

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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185336	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/11/2013
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069	

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

A Recertification/Abbreviated Survey investigating KY#00019582 was conducted 01/08/13 through 01/11/13. Deficiencies were cited with the highest Scope and Severity of an "E". KY#00019582 was substantiated with no deficiencies cited.

F 253 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES

SS=E

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 review of facility's policy, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

Observation on initial tour of the west general bathroom revealed a black substance in the corners of the shower wall, shower floor and on the drain; a soiled wash cloth with a brown substance on the bedside toilet; a whirlpool tub cluttered with items including attends, lift pads, pillows and a sweatshirt; and a walker which was turned over lying in the floor. In addition, there were two (2) mechanical lifts in the west general bath which were soiled with dust and a brown substance at the base.

The findings include:
Review of the facility's "Environmental Services

F 000

F253

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BY _____

1) West general bath was cleansed immediately and no longer has black substance on the shower wall, floor or drain. The soiled wash cloths on the bedside commode was immediately removed and washed. The whirlpool tub was immediately cleared of all items and cleansed. The walker was removed from the general bath. The two mechanical lifts on west side were cleansed immediately.

2) On 1/8/13, the administrator completed an audit of both general baths; all mechanical lifts, and all resident rooms to identify any areas that were unclean or cluttered. Any issues identified were immediately corrected.

A one time audit of all resident rooms, patient care areas, and patient care equipment (including mechanical lifts and general baths) was completed on 1/15/13 by the administrator, director of nurses, and maintenance manager to identify any patient areas, resident rooms and/or patient care areas that were unclean or cluttered. Any issue identified was immediately corrected.

3) Administrator, maintenance manager, and housekeeping manager to complete an audit of all resident care areas, resident rooms and resident care equipment 3 times a week for 6 weeks beginning the week of 1/29/13 to ensure that the center is maintained in a orderly, sanitary, and comfortable level.

Regional nurse consultant to complete a monthly audit of all resident rooms, resident care areas, and resident care equipment to ensure the center is maintained in a clean, sanitary, and comfortable manner; beginning 1/30/13 for 3 months.

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

TITLE
Administrator

(X6) DATE
2/19/13

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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F 253	<p>Continued From page 1</p> <p>Policy", undated, revealed it was the policy of the facility that all residents reside in a clean, sanitary, safe and homelike environment. Further review revealed central bath areas were to be cleaned daily and scrubbed down at least weekly. Nursing equipment such as lifts would be cleaned by nursing staff.</p> <p>Observation of initial tour, on 01/08/13 at 10:30 AM, revealed a foul odor upon entering the west general bathroom. In addition, the west general bathroom was cluttered with two (2) soiled mechanical lifts which were dusty and had a brown substance at the base. There was a Christmas Wreath and a soiled wash cloth with a brown substance on top of a bedside toilet. In addition there was a walker which was turned over in the floor by the whirlpool tub. The whirlpool tub contained a bag of wash cloths, lift pads, a pillow, and a sweatshirt.</p> <p>Interview, on 01/08/13 at 10:45 AM, with Housekeeper #1, who was assigned to clean the west general bathroom, revealed she also smelled the odor in the bathroom. She stated the black substance surrounding the tiles on the shower walls, floor, and drain was mold. She further stated she mopped the general bathroom and resident rooms once a day and sometimes used bleach when she noted mold. Further interview with the housekeeper revealed the mechanical lifts were "pretty dirty"; however, nursing was in charge of cleaning the lifts.</p> <p>Interview, on 01/08/13 at 11:15 AM, with Licensed Practical Nurse (LPN) #1, who was assigned to the west hall, revealed staff was to place soiled wash cloths in the hampers which were available</p>	F 253	<p>Director of nurses to monitor that all lifts and wheelchairs are cleaned 5 times a week beginning 2/4/13 for 4 weeks then 2 times a week ongoing to ensure all equipment is cleaned and maintained properly.</p> <p>Education manager to re-educate all staff regarding wheelchair and lift cleaning schedule; maintaining clean, comfortable and sanitary environment and the monitoring that would be completed. This education will be completed by 2/14/13.</p> <p>4) Quality Improvement Team consisting of the administrator, medical director, director of nurses, education manager, activities/dietary manager, social services manager, and MDS coordinator) will meet weekly for 4 weeks beginning week of 2/4/13; then 2 times per month for 2 months; and then monthly ongoing to review all audit findings and make recommendations for follow-up. This will be ongoing until corrected.</p> <p>5) Date of compliance: 2/15/13</p>	

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F 253	<p>Continued From page 2</p> <p>in the halls and the general bathrooms, and the Certified Nursing Assistants (CNAs) knew to clean up the general bathrooms after showers. She further stated the whirlpool worked and should be free of clutter and the nurses should be noticing these issues when making rounds.</p> <p>Interview, on 01/09/13 at 10:30 AM and 01/11/13 at 10:30 AM and 3:30 PM, with the Director of Nursing (DON) revealed the night shift staff was in charge of cleaning the mechanical lifts and she was unsure why the lifts were soiled on the initial day of the survey. She further stated the general baths should be cleaned and be uncluttered and the whirlpool bath should be clean and ready for use. Further interview revealed there was no housekeeping supervisor at that time and the Administrator was overseeing housekeeping until the position was filled.</p> <p>Interview, on 01/09/13 at 10:45 AM, with the Administrator revealed there was a cleaning schedule for the housekeepers to abide by and the general bathrooms were to be clean and have no mold or odors.</p> <p>Interview, on 01/10/13 at 3:45 PM, with Housekeeper #2 revealed when she worked she cleaned the central bathrooms daily which included emptying the trash, cleaning all surfaces, sweeping, and mopping. She stated she had noticed a mold problem in the past and had tried to clean it. Further Interview revealed after the survey started and the issue was noted as a concern, she had cleaned the central bath showers with a 10% bleach and a scrub brush and it had come clean. Further interview revealed prior to this survey the whirlpool tubs</p>	F 253		

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F 253	Continued From page 3 were not being cleaned on a regular basis. Interview, on 1/11/13 at 4:00 PM, with the Maintenance Director revealed it was a joint effort between housekeeping and maintenance to keep the odors down in the building. He stated fresh air was pulled in through the fan with the heating and cooling system and exhaust fans sent air outside.	F 253		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT Is not met as evidenced by: Based on interview, record review and review of facility's policy, it was determined the facility failed to ensure the services provided by the facility met professional standards of quality for one (1) of fifteen (15) sampled residents (Resident #12). The facility failed to ensure a Physician's order was followed for Resident #12. A Physician's order was given on 12/03/12 to repeat a urinalysis three (3) days after completion of the antibiotic, which would have been 12/14/12. However, there was no documented evidence the urinalysis was collected until 12/20/12. The findings include: Review of the facility's policy titled "Labs" revealed the facility was to follow all Physician's orders as given per the Physician.	F 281 F 281	1) Resident #12 physician and family were notified on 1/11/13 by the director of nurses that the urinalysis was ordered for 12/14/12 but was not completed until 12/20/12. No new orders were noted. Medical director was notified on 1/11/13 of the lab being completed late for resident #12 by the director of nurses. No new orders were noted. 2) A 100% one time audit will be completed by 2/11/13 to identify any labs ordered that were not completed per physician's order. This audit will be completed by the director of nurses, assistant director of nurses, education manager and/or regional nurse consultant. This will include a look back of lab orders from 12/1/12 through 2/8/13. Any issue identified will be immediately corrected. Regional nurse consultant to re-educate director of nurses, assistant director of nurses, and education manager regarding following physician orders for labs, lab processes, and meeting professional standards of care by 1/30/13. 3) Education manager to re-educate all licensed nurses regarding professional standards of care, following physician orders for labs and lab process by 2/11/13.	

