05/20/15 at 2:00 PM revealed SRNA #1 draped the catheter over Resident #8's left leg after completion of catheter care. The SRNAs left the room and failed to secure the urinary catheter to the resident's leg. Interview conducted with SRNA #1 on 05/20/15 at 2:25 PM revealed she was required to review the residents' care plans at the beginning of every	F 282	3. Re-education to nursing staff per facility D.O.N. and/or A.D.O.N.to ensure compliance and providing care per residents individualized plan of care (i.e. urinary catheter secured) to facilitate the highest functional level for each resident, (scheduled completion date 06/16/15). New nursing staff will receive same education during new hire orientation. New process implemented: Licensed Nurses will verify during daily "Daily Written Shift Rounds Audit" of resident care being provided as indicated by resident plan of care, correct or ensure correction of any identified non-compliance. Nurse's "Daily Written Shift Rounds" will be a continuing on-going process. Written rounds will be given to D.O.N. and/or A.D.O.N. daily for review and follow up.	06/23/15

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F 282	Continued From page 2 shift to identify any changes. The SRNA stated she was aware Resident #8 required a leg strap to secure his/her urinary catheter. SRNA #1 stated she should have secured the resident's urinary catheter prior to leaving the resident's room after providing catheter care. Interview conducted with SRNA #2 on 05/20/15 at 2:30 PM revealed she was required to review residents' care plans at the beginning of every shift to check for any changes. SRNA #2 stated she was aware Resident #8 had a care plan intervention requiring the use of a leg strap to secure the resident's urinary catheter. The SRNA stated she should have secured the catheter to the resident's leg prior to leaving the resident. Interview conducted with Registered Nurse (RN) #1 on 05/20/15 at 2:35 PM revealed staff was required to check residents' care plans at the beginning of every shift. The RN stated she made rounds every two hours to ensure care was being provided to the residents as directed in the care plans. The RN stated she had not identified Resident #8's urinary catheter was not secured to the resident's leg and should have been. Interview conducted with the Director of Nursing (DON) on 05/21/15 at 3:25 PM revealed she made rounds throughout the facility several times a day to ensure residents were being provided care and treatment as directed by the care plans. The DON stated staff was required to secure the urinary catheter to the resident's leg. The DON stated she made room rounds on residents daily and monitored urinary catheters to ensure they were being secured and had not identified Resident #8's urinary catheter had not been secured to the resident's leg as directed by the	F 282	4. QAPI Committee consisting of at least the Administrator, DON, A.D.O.N., Social Services Dir., Activity Dir., M.D.S. Coordinator and the Medical Director to meet at least monthly beginning 06/18/2015 to review all compliance audits (Licensed Nurses Daily Written Rounds Audit)and revise care plans as indicated. This process will be ongoing or until revisions to audit process is indicated.	06/23/15

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F 282	Continued From page 3 care plan.	F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. 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 ensure one (1) of fifteen (15) sampled residents (Resident #8) received appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. A review of the facility's policy for providing urinary catheter care revealed staff was required to secure the catheter to the resident's leg to prevent trauma. However, observation of catheter care for Resident #8 revealed the indwelling catheter was not secured to the resident's leg. The findings include: Review of the facility's policy titled "Providing Catheter Care," undated, revealed staff was required to secure the indwelling urinary catheter to the resident's leg after performing catheter	F 315	1. Resident # 8 urinary catheter has been secured with leg strap as directed by resident care plan, observation 06/09/15. 2. 100% audit/observation completed on 06/11/15 by facility D.O.N. and A.D.O.N confirmed residents with urinary catheters were provided and secured via leg strap. Supra Pubic Catheter secured with adhesive patch and/or as indicated by residents plan of care.	06/23/15

