



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

PRINTED: 08/28/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2014
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NAME OF PROVIDER OR SUPPLIER  PRESTONSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41663
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F 282	<p>Continued From page 1</p> <p>1. Review of Resident #2's medical record revealed the facility admitted the resident on 04/11/14, with diagnoses that included Senile Dementia, Muscle Weakness, Muscle Atrophy, and Urinary Incontinence. Review of the annual MDS assessment dated 05/21/14 and the quarterly MDS assessment dated 03/14/14 revealed Resident #2 was at high risk for pressure ulcers.</p> <p>Review of Resident #2's care plan dated 08/24/14 revealed the resident required the use of an indwelling urinary catheter to aid in the healing of an unstageable pressure ulcer to the coccyx area. Interventions included providing catheter care per facility policy, keeping the drainage bag below the level of the bladder, and preventing tension on the urinary meatus from the catheter tubing. Review of the Certified Nurse Aide (CNA) care plan revealed the facility noted catheter care would be provided every shift; however, the care plan did not include interventions to prevent tension on the catheter tubing.</p> <p>Observation of Resident #2 on 08/12/14/ at 2:45 PM revealed the resident utilized an indwelling catheter.</p> <p>On 08/13/14 at 3:55 PM, State Registered Nurse Aide (SRNA) #3 provided catheter care for Resident #2. The catheter was observed attached to a bedside drainage bag; however, the tubing was not secured to prevent tension as directed by the resident's plan of care.</p> <p>An interview conducted on 08/14/14 at 12:45 PM with SRNA #3 revealed she had been trained to follow the care plan interventions for each resident; however, the SRNA stated she had</p>	F 282	<p>8-19-14 to obtain leg straps for foley catheter to anchor. Leg straps were placed on resident #2, #8, #10 and #11.</p> <p><b>How the Facility will act to Protect Residents in similar Situation:</b></p> <p>All resident's care plans were reviewed between 8-14-14 and 8-20-14 by MDS nurse or DON to ensure resident's care plan corresponded to their care needs. No concerns were identified. All assessed residents with catheters had leg straps applied and are in use.</p> <p><b>Measures to Prevent Reoccurrence:</b></p> <p>Any changes to the resident's care needs will be reviewed and discussed daily in clinical meeting. Care plans will also be reviewed in this meeting to ensure that the care plan has been updated by the MDS nurse and corresponds to the resident's needs. Resident's care needs who are returning to the facility from an acute care setting will be reviewed and discussed in clinical meeting ( a daily meeting with the IDT to discuss physician orders, lab results, falls, wounds,etc) and their care plans updated accordingly by the MDS nurse. Inservice nurses on updating care plans per policy by DON/Designee on 8-20-14.</p>	
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F 282	<p>Continued From page 2</p> <p>been trained to perform catheter care every shift for residents and had not received training related to securing the tubing of the catheter.</p> <p>2. Review of the medical record revealed the facility admitted Resident #10 on 05/28/14 with diagnoses that included Diabetes Mellitus, Atrial Fibrillation, Hypertension, Urinary Retention, Neurogenic Bladder, and Chronic Kidney Disease. Review of the Minimum Data Set (MDS) dated 06/02/14 revealed the facility assessed Resident #10 to require the use of an indwelling urinary catheter due to Chronic Kidney Disease and Neurogenic Bladder. Review of the Comprehensive Care Plan revealed the facility addressed the use of the urinary catheter for Resident #10. Care plan interventions included positioning the drainage bag below the level of the bladder, and preventing tension on the urinary meatus from the catheter. Review of the CNA care plan revealed the facility noted catheter care would be provided every shift; however, the care plan did not include interventions to prevent tension on the catheter tubing.</p> <p>Facility staff was observed to use appropriate technique when providing urinary catheter care for Resident #10 on 08/14/14, at 1:15 PM; however, the catheter tubing was not secured to prevent tension on the resident.</p> <p>Interview with SRNA #5 on 08/14/14, at 1:30 PM revealed the SRNA had worked at the facility for approximately two years and was required to follow care plan interventions for each resident. SRNA #5 stated she had been trained on performing catheter care, but had not been trained to secure the catheter tubing to prevent tension on the resident.</p>	F 282	<p><b>Monitoring of Corrective Action:</b></p> <p>DON/Designee will audit 20% of resident's care plans weekly to ensure they are specific to each resident's needs weekly for 3 months, then biweekly for 3 months, then monthly for 3 months. DON/Designee will observe for the use of the leg straps and make sure they are in place on the residents weekly for 3 months, then biweekly for 3 months then monthly for 3 months. Results of the audit will be discussed in QAPI meeting to determine effectiveness and to determine if further education and/or interventions are needed.</p> <p><b>Completion date:</b></p> <p>8-20-14</p>	
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F 282	<p>Continued From page 3</p> <p>3. Review of the medical record revealed the facility admitted Resident #8 on 10/06/11 with diagnoses that included Hematuria and Obstructive Uropathy. Review of the quarterly MDS assessment dated 08/13/14 revealed the resident required extensive assistance for toileting needs and required an indwelling urinary catheter. Review of the resident's care plan dated 08/13/14 revealed the facility addressed the use of the indwelling catheter for Resident #8. According to the care plan interventions, the staff should prevent tension on the urinary meatus from the catheter.</p> <p>Review of the CNA care plan revealed the facility noted catheter care would be provided every shift; however, the care plan did not include interventions to prevent tension on the catheter tubing.</p> <p>Observation of Resident #8 on 08/12/14 at 4:30 PM revealed the resident utilized an indwelling urinary catheter. Observations during urinary catheter care performed by facility staff revealed the resident's catheter tubing was not secured to the resident's leg in accordance with the nursing care plan interventions for Resident #8.</p> <p>Interview with State Registered Nurse Aide (SRNA) #2 on 08/14/14 at 11:00 AM and SRNA #4 on 08/14/14 at 1:00 PM revealed the SRNAs had been trained to follow the care plan interventions to provide individual care for each resident. However, the SRNAs stated the training did not include the securing of the catheter tubing for residents.</p> <p>4. Review of the medical record revealed the</p>	F 282		
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F 282	<p>Continued From page 4</p> <p>facility admitted Resident #11 on 12/17/11 with diagnoses that included Congestive Heart Failure, Impaired Renal Function, Generalized Muscle Weakness, Urinary Tract Infection, and Benign Prostatic Hyperplasia with Urinary Obstruction.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment dated 06/18/14 revealed the resident had an indwelling urinary catheter. Review of the resident's Comprehensive Care Plan revealed the facility addressed the use of the urinary catheter. Care plan interventions included keeping the catheter tubing free of kinks, keeping the drainage bag below the level of the bladder, and preventing tension on the urinary meatus from the catheter.</p> <p>Review of the CNA care plan revealed the facility noted catheter care would be provided every shift; however, the care plan did not include interventions to prevent tension on the catheter tubing.</p> <p>Observation of catheter care provided by facility staff on 08/14/14 at 1:05 PM revealed staff provided appropriate care; however, staff failed to secure the urinary catheter tubing to prevent tension.</p> <p>Interview with SRNA #1 on 08/14/14 at 1:15 PM revealed he/she had not been trained to follow the care plan to provide individual care needs for each resident.</p> <p>Interview with the Director of Nursing (DON) on 08/14/14 at 5:00 PM revealed the SRNAs were required to provide care in accordance with the individual care plan for each resident. The DON</p>	F 282			