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F 281	<p>Continued From page 4</p> <p>Review of the clinical record revealed the facility admitted Resident #12 on 07/01/12 with diagnoses which include Hypothyroidism, Diabetes, Hypertension, Hyperlipdemia, Anemia and Asthma.</p> <p>Review of the Physician's Order, dated 12/03/12 revealed Resident #12 was to have a urinalysis collected on 12/03/12 and a follow up urinalysis three (3) days after completion of the antibiotic, Levaquin 500 Milligram (mg) twice daily for five (5) days. The antibiotic was completed on 12/11/12, and the follow up urinalysis should have been collected on 12/14/12. However, further record review revealed the urinalysis was not collected until 12/20/12.</p> <p>Review of Resident #12's Medication Administration Record (MAR) for December 2012 revealed Resident #12 completed the antibiotic as ordered on 12/11/12.</p> <p>Review of the lab report revealed no documented evidence the urinalysis was collected on 12/20/12.</p> <p>Interview with the Assistance Director of Nursing (ADON), on 01/11/13 at 5:30 PM, revealed she kept a lab log binder with daily labs that were to be obtained. The third shift nurse or whoever was on duty was responsible for checking the log to ensure lab specimens were obtained. The ADON revealed the follow up urinalysis for Resident #12 was not obtained as ordered, it got overlooked and should have been collected as ordered on 12/14/13.</p>	F 281	<p>Director of nurses, assistant director of nurses, and/or education manager to audit 10 records each week for 6 weeks beginning week of 2/11/13 to ensure all labs completed per physician orders.</p> <p>Assistant director of nurses to audit lab binder weekly for 4 weeks to ensure all lab orders are noted and a lab slip is completed timely.</p> <p>Regional nurse consultant to audit 10 records monthly for 3 months beginning week of 2/11/13 to ensure all labs are completed per physician orders.</p> <p>4) Quality Improvement Team consisting of the administrator, medical director, director of nurses, education manager, activities/dietary manager, social services manager, and MDS coordinator) will meet weekly for 4 weeks beginning week of 2/4/13; then 2 times per month for 2 months; and then monthly ongoing to review all audit findings and make recommendations for follow-up. This will be ongoing until corrected.</p> <p>5) Date of compliance: 2/15/13</p>		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282			

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F 282	Continued From page 5 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 review of facility's policy, it was determined the facility failed to ensure services were provided by the facility in accordance with each resident's written plan of care for one (1) of fifteen (15) sampled residents (Resident #8) Observations during the survey revealed a bottle of No Rinse Body Wash Shampoo and Incontinence Cleanser Spray and baby powder accessible to Resident #8 who had a history of placing toiletries in his/her mouth. The findings include: Review of Resident #8's clinical record revealed diagnoses which included Mental Retardation and Psychosis. Review of the Minimum Data Set (MDS) Assessment dated 12/14/12 revealed the facility assessed the resident as having severe impairment in cognitive skills. Review of the Comprehensive Plan of Care, dated 10/09/12, revealed Resident #8 had the inability to sense the need to urinate related to cognitive impairment. The approaches included keeping personal hygiene items locked in the top	F 282	F 282 1) Resident #8 did not have any issue with putting toiletries in his mouth during the survey. Resident condition is unchanged. Resident #8 physician and family were notified by the director of nurses that the toiletries were accessible to resident during the period of 1/8/13 through 1/11/13. No new orders were noted. Medical director was made aware that the toiletries were available to the resident but the resident did not get them during the period of 1/8/13 though 1/11/13. No new orders were noted. 2) A one time audit of all residents was made by the administrator, director of nurses, assistant director of nurses, and education manager on 1/14/13 to identify if care was provided to each resident per their individualized plan of care, if toiletries was on resident sinks and to identify any issue with toiletries being left at bedside that should not have been. Any issues identified were immediately corrected. A one time audit of 15 residents will be completed by the director of nurses, assistant director of nurses and the education manager by 2/5/13 to identify any resident not being supervised per their plan of care to prevent accidents and injuries; that all assistive devices are correct and to identify any resident that is not supervised. A one time audit of all accident and incident reports from a period of 1/1/13 though 2/8/13 to be completed by regional nurse consultant, director of nurses, assistant director of nurses or education manager to identify any accident and incident that occurred due to not following the individualized plan of care and/or due to an issue with resident supervision. This will be completed by 2/11/13 and that the physician and family were notified.		

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F 282	<p>Continued From page 6</p> <p>drawer including periwash, lotion, and deodorant. Further review revealed a problem, dated 10/02/12, which stated the resident had impaired cognition and required assistance with decision making. The approaches included assuring the dresser drawer was locked with personal items to include periwash, lotions, and deodorant.</p> <p>Observation of Resident #8, on 01/09/13 at 9:00 AM, revealed the resident was in his/her room sitting straight up in a recliner chair watching television. Further observation revealed there was a basket by the sink across the room which contained a bottle of baby powder with a label which stated, keep out of the reach of children and a bottle of No Rinse Body Wash Shampoo and Incontinence Cleanser Spray with a label which stated; contains Benzethonium Chloride 0.1%, external use only, if swallowed get medical help or call poison control immediately.</p> <p>Observation of Resident #8, on 01/10/13 at 9:15 AM, revealed the resident was in his/her room sitting in a recliner chair. It was noted there was a bottle of baby powder and a bottle of No Rinse Body Wash Shampoo and Incontinence Cleanser Spray on the floor to the left side of the recliner chair within the resident's reach. Interview, on 01/10/13 at 9:15 AM, with the Director of Nursing (DON) who entered the room at the surveyors request, revealed the toiletries should have been locked up in the resident's drawer out of sight.</p> <p>Interview, on 01/10/13 at 9:30 AM with Certified Nursing Assistant (CNA) #1, revealed she was assigned to Resident #8. She stated the resident's toiletries were to be locked up in the top drawer; however, these toiletries had been left</p>	F 282	<p>Director of nurses, assistant director of nurses, education manager or social services manager to audit all care plans by 2/12/13 to identify that care plan meets resident's individual needs and is correct. Any issue identified will be immediately corrected.</p> <p>3) Director of nurses, assistant director of nurses, or education manager to audit care being provided to at least 10 residents each week for 6 weeks; then 2 residents per week for 2 months to ensure the plan of care is followed, that no toiletries are available if identified as an issue.</p> <p>Administrator and education manager to complete a walk through 1 time daily; 5 days a week; for 4 weeks beginning week of 2/4/13 through all resident rooms to ensure residents are being supervised; that toiletries are not on sink; and that assistive devices are in place per plan of care; and that no chemical is available to resident, if care plan prohibits this.</p> <p>Education manager will re-educate all nursing staff regarding supervision of residents to prevent accidents and injuries, following the plan of care, ensuring toiletries are off the sink. AccuNurse system, specifically for resident #8 plan of care regarding chemicals at bed side is available.</p> <p>Director of nurses to audit 5 records weekly for 4 weeks beginning 2/11/13 to ensure care plan meets the resident needs and has been updated with any changes and that the care plan is being followed.</p> <p>Regional nurse consultant to audit at least 10 records monthly to ensure the care plan is correct, being followed and that toiletries are being stored properly and not on the sink. This is to begin the week of 2/1/13 for 3 months.</p>		

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F 282	<p>Continued From page 7</p> <p>out by accident. She further stated she checked the resident earlier in the shift and he/she did not need incontinence care at the time and she had not seen any toiletries out in the room. Continued interview revealed the previous shift must have left the top drawer unlocked and she failed to check the toiletries drawer to ensure it was locked when she did rounds. CNA #1 stated the resident could scoot the recliner chair around the room and could reach the sink counter or dresser drawer and obtain toiletries.</p> <p>Interview, on 01/10/13 at 2:10 PM, with Licensed Practical Nurse (LPN) #1 revealed she was assigned to Resident #8. She confirmed that confused residents including Resident #8 were to have their toiletries locked in the bedside table drawer. Further interview revealed the resident could scoot and get to the sink and toiletries were not to be left out on the counter by the sink. She stated the nurses did rounds while administering medications and observed for toiletries being out and she has had to remind the CNAs to lock up toiletries.</p> <p>Interview, on 01/10/13 at 3:30 PM, with LPN #3 revealed she worked the west hall where Resident #8 resided. She stated some residents had to have toiletries locked and secured and the nurses should check to ensure this was done during rounds. She stated, "to be honest", she had to clean up after the night shift CNAs who repeatedly left toiletries out.</p> <p>Further interview with the DON, on 01/11/13 at 3:30 PM, revealed one of the ways they ensured the care plans were followed was to have the management team use the CNA Assignment</p>	F 282	<p>4) Quality Improvement Team consisting of the administrator, medical director, director of nurses, education manager, activities/dietary manager, social services manager, and MDS coordinator) will meet weekly for 4 weeks beginning week of 2/4/13; then 2 times per month for 2 months; and then monthly ongoing to review all audit findings and make recommendations for follow-up. This will be ongoing until corrected.</p> <p>5) Date of compliance: 2/15/13</p>		

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F 282 Continued From page 8
Sheets as a reference when doing rounds. She stated the CNA Assignment Sheets had specific interventions to be followed for each resident including safety devices and Resident #8's Assignment Sheet included an Intervention for the toiletries to be locked up. She indicated staff needed to be more diligent with ensuring Resident #8's toiletries were locked up.

F 323 SS=E 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of facility's policy, it was determined the facility failed to ensure the resident environment remains as free of accident hazards as is possible.

Observation on initial tour on 01/08/13 revealed toiletries in residents' rooms by the sinks accessible to wandering residents.