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F 315	Continued From page 4 care. Review of the medical record for Resident #8 revealed the facility admitted Resident #8 on 05/15/13 with diagnoses that included Alzheimer's Disease and Neurogenic Bladder. Review of the physician's orders for Resident #8 revealed an order dated 11/01/13, for Resident #8 to have an indwelling urinary catheter due to a diagnosis of Neurogenic Bladder. Review of a quarterly Minimum Data Set (MDS) assessment dated 02/21/15 revealed Resident #8 had been assessed by the facility to have severely impaired cognition. The MDS also revealed the resident required the extensive assistance of two staff persons for toileting, was frequently incontinent of bowel, and required an indwelling urinary catheter. Observation of indwelling catheter care for Resident #8 by State Registered Nursing Assistant (SRNA) #1 and SRNA #2 on 05/20/15 at 2:00 PM revealed SRNA #1 draped the catheter over Resident #8's left leg after catheter care was completed. The SRNAs left the room and failed to secure the urinary catheter to the resident's leg. Interview conducted with SRNA #1 on 05/20/15 at 2:25 PM revealed she had been trained to use a leg strap to secure the catheter to the resident's leg and was aware she should have secured Resident #8's urinary catheter after performing catheter care. Interview conducted with SRNA #2 on 05/20/15 at 2:30 PM revealed she had been trained by the	F 315	3. Re-education of nursing staff per facility D.O.N. and/or A.D.O.N., to ensure compliance and providing care per residents individualized plan of care (i.e. urinary catheter and Super Pubic Catheter secured) to facilitate the highest functional level for each resident, (scheduled completion date 06/16/15). New nursing staff will receive same education during new hire orientation. New process implemented: Licensed Nurses will verify during daily "Daily Written Shift Rounds Audit" of resident care being provided as indicated by resident plan of care, correct or ensure correction of any identified non-compliance. Written rounds will be given to D.O.N. and/or A.D.O.N. daily for review and follow up.	06/23/15

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F 315	Continued From page 5 facility to place the urinary catheter tubing over the resident's leg and to use a leg strap to secure the catheter. The SRNA stated she should have secured the catheter to the resident's leg after performing catheter care. Interview conducted with Registered Nurse (RN) #1 on 05/20/15 at 2:35 PM revealed urinary catheters were required to be secured to the resident's leg to prevent trauma. The RN stated she made rounds every two hours and monitored to ensure urinary catheters were secured to the residents' legs. The RN stated she had not identified Resident #8's urinary catheter was not secured to the resident's leg and should have been. Interview conducted with the Director of Nursing (DON) on 05/21/15 at 3:25 PM revealed she made rounds throughout the facility several times a day to ensure residents were being provided the care and treatment they required. The DON stated staff was required to secure the urinary catheter to the resident's leg. The DON stated she made room rounds on residents daily and monitored urinary catheters to ensure they were being secured and had not identified Resident #8's urinary catheter had not been secured to the resident's leg.	F 315	4. QAPI Committee consisting of at least the Administrator, DON, A.D.O.N., Social Services Dir., Activity Dir., M.D.S. Coordinator and the Medical Director to meet at least monthly beginning 06/18/15 to review all compliance audits (Licensed Nurses Daily Written Rounds Audit)and revise care plans as indicated. This process will be ongoing until issue considered	06/23/15
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	F 371		

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F 371	Continued From page 6	F 371		
	This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of facility policies, it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions for fifty-seven (57) of fifty-eight (58) residents of the facility who received nutrition from the kitchen. Observations in the kitchen on 05/19/15 revealed food in the walk-in cooler was not dated or labeled, food was stored on the floor, and pans were being stored wet. Observations in the kitchen on 05/20/15 revealed staff was using thermometers that had not been calibrated, utensils were stored inappropriately, potentially hazardous foods were being stored incorrectly, the cook was touching food with bare hands, the cook placed dirty pans on a clean grill, the meat slicer had brown particles around the blade, cleaning rags were stored on top of the flour and sugar bins, a dietary aide was not taking temperatures of cold foods, and the sanitizer in the three-compartment sink was being tested incorrectly. The findings include: Review of the facility's policy for the "Three Compartment Sink" (no date) revealed Sink 3 should have at least 200ppm-400ppm of sanitizer. Review of the facility's policy, "Suggested Steps to Running /Organizing Tray Line," (no date)		1. Facility is preparing, storing, distributing and serving all foods under sanitary conditions for our current residents; areas listed under F-371 identified during survey 05/19/15-05/21/15 have been corrected. Foods in refrigerator dated, no food stored on floor, pans not stored wet, thermometers are calibrated daily, utensils stored appropriately, potentially hazardous food are stored correctly, no dietary cook or aides touching food with bare hands, dirty pans are placed in correct area to be washed and sanitized correctly, meat slicer has been cleaned and placed on cleaning checklist, cleaning rags are placed properly in sanitation buckets and are not stored on top of food containers, dietary aide now taking temperatures of cold foods, three compartment sink sanitizer now testing correctly.	06/23/15