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F 282	Continued From page 5 stated she conducted routine rounds throughout the facility to observe resident care and had not identified any problems with resident care. The DON stated the catheter tubing had not been secured for residents who required an indwelling catheter.	F 282			
F 315 SS=E	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 review of the facility's catheter policy, it was determined the facility failed to ensure four (4) of fourteen (14) sampled residents (Residents #2, #8, #10, and #11) received the appropriate treatment and services related to indwelling urinary catheter usage. The facility failed to secure residents' indwelling catheters to prevent pulling/pressure per the facility's policy.  The findings include:  Review of the facility policy titled "Foley Catheter Care," (dated December 2010) revealed staff was required to secure urinary catheters to the upper	F 315	F 315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Corrective Action for Resident(s) Affected:  Resident #2, #8, #10, and #11 and all other resident's with catheters were evaluated and reassessed for appropriateness for the use of catheters by DON/Designee on 8-19-14. All foley catheter care plans were reassessed and update to include leg strap for foley catheter anchor on 8-19-14 by the MDS nurse and/or DON/Designee. Leg straps were also applied to resident #2, #8, #10, and #11.  How the Facility will act to protect Residents in similar situation:  All other residents care plans will be reviewed for any change in continence care and/or for catheter use for the last year by MDS nurse/Designee between 8-14-14 and 8-20-14. Residents that have used a catheter will have care plans updated and reassessed to include the use leg strap for foley catheter anchor by the MDS nurse/Designee between 8-14-14 and 8-20-14.		