In addition, observation during the survey revealed a bottle of No Rinse Body Wash Shampoo and Incontinence Cleanser Spray and baby powder accessible to Resident #8 who had a history of placing toiletries in his/her mouth.

F 282

F 323

F323
1) Resident #8 did not have any issue with putting toiletries in his mouth during the survey. Resident condition is unchanged. Resident #8 physician and family were notified by the director of nurses that the toiletries were accessible to resident during the period of 1/8/13 through 1/11/13. No new orders were noted.

Medical director was made aware that the toiletries were available to the resident but the resident did not get them during the period of 1/8/13 through 1/11/13. No new orders were noted.

2) A one time audit of all residents was made by the administrator, director of nurses, assistant director of nurses, and education manager on 1/14/13 to identify if care was provided to each resident per their individualized plan of care, if toiletries was on resident sinks and to identify any issue with toiletries being left at bedside that should not have been. Any issues identified were immediately corrected.

A one time audit of 15 residents will be completed by the director of nurses, assistant director of nurses and the education manager by 2/5/13 to identify any resident not being supervised per their plan of care to prevent accidents and injuries; that all assistive devices are correct and to identify any resident that is not supervised.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185336	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/11/2013
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069		
(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 323	Continued From page 9 The findings include: Review of the facility's "Personal Care Items Policy", undated, revealed personal care items should be bagged and kept in resident's room to include lotions, shampoos, conditioners, toothpaste, mouthwash, etc. and all residents were provided with a bedside chest which could be used for resident's personal storage. 1. Observation during Initial tour, on 01/08/13 at 10:00 AM, revealed toiletries were in the following resident rooms accessible to wandering residents: Room 2 and Room 6 had baby powder on the bedside tables with a label which stated keep out of the reach of children. Room 24 had Vanilla Citrus White Tea Lotion on the bedside table with no lid with a label which stated keep out of the reach of children. Room 25 had baby powder with a label which stated keep out of the reach of children and No Rinse Body Wash Shampoo and Incontinence Care Spray which stated, keep out of the reach of children and if swallowed get medical help or contact poison control immediately in a basket at the sink. Room 29 had Aloe Vera Lotion in the window with a label which stated keep out of the reach of children. Room 39 had Classic Splash Aftershave and Old Spice Deodorant on the bedside table both with	F 323	A one time audit of all accident and incident reports from a period of 1/1/13 through 2/8/13 to be completed by regional nurse consultant, director of nurses, assistant director of nurses or education manager to identify any accident and incident that occurred due to not following the individualized plan of care and/or due to an issue with resident supervision. This will be completed by 2/11/13 and that the physician and family were notified. Director of nurses, assistant director of nurses, education manager or social services manager to audit all care plans by 2/12/13 to identify that care plan meets resident's individual needs and is correct. Any issue identified will be immediately corrected. 3) Director of nurses, assistant director of nurses, or education manager to audit care being provided to at least 10 residents each week for 6 weeks; then 2 residents per week for 2 months to ensure the plan of care is followed, that no toiletries are available if identified as an issue. Administrator and education manager to complete a walk through 1 time daily; 5 days a week; for 4 weeks beginning week of 2/4/13 through all resident rooms to ensure residents are being supervised; that toiletries are not on sink; and that assistive devices are in place per plan of care; and that no chemical is available to resident, if care plan prohibits this.		

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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069
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F 323	<p>Continued From page 10</p> <p>a label which stated keep out of the reach of children.</p> <p>Room 32 had Calazlme Lotion on the bedside table with a label which stated keep out of the reach of children.</p> <p>Interview, on 01/08/13 at 11:15 AM, with Licensed Practical Nurse (LPN) #1, who was working the west hall, revealed toiletries were to be placed in a bath basin and stored inside bedside tables and kept out of the sight of wandering residents. She stated there were five (5) wandering residents on the west hall.</p> <p>Interview with the Director of Nursing (DON), on 01/09/13 at 10:30 AM, revealed toiletries should be kept in residents' drawers out of sight of wandering residents and the management team did rounds to ensure these items were in place. She stated there were eight (8) wandering and confused residents in the building who were able to wander into others rooms.</p> <p>2. Review of Resident #8's medical record revealed diagnoses which included Mental Retardation and Psychosis. Review of the Minimum Data Set (MDS) Assessment dated 12/14/12, revealed the facility assessed the resident as having severe impalrment in cognitive skills for decision making.</p> <p>Review of the Accident/Incident Report with a date and time of incident as 03/17/12 at 5:30 PM, revealed Resident #8 had a spray bottle labeled Personal Cleanser and had it in his/her mouth sucking on it. According to the Report, Poision Control was notified and the resident was given</p>	F 323	<p>Education manger will re-educate all nursing staff regarding supervision of residents to prevent accidents and injuries, following the plan of care, ensuring toiletries are off the sink. AccuNurse system, specifically for resident #8 plan of care regarding chemicals at bed side is available.</p> <p>Director of nurses to audit 5 records weekly for 4 weeks beginning 2/11/13 to ensure care plan meets the resident needs and has been updated with any changes and that the care plan is being followed.</p> <p>Regional nurse consultant to audit at least 10 records monthly to ensure the care plan is correct, being followed and that toiletries are being stored properly and not on the sink. This is to begin the week of 2/1/13 for 3 months.</p> <p>4) Quality Improvement Team consisting of the administrator, medical director, director of nurses, education manger, activities/dietary manager, social services manager, and MDS coordinator) will meet weekly for 4 weeks beginning week of 2/4/13; then 2 times per month for 2 months; and then monthly ongoing to review all audit findings and make recommendations for follow-up. This will be ongoing until corrected.</p> <p>5) Date of compliance: 2/15/13</p>	

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(X3) DATE SURVEY COMPLETED
C
01/11/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

185336

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

NAME OF PROVIDER OR SUPPLIER

SPRINGFIELD NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

420 EAST GRUNDY AVENUE
SPRINGFIELD, KY 40069

(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 323

Continued From page 11
milk and house supplement to drink and placed on every fifteen (15) minute checks with vital signs every hour for twelve (12) hours.

Review of the Progress Notes, dated 03/17/12 at 6:30 PM, completed by LPN #2, revealed the Poison Control Center was notified and stated Secura Personal Cleanser was not dangerous even if two (2) to three (3) ounces were consumed.

Phone interview with LPN #2, on 01/11/13 at 3:05 PM, revealed a CNA who no longer worked at the facility had notified her the resident had a periwash spray bottle in his/her mouth and staff was not aware if the resident had swallowed any. She stated she called the Physician and the Polson Control Center. Further interview revealed she notified the previous Director of Nursing (DON) who told her to esnure the resident's toiletries were out of reach.

Review of the Comprehensive Plan of Care, dated 10/09/12, revealed the resident had the inability to sense the need to urinate related to cognitive impairment. The interventions included keeping personal hygiene items locked in the top drawer including periwash, lotion, and deodorant. Further review revealed a problem, dated 10/02/12, which stated the resident had impaired cognition with short and long term memory loss and required assistance with decislion making. The interventions included assuring the dresser drawer was locked with personal items to include periwash, lotions, and deodorant.

Observation of Resident #8, on 01/09/13 at 9:00 AM, revealed the resident was in his/her room

F 323

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F 323	<p>Continued From page 12</p> <p>sitting in a recliner chair watching television. There was a basket by the sink across the room which contained a bottle of baby powder with a label which stated to keep out of the reach of children. The basket also contained a bottle of No Rinse Body Wash Shampoo and Incontinence Cleanser Spray with a label which stated the product contained Benzethonium Chloride 0.1%, external use only, if swallowed get medical help or call poison control immediately.</p> <p>Further observation of Resident #8, on 01/10/13 at 9:15 AM, revealed the resident was in his/her room sitting in a recliner chair. There was a bottle of baby powder and a bottle of No Rinse Body Wash Shampoo and Incontinence Cleanser Spray on the floor to the left side of the recliner chair within the resident's reach. Interview, on 01/10/13 at 9:15 AM, with the DON who immediately entered the room at the surveyors request, revealed the toiletries should have been locked up in the resident's drawer out of sight.</p> <p>Interview, on 01/10/13 at 9:30 AM, with Certified Nursing Assltant (CNA) #1 revealed she was assigned to the resident. She stated Resident #8's toiletries were to be locked up in the top drawer; however, these toiletries had been left out by accident. She stated she checked the resident earlier in the shift and he/she did not need incontinence care at the time and she had not seen any toiletries out in the room. She further stated the previous shift must have left the top drawer unlocked and she failed to check the toiletries drawer to ensure it was locked when she did rounds. She stated the resident could scoot the recliner chair around the room and could reach the sink counter or dresser drawer and</p>	F 323			