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F 371	Continued From page 7 revealed temperatures of all items (including beverages) were to be taken for palatability. Review of the facility's policy, "Cold-Holding Guidelines," (no date) revealed staff was to use a food thermometer to measure the food's internal temperature and record the temperature on the "tray line food temperature record" prior to the start of meal service at breakfast, lunch, and dinner. Staff was to ensure that all cold food was at least 41 degrees Fahrenheit or colder. Review of the facility's policy, "Sanitation and Infection Control," (no date) revealed staff was to allow dishes to drain thoroughly and air dry after washing. Review of the facility's policy, "Safe Refrigerator Storage," (no date) revealed raw eggs were not to be stored on the top shelf of the refrigerator. The policy further revealed all food was to be stored above the floor on racks, shelves, or other surfaces that could be cleaned thoroughly. Review of the facility's policy, "Good Sanitation to Serve Food Safely," (no date) revealed staff was to always wear gloves or use tongs when handling food that is cooked or ready-to-eat. 1. Observations on 05/19/15 at 3:13 PM during the initial tour of the kitchen revealed the following; eight squeeze bottles of sauce in the walk-in cooler sitting on a shelf to the left of the door that were not dated, a tray that had sixteen bowls of assorted desserts sitting on top of milk crates that were not labeled or dated, and a five-gallon bucket of pickles stored on the floor of the walk-in-cooler.	F 371	2. Our current residents are served food that is stored, prepared, distributed within acceptable sanitary guidelines and regulations. (Foods in refrigerator dated, no food stored on floor, pans not stored wet, thermometers are calibrated daily, utensils stored appropriately, potentially hazardous food are stored correctly, no dietary cook or aides touching food with bare hands, dirty pans are placed in correct area to be washed and sanitized correctly, meat slicer has been cleaned and placed on cleaning checklist, cleaning rags are placed properly in sanitation buckets and are not stored on top of food containers, dietary aide now taking temperatures of cold foods, three compartment sink sanitizer now testing correctly.) Ecolab was contacted to service the dietary department sanitation equipment for the 3 compartment sink to ensure correct mix of sanitizer.	06/23/15

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F 371	Continued From page 8 Interview with the Dietary Manager on 05/21/15 at 9:10 AM revealed that the bottles of sauce and desserts should have had a date on them, and the bucket of pickles should not have been on the floor. 2. Observation on 05/19/15 at 3:15 PM during the initial tour revealed five clear full-size pans in a stack stored on a wire rack beside the three-compartment sink with standing water on all the pans. Interview with the Dietary Manager on 05/21/15 at 9:10 AM revealed that the pans should have been dried on the wire rack and not stored wet. 3. Observation on 05/19/15 at 3:22 PM during the initial tour revealed a flour bin under the end of the serving line with no date on it. Interview with the Dietary Manager on 05/21/15 at 9:10 AM revealed that the flour bin should have a date on it. 4. Observation on 05/20/15 at 9:45 AM revealed Cook #1 testing the sanitizer in the three-compartment sink. The cook was observed to use a testing strip and dip it into the sanitizer compartment. The strip read zero (0) parts per million (ppm) of sanitizer. Cook #1 repeated the process and the strip continued to show zero (0) ppm. Cook #1 stated it had "been that way a couple of weeks." Review of the "sink sanitizer log" revealed the log had been filled out every day and had readings from 200 to 400 ppm for the past week. Interview with Cook #1 on 05/21/15 at 3:45 PM revealed she had not been recording the sanitizer	F 371	3.. Dietary staff has been re-educated on facility Dietary procedures and sanitation processes to ensure sanitary storing, preparing, distributing and serving of resident foods, 06/12/15. Dietary Manager received same re-education per facility Registered Dietician on 06/12/15. In addition the Dietary Manager will complete the Food Handlers Manager Permit Course at Taylor County Health Department at the next scheduled course training. Dietary staff will complete the "Food Handlers Course" i.e. Food Handlers Permit provided by the Taylor County Health Department as courses are scheduled during 2015.. Re-education with return demonstration on sanitation in the 3 compartment sink completed for dietary staff and notification to Dietary Manager if not testing 200 ppm-400ppm.; 06/12/15, per Dietary manager and Registered Dietician. Future new Dietary Staff will be educated on same processes during new hire orientation.	06/23/15