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F 315	<p>Continued From page 6</p> <p>thigh to avoid tension on the catheter.</p> <p>1. Review of Resident #2's medical record revealed the facility admitted the resident on 04/11/14, with diagnoses that included Senile Dementia, Muscle Weakness, Muscle Atrophy, and Urinary Incontinence. Further review of the medical record, which included the annual comprehensive assessment dated 05/21/14 and the quarterly comprehensive assessment dated 03/14/14, revealed Resident #2 was at high risk for pressure ulcers.</p> <p>Review of Resident #2's care plan dated 06/24/14 revealed the resident required the use of an indwelling urinary catheter to aid in the healing of an unstageable pressure ulcer to the coccyx area.</p> <p>Observation of Resident #2 on 08/12/14 at 2:45 PM revealed the resident utilized an indwelling urinary catheter.</p> <p>On 08/13/14 at 3:55 PM, State Registered Nurse Aide (SRNA) #3 provided incontinence care to Resident #2. The catheter was observed attached to a bedside drainage bag; however, the tubing was not secured to the resident's leg as required per facility's policy.</p> <p>An interview conducted on 08/14/14 at 12:45 PM with SRNA #3 revealed the facility had trained the SRNA on catheter care; however, SRNA #3 stated he/she had not been trained to secure the catheter tubing.</p> <p>2. Review of the medical record revealed the facility admitted Resident #10 on 05/26/14 with diagnoses including Diabetes Mellitus, Atrial</p>	F 315	<p>Measures to prevent reoccurrence:</p> <p>Inservice was provided to all nursing staff by DON/ADON on 8-18-14 on foley catheter policy on how to anchor catheters and for skin care for resident's with the anchors. All nursing staff did a return demonstration of proper foley catheter care and anchoring. All new employees during onboarding stage will receive foley catheter education and will have to demonstrate their skills. Changes will be discussed in clinical meeting. Foley catheters will be reassessed for appropriateness of use. All new admits will be assessed for appropriateness weekly for 1 month then monthly.</p> <p>Monitoring of correction action:</p> <p>DON/Designee will monitor securing of catheters with leg straps weekly for 4 weeks then monthly for 6 months and findings will be discussed in QAPI meetings. Any concerns will be addressed immediately.</p> <p>Completion date:</p> <p>8-20-14</p>		

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F 315	<p>Continued From page 7</p> <p>Fibrillation, Hypertension, Urinary Retention, Neurogenic Bladder, and Chronic Kidney Disease. Review of the Minimum Data Set (MDS) dated 06/02/14 revealed Resident #10 required extensive assistance with toileting needs and required an indwelling urinary catheter due to Chronic Kidney Disease and Neurogenic Bladder. Review of the Comprehensive Care Plan revealed the facility addressed the use of the indwelling urinary catheter for Resident #10. Care plan interventions included positioning the drainage bag below the level of the bladder and preventing tension on the urinary meatus from the catheter.</p> <p>Facility staff was observed to provide catheter care for Resident #10 on 08/14/14, at 1:15 PM. SRNA #5 was observed to perform catheter care appropriately; however, the SRNA failed to secure the catheter tubing to the resident's thigh.</p> <p>Interview with SRNA #5 on 08/14/14, at 1:30 PM revealed the SRNA had worked at the facility for approximately two years and had never observed Resident #10's catheter tubing secured. SRNA #5 stated she had not been trained to secure the catheter tubing to prevent tension on the resident.</p> <p>3. Review of the medical record revealed the facility admitted Resident #8 on 10/06/11 with diagnoses that included Hematuria and Obstructive Uropathy. A review of the quarterly MDS assessment dated 06/13/14 revealed the resident required extensive assistance for toileting needs and required an indwelling urinary catheter. Review of the resident's care plan dated 06/13/14 revealed the resident required the use of a urinary catheter related to Obstructive Uropathy, Hematuria, Untreatable Blockage,</p>	F 315		