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F 323	<p>Continued From page 13 obtain toiletries.</p> <p>Interview, on 01/10/13 at 2:10 PM, with LPN #1 revealed she was assigned to Resident #8. She stated confused residents including Resident #8 were to have their toiletries locked in the bedside table drawer. She further stated the resident could scoot and get to the sink and toiletries were not to be left out on the counter by the sink. Continued interview revealed the nurses did rounds while administering medications and observed for toiletries being out and she has had to remind the CNAs to lock up toiletries.</p> <p>Interview, on 01/10/13 at 3:30 PM, with LPN #3 revealed she also worked the west hall where Resident #8 resided. She stated some residents had to have toiletries locked and secured and the nurses should check to ensure this was done. She stated she had to clean up after the night shift CNAs who repeatedly left toiletries out.</p> <p>Further interview with the DON, on 01/11/13 at 3:30 PM, revealed the management team used the CNA Assignment Sheets which had specific interventions to be followed for each resident to do rounds and ensure safety devices were in place as well as other interventions such as toiletries locked. She stated she was unaware until this survey of Resident #8's history of placing toiletries in his/her mouth and indicated staff needed to be more diligent with ensuring the resident's toiletries were locked up.</p>	F 323		
F 367 SS=D	<p>483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN</p> <p>Therapeutic diets must be prescribed by the attending physician.</p>	F 367		

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F 367	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide food of the appropriate nutritive content as prescribed by the Physician for one (1) of fifteen (15) sampled residents (Resident #6). The facility failed to serve Resident #6 the Physician's ordered diet as the resident was observed to have tomato-based vegetable soup on the evening meal tray on 01/09/13, in spite of the Physician's order for "no tomato products". The findings include: Review of the clinical record revealed the facility admitted Resident #6 on 10/11/12 with diagnoses which included End Stage Renal Disease. Review of the Physician's Order, dated 12/06/12, revealed the following dietary restrictions: No tomato products, no orange juice, no oranges, no potatoes, and no bananas. Observation of the evening meal service, on 01/09/13 at 5:55 PM, revealed Resident #6 was served the meal tray in the resident's room. Continued observation revealed the meal included what appeared to be a tomato-based vegetable soup. Review of the meal ticket revealed no dietary restrictions were printed on the ticket. Interview with the Consultant Dietician, on 01/09/13 at 6:00 PM, revealed dietary restrictions ordered by the Physician should be on the tray ticket.	F 367	F367 1) Resident #6 physician and family were notified immediately that resident had received tomato based soup although she had an order for "no tomato products". No new orders were noted. Resident #6 diet order was changed per the physician and no longer has an order for "no tomato products". The medical director was notified of resident and that she had received tomato based soup and had an order for "no tomato products". No new orders were noted. 2) Dietary manager to audit all diet orders by 2/4/13 to identify that dietary department is serving all diets per the prescribed physician's order. Any issue identified will be immediately corrected. Administrator, director of nurses, assistant director of nurses, education manager, and/or dietary manager will complete a one time audit of every tray served at one meal by 2/7/13 to identify any issue with tray card directions, resident diet order, and what is served to resident. Any issues with tray card not matching physician prescribed diet order and resident receiving the physician prescribed diet order will be immediately corrected. 3) The education manager will re-educate all staff regarding following physician orders for prescribed diet, to compare tray card with the food on the tray to ensure that it is correctly served and that all resident receive care and diet per the physician order. This will be completed by 2/11/13. Dietary manager will re-educate all dietary staff regarding procedures to ensure that physician prescribed therapeutic diet is recorded in the dietary department and served to the resident as ordered. This will be completed by 2/11/13.	

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F 367	Continued From page 15 During interview on 01/09/13 at 6:05 PM, the Dietary Manager confirmed Resident #6's dietary restrictions, based on the Physician's order. She stated Resident #6 should not have received the vegetable soup, which was tomato-based. She further stated the restrictions should have been on the tray ticket, and the food checked for accuracy, first by the cook, then by the aide. Continued interview revealed she could not say why the restrictions were not noted on the tray ticket, but acknowledged there was no way for the cook or the aide to know the wrong food was served without an accurate tray ticket. Interview with the Director of Nursing (DON), on 01/11/13 at 4:40 PM, revealed she had investigated the incident and had determined the nursing staff had failed to send the proper communication to the kitchen regarding the dietary restrictions for Resident #6. She further stated the restrictions had been discussed in an interdisciplinary team meeting attended by the Dietary Manager, and an opportunity to identify and correct the error was missed.	F 367	Director of nurses, assistant director of nurses, charge nurse, and dietary manger to audit at least 10 trays a day; for 5 days each week for 4 weeks to ensure that diet is served correctly per physicians order and that the tray card is correct. Dietitian to complete a monthly audit of 10 records and trays to ensure that physician order is reflected on the tray card and that prescribed diet is being served. 4) Quality Improvement Team consisting of the administrator, medical director, director of nurses, education manger, activities/dietary manager, social services manager, and MDS coordinator) will meet weekly for 4 weeks beginning week of 2/4/13; then 2 times per month for 2 months; and then monthly ongoing to review all audit findings and make recommendations for follow-up. This will be ongoing until corrected. 5) Date of compliancc: 2/15/13	
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	F 431	1) No specific resident was identified. All residents have the potential to be affected. 2) Director of nurses and education manager to audit medication rooms 2 times a week for 4 weeks beginning week of 2/4/13 to ensure that all narcotics are stored and counted per state and federal laws. Director of nurses and education manager to audit all medication rooms 2 times a week beginning week of 2/4/13 to ensure temperature of the medication refrigerators are within appropriate parameters to store medications.	

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F 431	<p>Continued From page 16</p> <p>labeled in accordance with currently accepted 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 facility's policy, it was determined the facility failed to ensure all medications were labeled, to include the expiration date, in accordance with currently accepted professional principles. In addition, medications were not stored appropriately according to facility policy. Observation of the medication refrigerator on the East Hall revealed a multi-dose vial of Tuberculin serum had been opened more than thirty (30) days prior. Also, food items were noted stored in the refrigerator with the medications.</p>	F 431	<p>Education manager to re-educate all licensed nursing staff regarding following state and federal laws for storage of and locking of narcotics. This will be completed by 2/10/13.</p> <p>Education manager to re-educate licensed nurses regarding medication storage temperatures be kept at manufacturers recommendations; this will be completed by 2/11/13.</p> <p>Regional nurse consultant will re-educate the director of nurses, assistant director of nurses, and education manager regarding the storage of biologicals, dating opened medications, noted to be stored in refrigerator; and following manufacturers recommendations for all opened medications by 2/11/13.</p> <p>Pharmacy representative to audit both medication rooms and medication refrigerators for expired or undated opened medications by 2/11/13.</p> <p>Director of nurses to audit all medication refrigerators 2 times a week for 4 weeks, beginning week of 2/4/13, to ensure all medications are dated if opened and discarded per manufacturers recommendation, and that there is no food items present.</p> <p>Education manager to audit once a week for 4 weeks beginning week of 2/4/13 medication and treatment carts to ensure opened liquids are dated and discarded per manufacturer's recommendations.</p> <p>4) Quality Improvement Team consisting of the administrator, medical director, director of nurses, education manger, activities/dietary manager, social services manager, and MDS coordinator) will meet weekly for 4 weeks beginning week of 2/4/13; then 2 times per month for 2 months; and then monthly ongoing to review all audit findings and make recommendations for follow-up. This will be ongoing until corrected.</p> <p>5) Date of compliance: 2/15/13</p>		

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F 431	<p>Continued From page 17</p> <p>The findings include:</p> <p>Review of facility's policy titled "Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles", dated 12/01/07, revealed the following: "Once any drug or biological package is opened, the facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications." Continued review of the policy revealed food was not to be kept in the refrigerator where drugs were stored.</p> <p>Observation of the medication refrigerator on the East Hall, on 01/03/13 at 5:00 PM, revealed an open vial of Tuberculin serum was dated 11/21/12. Continued observation of manufacturer's label revealed the medication should be discarded thirty (30) days after opening. Further observation of the refrigerator revealed three (3) cups of chocolate milk were stored in with the medications.</p> <p>During interview at the time of the observation, the Nurse Educator confirmed the vial of Tuberculin serum had been opened longer than thirty (30) days, and should have been discarded. Continued interview revealed all food products should have been stored in the pantry refrigerator.</p> <p>Interview with the Regional Nurse Consultant, on 01/08/13 at 6:05 PM, revealed opened medication vials typically should be discarded after thirty (30) days, or after twenty-eight (28) days for insulin. She also stated food was not to be stored in the medication refrigerator.</p>	F 431		

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STREET ADDRESS, CITY, STATE, ZIP CODE

420 EAST GRUNDY AVENUE
SPRINGFIELD, KY 40069

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(X5) COMPLETION DATE

F 441
SS-E

483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

F 441

F441

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.