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F 371	Continued From page 9 readings because she did not want to lie about it not being correct. Cook #1 further stated she had been getting readings of zero (0) for a "week or two." She stated, "Sometimes it wouldn't show anything" (0 ppm) and "sometimes it would be dark blue" (400+ ppm), but that she would let the DM know immediately if she took a bad reading. Interview with the Dietary Manager on 05/21/15 at 9:10 AM revealed that she had received an e-mail from "someone higher up" about the sanitizer for the three-compartment sink and that they were supposed to send someone to look at it. She stated she thought the sanitizer mixed in automatically. 5. Observation on 05/20/15 at 11:11 AM revealed a spatula stored in a drawer that had work gloves with black stains on them lying against the spatula; the drawer also had two screwdrivers, tape, and ink pens lying against the spatula. Interview with the Dietary Manager on 05/21/15 at 9:10AM revealed that the spatula should not have been in the drawer. 6. Observation on 05/20/15 at 11:15 AM revealed liquid eggs stored in a clear pitcher on the top of a wire rack in the walk-in cooler. The pitcher had liquid eggs spilled on the outside of it, and the pitcher was stored directly above three bags of fresh spinach and an open bag of fresh parsley. Interview with Cook #1 on 05/21/15 at 3:45 PM revealed that she had put the eggs on the top shelf. Cook #1 stated she knew the eggs were supposed to be stored on the bottom. Interview with the Dietary Manager on 05/21/15 at	F 371	4. Dietary Checklist/Sanitation Audit tool will be completed daily by the facility Dietary manager and/or Administrator 5 times per week times 4 weeks, then 3 times per week times 2 weeks then 2 times per week times 2 weeks then weekly ongoing. Immediate corrections completed for any areas identified. Audit tool will be reviewed during weekly Dietary QA meeting beginning 06/11/15. QAPI Committee consisting of at least the Administrator, D.O.N., A.D.O.N., Dietary Manager, Maintenance, Housekeeping Supervisor and the Medical Director to meet at least monthly beginning 06/23/15. This process will be ongoing until issue considered corrected or revisions to audit process is indicated.	06/23/15

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F 371	Continued From page 10 9:10 AM revealed that the liquid eggs should be stored on the bottom shelf; she did not know why they were on the top shelf. 7. Observation on 05/20/15 at 11:25 AM revealed Cook #1 was taking temperatures of the food on the steam table. Cook #1 was not wearing gloves and was placing the entire thermometer all the way into the food she was checking, occasionally touching the food with her bare hands. Cook #1 was not observed calibrating the thermometer before taking temperatures. Interview with Cook #1 on 05/21/15 at 3:45 PM revealed that she thought the thermometer was to be calibrated once a week, but had been informed by the DM it should be done at least once a day. Cook #1 also stated she should have been wearing gloves when taking food temperatures. Interview with the Dietary Manager on 05/21/15 at 9:10 AM revealed that thermometers should be calibrated daily, and staff was always supposed to have gloves on when checking food temperatures. 8. Observation on 05/20/15 at 10:40 AM revealed Dietary Aide #1 did not take temperatures of the milk or cold foods before serving the food items. Interview with Dietary Aide #1 on 05/21/15 at 3:10 PM revealed she should have taken the temperatures of the cold food items. Interview with the Dietary Manager on 05/21/15 at 9:10 AM revealed Dietary Aide #1 should have taken the cold food temperatures.	F 371		

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	185330		05/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 11 9. Observation on 05/20/15 at 11:48 AM revealed Dietary Aide #1covered all of the drinks and cold items to be served completely with ice allowing melted water to collect on the items. Interview with Dietary Aide #1 on 05/21/15 at 3:10 PM revealed she should have put the ice in the bottom and not covered the items completely. She stated that she "got in a hurry" while preparing the drinks. Interview with the Dietary Manager on 05/21/15 at 9:10 AM revealed that cold food items that are being served on the tray line should not be completely covered in ice. 10. Observation on 05/20/15 at 11:51 AM revealed Cook #1 placed a used/soiled dish on top of the clean grill. There was also a used/soiled pan on top of the grill. Interview with Cook #1 on 05/21/15 at 3:45 PM revealed she should not have put the dirty dishes on the clean grill. Interview with the Dietary Manager on 05/21/15 at 9:10 AM revealed that Cook #1 should not have put the dirty dishes on the grill. 11. Observation on 05/20/15 at 12:09 PM revealed a meat slicer that had brown particles around the blade. Interview with the Dietary Manager on 05/21/15 at 9:10 AM revealed that the brown particles should not have been on the meat slicer and she did not know the last time it had been used. 12. Observation on 05/20/15 at 9:45 AM revealed	F 371		