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F 315	<p>Continued From page 8</p> <p>History of inability to void after having a catheter removed in the past, and Neurogenic Bladder. The care plan revealed the staff should prevent tension on the urinary meatus from the catheter.</p> <p>Observation of Resident #8 on 08/12/14 at 4:30 PM revealed the resident utilized an indwelling urinary catheter. Further observation during urinary catheter care revealed the resident's catheter tubing was not secured to the resident's leg as required by the facility policy.</p> <p>Interview with State Registered Nurse Aide (SRNA) #2 on 08/14/14 at 11:00 AM and SRNA #4 on 08/14/14 at 1:00 PM revealed they had not been trained to secure catheter tubing to a resident's thigh.</p> <p>4. Review of the medical record revealed the facility admitted Resident #11 on 12/17/11 with diagnoses that included Congestive Heart Failure, Impaired Renal Function, Generalized Muscle Weakness, Urinary Tract Infection, and Benign Prostatic Hyperplasia with Urinary Obstruction. A review of the quarterly Minimum Data Set (MDS) assessment, dated 06/18/14, revealed the resident required extensive assistance for bed mobility and total assistance for toileting. Review of the MDS further revealed the resident was always incontinent of bowel and had an indwelling urinary catheter. Review of the Comprehensive Care Plan revealed the facility addressed the use of the urinary catheter. Care plan interventions included keeping the catheter tubing free of kinks, keeping the drainage bag below the level of the bladder, and preventing tension on the urinary meatus from the catheter.</p> <p>Observation on 08/14/14 at 1:05 PM revealed</p>	F 315			

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F 315	Continued From page 9 staff provided appropriate catheter care to Resident #11; however, staff failed to secure the catheter tubing to the resident's thigh in order to prevent tension.  Interview with SRNA #1 on 08/14/14 at 1:15 PM revealed he/she had not been trained to secure urinary catheter tubing to the resident's thigh.  Interview with the Director of Nursing (DON) on 08/14/14 at 5:00 PM revealed the facility provided training routinely for catheter care; however, the training did not include securing the catheter tubing. The DON acknowledged the catheter tubing had not been secured for residents with indwelling catheters.	F 315		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's psychotropic drug use policy, the facility failed to ensure the consultant pharmacist reported drug irregularities to the attending physician and the Director of Nursing regarding	F 428	483.60© DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  Corrective action for Resident(s) affected:  Resident #4, # 7, #8, and #9 were evaluated by the pharmacist on 8-19-14 for a Gradual Dose Reduction. Recommendations were sent to resident's physician.  How the Facility will act to protect Residents in similar situation:  All residents were reviewed by the pharmacist on 8-19-14. Recommendations were sent to resident's physician. DON and pharmacist reviewed appropriateness of all medications with strong emphases on psychotropics.	