1) Resident #8 physician was notified of personal care and infection control concerns during perinical care on 1/14/13 by the director of nursing; no new orders were noted. Resident #8 has had no change in condition.

Resident #11 has had no changes related to staff member assisting resident and not washing her hands. Resident #11 physician was notified by director of nursing of staff assisting resident and not washing hands. No new orders noted.

The staff member left the room and did not wash her hands; but did was her hands prior to caring for other residents. Education director immediately began re-educating staff 1/8/13 regarding prevention of the spread of infection. No other specific residents were identified.

All bedpans, urinals, denture cups, and emesis basins, tooth brushes, hair brushes that were not covered were immediately replaced and the new ones labeled with the resident's name and covered or bagged to ensure prevention of the spread of infection.

All UTIs were trended by the regional nurse consultant and the director of nurses on 1/15/13. Currently the center has no residents requiring isolation.

2) Director of nursing, administrator and department managers (activities, dietary, social services and MDS coordinator) to do a one time audit of every room to identify any bedpan, urinal, denture cup, emesis basin, tooth brush, or hair brush that is not labeled and/or stored per state and federal regulations will be discarded and replaced immediately.

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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069	

(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 441	<p>Continued From page 19</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility's policy, it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>Observation on 01/08/12, on initial tour, revealed hair brushes, denture cups, and toothbrushes unlabeled in resident rooms at the sinks and bed pans were stored in resident bathrooms unlabeled and unbagged.</p> <p>In addition, observation of perineal care for Resident #8 revealed poor infection control technique.</p> <p>Also, observation revealed a staff member delivered a meal tray to Resident #11 and assisted the resident from a lying to a sitting position. Although the resident was in contact isolation for Methicillin Resistant Staph Aureus (MRSA) (term used to describe a number of strains of bacteria, staphylococcus aureus that are resistant to a number of strains of antibiotics including methicillin) of an abdominal wound, the staff member failed to don a gown and gloves prior to assisting the resident out of the bed. The staff member left the isolation room without washing or sanitizing her hands.</p> <p>Additionally, although the Urinary Tract Infections for the months of November 2012 and December 2012 indicated there were trends and clusters of</p>	F 441	<p>Assistant director of nurses and education manager to audit at least 15 residents receiving care to identify that staff are washing their hands per state and federal regulations and that perineal care is provided per the infection control protocol. Any issue identified will be immediately corrected.</p> <p>Presently the center has no resident requiring isolation but when isolation is ordered the director of nurses and assistant director of nurses will monitor care provided on a total of 5 isolation residents to ensure staff are following the infection control protocol.</p> <p>3) Education manager will re-educate all staff by 2/11/13 regarding storage and labeling of hair brushes, toothbrushes, bedpans, urinals, emesis basins, and toiletries.</p> <p>Education manager to re-educate all staff regarding isolation type and procedure by 2/11/13. When a resident is placed in and isolation is ordered; the education manager will re-educate staff and this will be ongoing.</p> <p>Education manager to re-educate staff regarding procedure for perineal care and monitor at least 3 staff members providing care on each shift to ensure competency by 2/12/13. This will total 9 staff members.</p> <p>Education manager will re-educate housekeeping and laundry staff regarding linens storage and transport as to prevent the spread of infection by 2/11/13.</p> <p>Director of nursing and assistant director of nurses to audit staff providing direct care to 10 residents weekly for 8 weeks to ensure hands are washed per the infection control policy and procedure and that staff are able to perform procedure as to prevent the spread of infection. At this time, there are no residents who require isolation; however, when isolation is ordered for any resident, the director of nurses and the assistant director of nurses will monitor a total of the next 5 residents requiring isolation to ensure isolation policy and procedure is followed and handwashing occurs per the policy and procedure.</p>	

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F 441	<p>Continued From page 20</p> <p>the same organisms within the building, there was no documented evidence of education to prevent the spread of Infection after the data was analyzed for those two (2) months.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the facility "Personal Care Items Policy", undated, revealed all personal toiletries, hair brushes, combs, and toothbrushes should be bagged and kept in the resident's room. <p>A policy was requested on the proper storage and labeling of bed pans; however, was not received.</p> <p>Observation during initial tour on 01/08/13 at 10:30 AM revealed the following:</p> <p>Room 22 bathroom had three (3) bed pans and one (1) emesis basin unbagged and unlabeled on a shelf.</p> <p>Room 28 had a hair brush, toothbrush, two (2) denture cups, and an emesis basin unlabeled at the sink.</p> <p>Room 31 bathroom had one (1) bedpan unbagged and unlabeled on a shelf over the toilet.</p> <p>Room 23 had a denture cup at the sink unlabeled.</p> <p>Room 27 bathroom had a bed pan unlabeled and unbagged and a hairbrush unlabeled on a shelf.</p> <p>Room 29 had two (2) hairbrushes unlabeled, and two (2) toothbrushes in a toothbrush holder unlabeled at the sink.</p>	F 441	<p>Administrator, director of nursing, and department managers will complete an audit of 10 rooms weekly for 8 weeks beginning the week of 2/4/13 to ensure hair brushes, tooth brushes, denture cups, emesis basins, urinals, and bedpans are labeled and stored per state and federal regulations.</p> <p>Administrator to monitor linen transport 1 time per week beginning the week of 2/4/13 to ensure linens are stored and transported as to prevent the spread of infection.</p> <p>4) Quality Improvement Team consisting of the administrator, medical director, director of nurses, education manger, activities/dietary manager, social services manager, and MDS coordinator) will meet weekly for 4 weeks beginning week of 2/4/13; then 2 times per month for 2 months; and then monthly ongoing to review all audit findings and make recommendations for follow-up. This will be ongoing until corrected.</p> <p>5) Date of compliance: 2/15/13</p>		

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F 441	<p>Continued From page 21</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 01/08/13 at 11:15 PM, who was assigned to the west wing, revealed denture cups and toothbrushes should be labeled. She also stated, every bed pan should be labeled with a bed and room number and placed in a plastic bag.</p> <p>Interview with the Director of Nursing (DON), on 01/09/13 at 10:30 AM, revealed toothbrushes should be bagged and placed in the resident's drawer, and denture cups should be labeled with the resident's name. She further stated the bed pans should be labeled and bagged. Continued interview revealed the management team did rounds; however, she did not think they were observing to ensure items were labeled.</p> <p>2. Review of the facility's policy titled "Guidelines for Providing Perineal Care", undated, revealed: cleanse a man's penis before the peri-rectal area is cleansed, rinse the skin, pat the skin dry. Remove your gloves and wash your hands before touching clean clothing, linens, or the resident.</p> <p>Observation of perineal care for Resident #8, on 01/09/13 at 10:45 AM, revealed Certified Nursing Assistant (CNA) #2 and CNA #3 assisted the resident to a standing position with a mechanical stand up lift. CNA #2 proceeded to cleanse the resident's anal area and buttocks with a wet wash cloth, then obtained a clean wash cloth, and with the same soiled gloves cleansed the penis and scrotum. CNA #2 then lowered the lift to sit the resident in the chair and obtained a new wash cloth and wiped the resident's face with the same soiled gloves. CNA #2 then proceeded with the same soiled gloves to assist the resident to don a new shirt, then moved the lift to the center of the</p>	F 441		

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F 441	<p>Continued From page 22</p> <p>room, opened the closet door, removed her gloves, and pushed the lift out the door without washing her hands prior to exiting the room. Continued observation revealed CNA #3 who was assisting, bagged the soiled wash cloths and attends in plastic bags and with soiled gloves on, walked out of the room.</p> <p>Interview with CNA #2, on 01/09/13 at 11:00 AM, revealed she had cleansed the stool from the resident's buttocks with one hand and used the other hand to cleanse the penis and scrotum and therefore did not see a problem. She agreed the resident had stool on the buttocks and she used the same soiled gloves in which she had washed the resident's buttocks to wash his/her face. She stated she should have washed her hands and changed gloves after incontinence care and prior to washing the resident's face and prior to dressing the resident and handling the lift and other objects in the room.</p> <p>Interview with CNA #3, on 11/09/13 at 11:05 AM, revealed she should have removed her gloves and washed her hands prior to exiting the room.</p> <p>3. Review of the facility's policy titled, "Type and Duration of Precautions Recommended for Selected Infections and Conditions", guideline, undated, revealed contact precautions was recommended for Multi-Drug Resistant Organisms such as MRSA. Further review revealed health care personnel caring for patients on Contact Precautions were to wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning of glove and gowns upon entry, removal</p>	F 441			