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F 371	Continued From page 12 used/soiled cleaning rags and used gloves lying on the top of a flour bin and a sugar bin underneath the end of the serving line. Interview with the Dietary Manager on 05/21/15 at 9:10 AM revealed that the used cleaning rags and used gloves should not have been on top of the flour bin and sugar bin.	F 371		
F 441 SS=E	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	F 441		

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F 441	Continued From page 13 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, and review of facility policy it was determined the facility failed to establish and maintain an effective infection control program designed to provide a safe and sanitary environment to prevent the transmission of disease and infection for four (4) unsampled residents (Resident A, Resident B, Resident C, and Resident D). Observation of the noon meal on 05/20/15 at 12:20 PM, revealed staff removing bread from plastic wrap and serving the bread to residents without gloves. The findings include: A review of the facility's policy titled "Assistance with Meals Procedure," with a revision date of 08/2014, revealed staff will serve resident trays and staff will help residents who require assistance with eating. The policy failed to address hand hygiene or wearing gloves when handling residents' food. Observations during the noon meal on 05/20/15 at 12:20 PM in the dining room revealed Licensed Practical Nurse (LPN) #2 delivered and set up	F 441	1. Staff is wearing gloves when handling ready to eat foods while assisting with meals for the four unsampled residents, Resident A, B, C, & D. 2. Residents who require assistance with food or for residents who request assistance with meals or any time ready to eat food is provided to residents; Staff is wearing gloves when assisting with ready to eat foods. 3. Infection Control Prevention Re-education on meal service and food handling of resident foods has been provided to facility staff to wear gloves and proper hand hygiene when serving ready to eat foods New process: Bread will be served on "Bread Plates", Dietary Manager & Registered Dietician provided education, 06/12/15. New staff will receive same education upon new hire orientation.	06/23/15

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F 441	Continued From page 14 Resident A's lunch tray. Further observation revealed LPN #2 removed the plastic wrap from Resident A's bread without wearing gloves and served it to the resident. At 12:22 PM, LPN #3 delivered and set up Resident B's lunch tray. Further observation revealed LPN #3 removed the plastic wrap from Resident B's bread without wearing gloves and served it to the resident. At 12:24 PM Certified Nurse Aide (CNA) #3 delivered and set up Resident C's lunch tray. Further observation revealed CNA #3 removed the plastic wrap from Resident C's bread without wearing gloves. At 12:26 PM, Business Office Manager #8 delivered and set up Resident D's lunch tray. Further observation revealed Business Office Manager #8 removed the plastic wrap from Resident D's bread without wearing gloves. Interview with LPN #2 on 05/21/15 at 8:40 AM revealed she had been trained to wear gloves before touching residents' food but just forgot to put them on. Interview with LPN #3 on 05/20/15 at 2:45 PM revealed she had been trained to wear gloves before touching residents' food and did not know why she forgot to put on gloves prior to touching the resident's food. Interview with Business Office Manager #8 on 05/21/15 at 11:20 PM revealed she had been trained to wear gloves when handling resident food, but did not realize she had touched the bread. Attempts to call CNA #3 three times on 05/21/15 for an interview were unsuccessful and an interview was not obtained.	F 441	4. "Meal Observation Audit" will be completed to ensure proper food handling, and staff wearing of gloves when assisting with resident food service. This observation audit will be completed 5 days per week times 4 weeks, then 3 times per week times 2 weeks then weekly then weekly ongoing. Audit will be completed by D.O.N., A.D.O.N., Administrator, Dietary Manager, and facility Department Managers. QAPI Committee consisting of at least the Administrator, DON, A.D.O.N., Dietary Manager, Social Services, Activity Director and the Medical Director to meet at least monthly beginning 06/23/15.	06/23/15