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F 428	<p>Continued From page 10</p> <p>recommendations for a Gradual Dose Reduction (GDR) for four (4) of fourteen (14) sampled residents (Residents #4, #7, #8, and #9).</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Psychotropic Drug Use," (dated December 2010) revealed the consultant pharmacist (RPh) would perform a medication regimen review for each resident in the facility monthly and would address recommendations for medication reduction at least quarterly. The policy further revealed that Pharmacy would document medication/dosage change recommendations and Nursing would notify the physician for recommendations if they were not noted in the physician progress notes.</p> <p>1. Review of the medical record for Resident #9 revealed the facility admitted the resident on 03/15/12 with diagnoses that included Depressive Disorder. Review of the September 2012 physician's orders revealed the physician had prescribed Celexa (antidepressant) 20 mg to be administered daily.</p> <p>Review of the quarterly comprehensive assessment dated 05/07/14 revealed the facility assessed Resident #9 to have a depression score of 1 with 0 to 4 being a minimal score of depression. Furthermore, the annual comprehensive assessment dated 10/29/13 revealed the facility assessed Resident #9 to have a depression score of 3 with 0 to 4 being a minimal score of depression.</p> <p>Further review of the medical record revealed the consultant pharmacist had conducted a monthly medication regimen review for Resident #9 from</p>	F 428	<p><b>Measures to prevent reoccurrence:</b></p> <p>Inservice the pharmacist on GDR's and policy of their use by DON on 8-19-14. Inserviced all nurses on policy and procedure of policy of GDR's. DON/Designee will keep a log of all psychotropic meds, appropriateness, and their reductions and will be monitored daily in clinical meeting. DON/Designee will monitor monthly audits of pharmacy recommendations for Gradual Dose Reduction. Any findings will be discussed in clinical meeting and physician and pharmacist will be notified.</p> <p><b>Monitoring of corrective action:</b></p> <p>DON/Designee will monitor for Gradual Dose Reduction monthly for 6 months then every 2 months for 6 months and findings will be discussed in QAPI meetings and pharmacist and physician will be notified.</p> <p><b>Completion date:</b></p> <p>8-25-14</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2014
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NAME OF PROVIDER OR SUPPLIER  PRESTONSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653
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F 428	<p>Continued From page 11</p> <p>08/19/13 through 07/25/14. However, there was no evidence during this timeframe that the pharmacist had recommended a dosage reduction attempt for the (antidepressant) Celexa.</p> <p>Interview with the pharmacist (RPh) on 08/14/14 at 3:40 PM revealed he was responsible for conducting monthly medication regimen reviews for residents at the facility. The RPh stated the Celexa dosage had not been reduced since it was started.</p> <p>2. Review of the medical record revealed the facility admitted Resident #7 on 03/05/13 with diagnoses including Senile Dementia with Behavioral Disturbances, Parkinson's disease, Alzheimer's disease, and Depressive Disorder. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #7 dated 07/11/14 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 1, which indicated the resident's cognition was severely impaired. In addition, the facility assessed the resident to exhibit no episodes of delirium or behaviors during the assessment period.</p> <p>Review of the August 2014 (dated 08/01/14) physician's orders revealed the physician prescribed 30 mg (milligrams) of Remeron (antidepressant) to be administered routinely for Resident #7 every night. Further review of the physician's orders revealed the physician had originally prescribed the 30 mg of Remeron on 04/16/13.</p> <p>Review of the consultant pharmacist's reviews from July 2013 to August 2014 revealed the Pharmacist had conducted a monthly medication regimen review for Resident #7; however, there</p>	F 428		
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F 428	<p>Continued From page 12</p> <p>was no evidence the pharmacist had considered recommendations for gradual dose reduction of the antidepressant medication, Remeron, during this time period.</p> <p>3. Review of the medical record for Resident #8 revealed the facility admitted the resident on 10/06/11 with diagnoses that included Alzheimer's, Episodic Mood Disorder, Senile Dementia, and Generalized Anxiety. Review of December 2011 physician orders revealed the resident was prescribed Depakote Sprinkles (mood stabilizer) 250 mg to be administered three times per day.</p> <p>Review of the quarterly comprehensive assessment dated 06/13/14 and the annual comprehensive assessment dated 04/03/14 revealed the facility assessed Resident #8 to have mood and behavior frequency scores of 0, meaning a frequency of never or one per day.</p> <p>Further review of the medical record revealed the consultant pharmacist had conducted a monthly medication regimen review for Resident #8 from 09/17/13 through 07/25/14. However, the consultant pharmacist failed to recommend a gradual dose reduction for Depakote Sprinkles.</p> <p>Interview with the consultant pharmacist on 08/14/14 at 3:40 PM revealed Resident #8's Depakote Sprinkles had not been reduced since being started nor had the required recommendations been made.</p> <p>Interview with the Director of Nursing on 08/14/14 at 5:00 PM revealed the pharmacy recommendations are reviewed monthly and it was "assumed" the consultant pharmacist was</p>	F 428			