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F 441	<p>Continued From page 23</p> <p>before exiting the patient rooms and performance of hand hygiene immediately upon exiting were to be done to contain pathogens.</p> <p>Review of Resident #11's medical record revealed diagnoses which included Congestive Heart Failure (CHF) and Hypoxia. Review of the Minimum Data Set (MDS) Assessment, dated 10/12/12, revealed the resident had a Brief Interview for Mental Status (BIMS) of fifteen (15) out of fifteen (15) indicating no cognitive loss.</p> <p>Review of the laboratory data revealed an abdominal wound culture was collected 12/31/12 and reported on 01/03/13 as Morganella Morganii, Gram Positive cocci, and MRSA. Review of the Physician's Orders, dated 01/04/13, revealed orders for a Hibiclens bath every day for seven (7) days, Bactrim DS (antibiotic) twice a day for seven (7) days, and Tobramycin 83 milligrams (mg's) (antibiotic) daily for seven (7) days, and contact precautions.</p> <p>Observation, on 01/09/13 at 6:00 PM, revealed a sign on Resident #11's door which stated, "see nurse prior to entering". There was also an isolation cart in the hall beside the resident's door containing gowns, gloves, and masks.</p> <p>Observation, on 01/09/13 at 6:00 PM, revealed Certified Nursing Assistant (CNA) #3 entered Resident #11's room and set up the meal tray. The CNA then assisted the resident from a lying position to a sitting position. The resident's shirt did not fully cover his/her abdomen and an abdominal dressing and a colostomy bag were exposed. The CNA then exited the room without washing her hands.</p>	F 441		
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F 441	Continued From page 24 Interview, on 01/09/13 at 6:00 PM immediately after the observation, with CNA #3, revealed she was tired because she had worked seven (7) hours and she forgot to wash her hands prior to exiting. When questioned if Resident #11 was in isolation, she stated, only the roommate who had the bed by the window was in isolation. Interview, on 01/09/13 at 6:10 PM, with the Director of Nursing (DON) revealed Resident #11 had an infection in a small wound next to the colostomy which was contained and covered with a dressing. She stated both residents in the room (Resident #11 and Resident #5) were in contact isolation. Further interview revealed if a staff member was assisting Resident #11 out of bed or to a sitting position, they should don a gown and gloves prior to assisting and removed the gown and gloves as well as wash hands prior to exiting the room. She stated the CNAs received information on the headset as well as used the Nurse Aide Assignment Sheet to reference for specific information for each resident. Review of the Nurse Aide Assignment Sheet revealed there was an intervention for Resident #11 for contact precautions. She stated she was unaware of any specific contact isolation inservice done at the time Resident #11 and room mate Resident #5 were placed on contact precautions. Interview with the Staff Development Nurse, on 01/11/13 at 2:30 PM, revealed she had just started the position recently and the previous Staff Development Nurse no longer worked at the facility. She stated staff received information related to who was in isolation from the nurse prior to the shift starting which would include	F 441			

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F 441	<p>Continued From page 25</p> <p>specific information related to illnesses or isolation. Further interview revealed the last inservice related to Infection control and universal precautions was given in august of 2012, and she confirmed there had been no recent inservices in order to refresh the staff on contact precaution at the time Resident #11 and Resident #5 were being placed on contact precautions.</p> <p>4. Review of the facility's infection control data, revealed there was a total of ten (10) Urinary Tract Infections in the building for the month of November 2012. The East Wing had four (4) UTI's, two (2) of which were Ecoli infections for a resident in Room 3 and a resident in Room 6 which were in close proximity. In addition, the West Wing had six (6) UTI's, two (2) of which were Ecoli ESBL for a resident in room 23 and a resident in room 26 which were in close proximity. Also there was Ecoli Infections for a resident in Room 27 and a resident in Room 37.</p> <p>Review of the facility's infection control data, revealed there was a total of nine (9) UTI's in the building for the month of December 2012. The West Wing data denoted a resident in Room 27 and a resident in Room 37 had Ecoli infections and a resident in Room 35 and a resident in Room 26 had Enterococcus Faecalis infections.</p> <p>Interview with the Infection Control Nurse, on 01/11/13 at 2:10 PM, revealed she logged infections and also plotted the Infections on a map in color code. She stated she analyzed the data from the previous month on the first through fifth day of the current month and looked for patterns and trends of organisms and looked to see if residents in close proximity had the same</p>	F 441			

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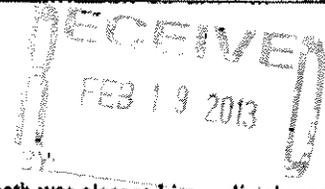
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F 441	<p>Continued From page 26</p> <p>organisms. She stated this information alerted her to the need for inservices related to hand washing or perineal care, or other types of inservices. She further stated this information was also taken to the Quality Assurance Committee each month and the Staff Development Nurse received the findings. Continued interview revealed she also looked to see if residents were symptomatic of the UTI's such as having chills, fever, or pain. She stated the majority of the residents for the November and December 2012 data were showing no signs and symptoms of infections and she did not recognize the need for Inservices after analyzing the data.</p> <p>Interview, on 01/11/13 at 3:30 PM, with the Director of Nursing (DON) revealed the data from the UTI's noted for November 2012 and December 2012 should have triggered Inservices to be done; however, staff was busy working on the Plan of Correction for the last Abbreviated Survey in November 2012 and did not recognize the need for the Inservices.</p> <p>Interview, on 01/11/13 at 2:30 PM, with the Staff Development Nurse, verified the last inservice related to perineal care was done February 2012.</p>	F 441		

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N 000	INITIAL COMMENTS A Relicensure and Complaint Survey Investigating KY#00019582 was conducted 01/08/13 through 01/11/13 with deficiencies cited. KY#00019582 was substantiated with no deficiencies cited.	N 000		
N 134	902 KAR 20:300-6(7)(a)2. Section 6. Quality Of Life (7) Environment. (a) The facility shall provide: 2. 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 review of facility's policy, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Observation on initial tour of the west general bathroom revealed a black substance in the corners of the shower wall, shower floor and on the drain; a soiled wash cloth with a brown substance on the bedside toilet; a whirlpool tub cluttered with items including attendants, lift pads, pillows and a sweatshirt; and a walker which was turned over lying in the floor. In addition, there were two (2) mechanical lifts in the west general bath which were soiled with dust and a brown substance at the base. The findings include: Review of the facility's "Environmental Services Policy", undated, revealed it was the policy of the facility that all residents reside in a clean,	N 134	 <p>N134</p> <p>1) West general bath was cleansed immediately and no longer has black substance on the shower wall, floor or drain. The soiled wash cloths on the bedside commode was immediately removed and washed. The whirlpool tub was immediately cleared of all items and cleansed. The walker was removed from the general bath. The two mechanical lifts on west side were cleaned immediately.</p> <p>2) On 1/8/13, the administrator completed an audit of both general baths; all mechanical lifts, and all resident rooms to identify any areas that were unclean or cluttered. Any issues identified were immediately corrected.</p> <p>A one time audit of all resident rooms, patient care areas, and patient care equipment (including mechanical lifts and general baths) was completed on 1/15/13 by the administrator, director of nurses, and maintenance manager to identify any patient areas, resident rooms and/or patient care areas that were unclean or cluttered. Any issue identified was immediately corrected.</p> <p>3) Administrator, maintenance manager, and housekeeping manager to complete an audit of all resident care areas, resident rooms and resident care equipment 3 times a week for 6 weeks beginning the week of 1/29/13 to ensure that the center is maintained in a orderly, sanitary, and comfortable level.</p> <p>Regional nurse consultant to complete a monthly audit of all resident rooms, resident care areas, and resident care equipment to ensure the center is maintained in a clean, sanitary, and comfortable manner; beginning 1/30/13 for 3 months.</p>	