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F 441	Continued From page 15	F 441		
	Interview with the Director of Nursing (DON) on 05/21/15 at 11:20 AM, revealed staff was trained to wear gloves when handling resident food. The DON stated staff was watched at least weekly in the dining room, serving food and setting up meal trays for the residents, and no problems had been identified in the dining room with meal tray setup.		1. The gallon of unopened water and unopened fruit cocktail were removed from the refrigerator on 05/19/15 by facility Dietary Manager. Arrangements for floor dolly and trailer to come to the facility on 05/21/15 to assist in removal of Reach refrigerator located in the kitchen which was noted in F-456. The refrigerator was removed from the property on 05/21/15.	06/23/15
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to assure that a reach-in refrigerator was in safe operating condition. Observation on 05/19/15 revealed a reach-in refrigerator that was in use that was not in safe operating condition. The findings include: A post survey interview with the facility Administrator on 06/01/15 at 12:15 PM revealed the facility does not have a policy regarding equipment. Observations on 05/19/15 at 3:11 PM revealed a reach-in refrigerator in the kitchen that had an inside temperature of 60 degrees. Stored inside the refrigerator were a gallon of water and a #10 can of fruit cocktail.	F 456	2. All foods requiring refrigeration are stored in the walk-in refrigerator. Dietary manager completed a 100% audit of department food storage to ensure proper storage of all foods, 05/22/15. Maintenance Director completed a Dietary Department equipment check to ensure all equipment was in safe operating condition, 05/22/15. New refrigerator has been ordered, Administrator has received e mail verification number assigned for order, purchasing department sent to Direct Supply for processing and shipment.	

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F 456	Continued From page 16 Interview on 05/19/15 at 3:12 PM with Dietary Aide #6 revealed the refrigerator had been "down for months." Interview on 5/21/15 at 9:10 AM with the Dietary Manager revealed that she did not know why the can of fruit cocktail or the water was in the reach-in cooler. The Dietary Manager stated the refrigerator "went down" at the end of March or April of this year, and that the new refrigerator had not been ordered. Interview on 05/21/15 at 4:20 PM with the Registered Dietitian revealed that she did not know when the cooler went down; it was not down when she did her audit two months ago. Review of a facility e-mail dated 04/14/15 from the facility Administrator revealed a request to purchase a reach-in refrigerator due to the current unit not keeping appropriate temperatures. An e-mail dated 04/14/15 to the Administrator revealed that the request had been approved to purchase a new reach-in refrigerator. Review of a Capital Expenditure Request revealed a request for one reach-in refrigerator that had the electronic signature of the Administrator, but had no date or approval signatures included on the report. There was no evidence that the refrigerator had been ordered. A post survey interview on 06/01/15 at 12:15 PM with the Administrator revealed that they were still awaiting approval from the Divisional Director of Operations, and she was not aware that it had been ordered as of this date.	F 456	3. Re-education of Dietary staff on proper food storage, and refrigeration of foods. Re-education of Dietary staff of facility process for reporting equipment repairs, entry into the facility electronic work order system, education provided by Dietary Manager and Dietician. Kitchen equipment has been placed on routine maintenance log for on going routine maintenance check of kitchen equipment, Re-education completed on 06/12/15. Approval notification received from Regional and Divisional Director for Purchase of new reach in Refrigerator, sent to Purchasing/ordering Department on 06/08/15. 4. Dietary Audit too will be completed daily by the facility Dietary Manager and/or Administrator 5 times per week times 4 weeks then 3 times per week times 2 weeks, then 2 times per week times 2 weeks then weekly ongoing. QAPI Committee consisting of at least the Administrator, DON, A.D.O.N., Dietary Manager, Maintenance Director, Activity Dir., and the Medical Director to meet at least monthly beginning 06/23/15 to review all compliance audits This process will be ongoing until issue considered corrected or revisions to audit process is indicated.	06/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	(X3) DATE SURVEY COMPLETED
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1990 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 111 (000) SMOKE COMPARTMENTS: Three FIRE ALARM: Complete automatic fire alarm system SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system GENERATOR: Type II natural gas generator A life safety code survey was initiated and concluded on 05/19/15, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. No deficiencies were identified during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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.