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NAME OF PROVIDER OR SUPPLIER  PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41663		
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F 428	Continued From page 13 completing the recommendations accurately.  4. Review of the medical record for Resident #4 revealed the facility admitted the resident on 04/28/13 with diagnoses that included Malignant Brain Neoplasm, Senile Dementia, and Anxiety. Further review of the record revealed on 06/04/13 the resident's physician prescribed Depakote (Mood Stabilizer) 125 mg sprinkles, two capsules to be administered daily.  Review of the quarterly comprehensive assessment dated 05/23/14 and the annual MDS assessment dated 03/06/14 revealed the facility assessed Resident #4 to have 0, meaning never or one day for frequency of mood and behaviors.  Further review of the medical record revealed the consultant pharmacist had conducted a monthly medication regimen review for Resident #4 from 07/16/13 through 07/25/14. However, there was no evidence the pharmacist had recommended a dosage reduction attempt for Depakote during this time period.  Interview with the Consultant Pharmacist on 08/13/14 at 4:00 PM revealed he had not considered a GDR for Depakote for the resident since a low dose was prescribed by the physician.	F 428			
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.	F 441	F 441 483.65 INFECTION CONTROL, PREVENT SPREAD LINENS		

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F 441	<p>Continued From page 14</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of the facility's linen handling policy it was determined the facility failed to maintain effective infection control technique in a manner to prevent the development and transmission of disease and infection for one (1) of fourteen (14) sampled</p>	F 441	<p><b>Corrective action for Resident(s) affected:</b></p> <p>Staff cleaned resident #11 over bed table immediately. Nurse aide was coached and reeducated on proper technique of handling dirty linens and policy of infection control by DON on 8-14-14. The nurse aide did a return demonstration on proper technique of handling of dirty linen.</p> <p><b>How the Facility will act to protect Residents in similar situation:</b></p> <p>All nurse aides were inserviced by DON/Designee on proper handling of dirty linens and infection control policy on 8-14-14. All nurse aides did return demonstration of proper handling of dirty linen. DON reviewed infection log for any trends. No concerns identified.</p> <p><b>Measures to prevent reoccurrence:</b></p> <p>All nursing staff were inserviced on proper technique of handling dirty linens and our infection control policy by DON/Designee on 8-18-14. All nursing staff did return demonstration of handling of dirty linen.</p>		

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F 441	<p>Continued From page 15 residents (Resident #11). Observation of catheter care for Resident #11 on 08/14/14 at 1:05 PM revealed State Registered Nurse Aide (SRNA) #1 placed soiled washcloths directly on the bedside table, which was not in accordance with the facility's policy.</p> <p>The findings include:</p> <p>Review of facility policy titled "Linen Handling," dated December 2012, revealed soiled linen should be directly deposited into the covered linen receptacle or plastic bag. The policy stated that soiled linen should never be placed on the floor, overbed table, bedside stand, or chair.</p> <p>Review of the medical record revealed the facility admitted Resident #11 on 12/17/11 with diagnoses including Impaired Renal Function, Congestive Heart Failure, Urinary Tract Infection, Generalized Muscle Weakness, and Benign Prostatic Hyperplasia with Urinary Obstruction. A review of the quarterly Minimum Data Set (MDS) assessment, dated 08/18/14, revealed the resident required extensive assistance for bed mobility and total assistance for toileting. Review of the MDS further revealed the resident was always incontinent of bowel and had an indwelling urinary catheter.</p> <p>Observation on 08/14/14 at 1:05 PM revealed SRNA #1 provided catheter care to Resident #11 and placed the soiled washcloths that the SRNA used to clean the resident's catheter tubing directly on the bedside table.</p> <p>Interview on 08/14/14 at 1:15 PM with SRNA #1 revealed she should not have placed the soiled washcloths directly on the bedside table. The</p>	F 441	<p>Monitoring of corrective action:</p> <p>DON/Designee will observe 5 nurse aides technique of handling of dirty linens weekly for 3 months then monthly for 3 months. All findings will be discussed in clinical meeting and reported to QAPI meeting.</p> <p>Completion Date:</p> <p>8-20-14</p>		

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F 441	Continued From page 16 Interview further revealed placing the soiled washcloths on the bedside table could create an infection control problem.  Interview on 08/14/14 at 5:00 PM with the Director of Nursing revealed staff should never place soiled linen on the bedside table. She stated staff should place soiled linen in a bag and take to the soiled linen container.	F 441			