Susan Palmer

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

TITLE

Administrator

(X6) DATE

2/19/13

Office of Inspector General

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N 134	<p>Continued From page 1</p> <p>sanitary, safe and homelike environment. Further review revealed central bath areas were to be cleaned daily and scrubbed down at least weekly. Nursing equipment such as lifts would be cleaned by nursing staff.</p> <p>Observation of initial tour, on 01/08/13 at 10:30 AM, revealed a foul odor upon entering the west general bathroom. In addition, the west general bathroom was cluttered with two (2) soiled mechanical lifts which were dusty and had a brown substance at the base. There was a Christmas Wreath and a soiled wash cloth with a brown substance on top of a bedside toilet. In addition there was a walker which was turned over in the floor by the whirlpool tub. The whirlpool tub contained a bag of wash cloths, lift pads, a pillow, and a sweatshirt.</p> <p>Interview, on 01/08/13 at 10:45 AM, with Housekeeper #1, who was assigned to clean the west general bathroom, revealed she also smelled the odor in the bathroom. She stated the black substance surrounding the tiles on the shower walls, floor, and drain was mold. She further stated she mopped the general bathroom and resident rooms once a day and sometimes used bleach when she noted mold. Further interview with the housekeeper revealed the mechanical lifts were "pretty dirty"; however, nursing was in charge of cleaning the lifts.</p> <p>Interview, on 01/08/13 at 11:15 AM, with Licensed Practical Nurse (LPN) #1, who was assigned to the west hall, revealed staff was to place soiled wash cloths in the hampers which were available in the halls and the general bathrooms, and the Certified Nursing Assistants (CNAs) knew to clean up the general bathrooms after showers. She further stated the whirlpool worked and</p>	N 134	<p>Director of nurses to monitor that all lifts and wheelchairs are cleaned 5 times a week beginning 2/4/13 for 4 weeks then 2 times a week ongoing to ensure all equipment is cleaned and maintained properly.</p> <p>Education manager to re-educate all staff regarding wheelchair and lift cleaning schedule; maintaining clean, comfortable and sanitary environment and the monitoring that would be completed. This education will be completed by 2/14/13.</p> <p>4) Quality Improvement Team consisting of the administrator, medical director, director of nurses, education manager, activities/dietary manager, social services manager, and MDS coordinator) will meet weekly for 4 weeks beginning week of 2/4/13; then 2 times per month for 2 months; and then monthly ongoing to review all audit findings and make recommendations for follow-up. This will be ongoing until corrected.</p> <p>5) Date of compliance: 2/15/13</p>		

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N 134	<p>Continued From page 2</p> <p>should be free of clutter and the nurses should be noticing these issues when making rounds.</p> <p>Interview, on 01/09/13 at 10:30 AM and 01/11/13 at 10:30 AM and 3:30 PM, with the Director of Nursing (DON) revealed the night shift staff was in charge of cleaning the mechanical lifts and she was unsure why the lifts were soiled on the initial day of the survey. She further stated the general baths should be cleaned and be uncluttered and the whirlpool bath should be clean and ready for use. Further interview revealed there was no housekeeping supervisor at that time and the Administrator was overseeing housekeeping until the position was filled.</p> <p>Interview, on 01/09/13 at 10:45 AM, with the Administrator revealed there was a cleaning schedule for the housekeepers to abide by and the general bathrooms were to be clean and have no mold or odors.</p> <p>Interview, on 01/10/13 at 3:45 PM, with Housekeeper #2 revealed when she worked she cleaned the central bathrooms daily which included emptying the trash, cleaning all surfaces, sweeping, and mopping. She stated she had noticed a mold problem in the past and had tried to clean it. Further interview revealed after the survey started and the issue was noted as a concern, she had cleaned the central bath showers with a 10% bleach and a scrub brush and it had come clean. Further interview revealed prior to this survey the whirlpool tubs were not being cleaned on a regular basis.</p> <p>Interview, on 1/11/13 at 4:00 PM, with the Maintenance Director revealed it was a joint effort between housekeeping and maintenance to keep the odors down in the building. He stated fresh</p>	N 134		

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N 134	Continued From page 3 air was pulled in through the fan with the heating and cooling system and exhaust fans sent air outside.	N 134		
N 144	902 KAR 20:300-6(7)(b)2.a. Section 6. Quality of Life (7) Environment. (b) Infection control and communicable diseases. 2. The facility shall establish an Infection control program which: a. Investigates, controls and prevents infections in the facility; This requirement is not met as evidenced by: Based on observation, interview, record review, and review of facility's policy, it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Observation on 01/08/12, on initial tour, revealed hair brushes, denture cups, and toothbrushes unlabeled in resident rooms at the sinks and bed pans were stored in resident bathrooms unlabeled and unbagged. In addition, observation of perineal care for Resident #8 revealed poor infection control technique. Also, observation revealed a staff member delivered a meal tray to Resident #11 and assisted the resident from a lying to a sitting position. Although the resident was in contact isolation for Methicillin Resistant Staph Aureus (MRSA) (term used to describe a number of	N 144	N144 1) Resident #8 physician was notified of personal care and infection control concerns during perinical care on 1/14/13 by the director of nursing; no new orders were noted. Resident #8 has had no change in condition. Resident #11 has had no changes related to staff member assisting resident and not washing her hands. Resident #11 physician was notified by director of nursing of staff assisting resident and not washing hands. No new orders noted. The staff member left the room and did not wash her hands; but did was her hands prior to caring for other residents. Education director immediately began re-educating staff 1/8/13 regarding prevention of the spread of infection. No other specific residents were identified. All bedpans, urinals, denture cups, and emesis basins, tooth brushes, hair brushes that were not covered were immediately replaced and the new ones labeled with the resident's name and covered or bagged to ensure prevention of the spread of infection. All UTIs were trended by the regional nurse consultant and the director of nurses on 1/15/13. Currently the center has no residents requiring isolation. 2) Director of nursing, administrator and department managers (activities, dietary, social services and MDS coordinator) to do a one time audit of every room to identify any bedpan, urinal, denture cup, emesis basin, tooth brush, or hair brush that is not labeled and/or stored per state and federal regulations will be discarded and replaced immediately.	

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N 144	<p>Continued From page 4</p> <p>strains of bacteria, staphylococcus aureus that are resistant to a number of strains of antibiotics including methicillin) of an abdominal wound, the staff member failed to don a gown and gloves prior to assisting the resident out of the bed. The staff member left the isolation room without washing or sanitizing her hands.</p> <p>Additionally, although the Urinary Tract Infections for the months of November 2012 and December 2012 indicated there were trends and clusters of the same organisms within the building, there was no documented evidence of education to prevent the spread of infection after the data was analyzed for those two (2) months.</p> <p>The findings include:</p> <p>1. Review of the facility "Personal Care Items Policy", undated, revealed all personal toiletries, hair brushes, combs, and toothbrushes should be bagged and kept in the resident's room.</p> <p>A policy was requested on the proper storage and labeling of bed pans; however, was not received.</p> <p>Observation during initial tour on 01/08/13 at 10:30 AM revealed the following:</p> <p>Room 22 bathroom had three (3) bed pans and one (1) emesis basin unbagged and unlabeled on a shelf.</p> <p>Room 28 had a hair brush, toothbrush, two (2) denture cups, and an emesis basin unlabeled at the sink.</p> <p>Room 31 bathroom had one (1) bedpan unbagged and unlabeled on a shelf over the toilet.</p>	N 144	<p>Assistant director of nurses and education manager to audit at least 15 residents receiving care to identify that staff are washing their hands per state and federal regulations and that perineal care is provided per the infection control protocol. Any issue identified will be immediately corrected.</p> <p>Presently the center has no resident requiring isolation but when isolation is ordered the director of nurses and assistant director of nurses will monitor care provided on a total of 5 isolation residents to ensure staff are following the infection control protocol.</p> <p>3) Education manager will re-educate all staff by 2/11/13 regarding storage and labeling of hair brushes, toothbrushes, bedpans, urinals, emesis basins, and toiletries.</p> <p>Education manager to re-educate all staff regarding isolation type and procedure by 2/11/13. When a resident is placed in and isolation is ordered; the education manager will re-educate staff and this will be ongoing.</p> <p>Education manager to re-educate staff regarding procedure for perineal care and monitor at least 3 staff members providing care on each shift to ensure competency by 2/12/13. This will total 9 staff members.</p> <p>Education manager will re-educate housekeeping and laundry staff regarding linens storage and transport as to prevent the spread of infection by 2/11/13.</p> <p>Director of nursing and assistant director of nurses to audit staff providing direct care to 10 residents weekly for 8 weeks to ensure hands are washed per the infection control policy and procedure and that staff are able to perform procedure as to prevent the spread of infection. At this time, there are no residents who require isolation; however, when isolation is ordered for any resident, the director of nurses and the assistant director of nurses will monitor a total of the next 5 residents requiring isolation to ensure isolation policy and procedure is followed and handwashing occurs per the policy and procedure.</p>	

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N 144	<p>Continued From page 5</p> <p>Room 23 had a denture cup at the sink unlabeled.</p> <p>Room 27 bathroom had a bed pan unlabeled and unbagged and a hairbrush unlabeled on a shelf.</p> <p>Room 29 had two (2) hairbrushes unlabeled, and two (2) toothbrushes in a toothbrush holder unlabeled at the sink.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 01/08/13 at 11:15 PM, who was assigned to the west wing, revealed denture cups and toothbrushes should be labeled. She also stated, every bed pan should be labeled with a bed and room number and placed in a plastic bag.</p> <p>Interview with the Director of Nursing (DON), on 01/09/13 at 10:30 AM, revealed toothbrushes should be bagged and placed in the resident's drawer, and denture cups should be labeled with the resident's name. She further stated the bed pans should be labeled and bagged. Continued interview revealed the management team did rounds; however, she did not think they were observing to ensure items were labeled.</p> <p>2. Review of the facility's policy titled "Guidelines for Providing Perineal Care", undated, revealed: cleanse a man's penis before the peri-rectal area is cleansed, rinse the skin, pat the skin dry. Remove your gloves and wash your hands before touching clean clothing, linens, or the resident.</p> <p>Observation of perineal care for Resident #8, on 01/09/13 at 10:45 AM, revealed Certified Nursing Assistant (CNA) #2 and CNA #3 assisted the resident to a standing position with a mechanical stand up lift. CNA #2 proceeded to cleanse the resident's anal area and buttocks with a wet wash cloth, then obtained a clean wash cloth, and with</p>	N 144	<p>Administrator, director of nursing, and department managers will complete an audit of 10 rooms weekly for 8 weeks beginning the week of 2/4/13 to ensure hair brushes, tooth brushes, denture cups, emesis basins, urinals, and bedpans are labeled and stored per state and federal regulations.</p> <p>Administrator to monitor linen transport 1 time per week beginning the week of 2/4/13 to ensure linens are stored and transported as to prevent the spread of infection.</p> <p>4) Quality Improvement Team consisting of the administrator, medical director, director of nurses, education manger, activities/dietary manager, social services manager, and MDS coordinator) will meet weekly for 4 weeks beginning week of 2/4/13; then 2 times per month for 2 months; and then monthly ongoing to review all audit findings and make recommendations for follow-up. This will be ongoing until corrected.</p> <p>5) Date of compliance: 2/15/13</p>	

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N 144	<p>Continued From page 6</p> <p>the same soiled gloves cleansed the penis and scrotum. CNA #2 then lowered the lift to sit the resident in the chair and obtained a new wash cloth and wiped the resident's face with the same soiled gloves. CNA #2 then proceeded with the same soiled gloves to assist the resident to don a new shirt, then moved the lift to the center of the room, opened the closet door, removed her gloves, and pushed the lift out the door without washing her hands prior to exiting the room. Continued observation revealed CNA #3 who was assisting, bagged the soiled wash cloths and attends in plastic bags and with soiled gloves on, walked out of the room.</p> <p>Interview with CNA #2, on 01/09/13 at 11:00 AM, revealed she had cleansed the stool from the resident's buttocks with one hand and used the other hand to cleanse the penis and scrotum and therefore did not see a problem. She agreed the resident had stool on the buttocks and she used the same soiled gloves in which she had washed the resident's buttocks to wash his/her face. She stated she should have washed her hands and changed gloves after incontinence care and prior to washing the resident's face and prior to dressing the resident and handling the lift and other objects in the room.</p> <p>Interview with CNA #3, on 11/09/13 at 11:05 AM, revealed she should have removed her gloves and washed her hands prior to exiting the room.</p> <p>3. Review of the facility's policy titled, "Type and Duration of Precautions Recommended for Selected Infections and Conditions", guideline, undated, revealed contact precautions was recommended for Multi-Drug Resistant Organisms such as MRSA. Further review revealed health care personnel caring for</p>	N 144		

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N 144	<p>Continued From page 7</p> <p>patients on Contact Precautions were to wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning of glove and gowns upon entry, removal before exiting the patient rooms and performance of hand hygiene immediately upon exiting were to be done to contain pathogens.</p> <p>Review of Resident #11's medical record revealed diagnoses which included Congestive Heart Failure (CHF) and Hypoxia. Review of the Minimum Data Set (MDS) Assessment, dated 10/12/12, revealed the resident had a Brief Interview for Mental Status (BIMS) of fifteen (15) out of fifteen (15) indicating no cognitive loss.</p> <p>Review of the laboratory data revealed an abdominal wound culture was collected 12/31/12 and reported on 01/03/13 as Morganella Morganii, Gram Positive cocci, and MRSA. Review of the Physician's Orders, dated 01/04/13, revealed orders for a Hibiclens bath every day for seven (7) days, Bactrim DS (antibiotic) twice a day for seven (7) days, and Tobramycin 83 milligrams (mg's) (antibiotic) daily for seven (7) days, and contact precautions.</p> <p>Observation, on 01/09/13 at 6:00 PM, revealed a sign on Resident #11's door which stated, "see nurse prior to entering". There was also an isolation cart in the hall beside the resident's door containing gowns, gloves, and masks.</p> <p>Observation, on 01/09/13 at 6:00 PM, revealed Certified Nursing Assistant (CNA) #3 entered Resident #11's room and set up the meal tray. The CNA then assisted the resident from a lying position to a sitting position. The resident's shirt did not fully cover his/her abdomen and an</p>	N 144			

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N 144	<p>Continued From page 8</p> <p>abdominal dressing and a colostomy bag were exposed. The CNA then exited the room without washing her hands.</p> <p>Interview, on 01/09/13 at 6:00 PM immediately after the observation, with CNA #3, revealed she was tired because she had worked seven (7) hours and she forgot to wash her hands prior to exiting. When questioned if Resident #11 was in isolation, she stated, only the roommate who had the bed by the window was in isolation.</p> <p>Interview, on 01/09/13 at 6:10 PM, with the Director of Nursing (DON) revealed Resident #11 had an infection in a small wound next to the colostomy which was contained and covered with a dressing. She stated both residents in the room (Resident #11 and Resident #5) were in contact isolation. Further interview revealed if a staff member was assisting Resident #11 out of bed or to a sitting position, they should don a gown and gloves prior to assisting and removed the gown and gloves as well as wash hands prior to exiting the room. She stated the CNAs received information on the headset as well as used the Nurse Aide Assignment Sheet to reference for specific information for each resident. Review of the Nurse Aide Assignment Sheet revealed there was an intervention for Resident #11 for contact precautions. She stated she was unaware of any specific contact isolation inservice done at the time Resident #11 and room mate Resident #5 were placed on contact precautions.</p> <p>Interview with the Staff Development Nurse, on 01/11/13 at 2:30 PM, revealed she had just started the position recently and the previous Staff Development Nurse no longer worked at the facility. She stated staff received information related to who was in isolation from the nurse</p>	N 144		

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N 144	<p>Continued From page 9</p> <p>prior to the shift starting which would include specific information related to illnesses or isolation. Further interview revealed the last inservice related to infection control and universal precautions was given in August of 2012, and she confirmed there had been no recent inservices in order to refresh the staff on contact precaution at the time Resident #11 and Resident #5 were being placed on contact precautions.</p> <p>4. Review of the facility's infection control data, revealed there was a total of ten (10) Urinary Tract Infections in the building for the month of November 2012. The East Wing had four (4) UTI's, two (2) of which were E. coli infections for a resident in Room 3 and a resident in Room 6 which were in close proximity. In addition, the West Wing had six (6) UTI's, two (2) of which were E. coli ESBL for a resident in room 23 and a resident in room 26 which were in close proximity. Also there was E. coli infections for a resident in Room 27 and a resident in Room 37.</p> <p>Review of the facility's infection control data, revealed there was a total of nine (9) UTI's in the building for the month of December 2012. The West Wing data denoted a resident in Room 27 and a resident in Room 37 had E. coli infections and a resident in Room 35 and a resident in Room 26 had Enterococcus Faecalis infections.</p> <p>Interview with the Infection Control Nurse, on 01/11/13 at 2:10 PM, revealed she logged infections and also plotted the infections on a map in color code. She stated she analyzed the data from the previous month on the first through fifth day of the current month and looked for patterns and trends of organisms and looked to see if residents in close proximity had the same organisms. She stated this information alerted</p>	N 144			

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N 144	Continued From page 10 her to the need for inservices related to hand washing or perineal care, or other types of inservices. She further stated this information was also taken to the Quality Assurance Committee each month and the Staff Development Nurse received the findings. Continued interview revealed she also looked to see if residents were symptomatic of the UTI's such as having chills, fever, or pain. She stated the majority of the residents for the November and December 2012 data were showing no signs and symptoms of infections and she did not recognize the need for inservices after analyzing the data. Interview, on 01/11/13 at 3:30 PM, with the Director of Nursing (DON) revealed the data from the UTI's noted for November 2012 and December 2012 should have triggered inservices to be done; however, staff was busy working on the Plan of Correction for the last Abbreviated Survey in November 2012 and did not recognize the need for the inservices. Interview, on 01/11/13 at 2:30 PM, with the Staff Development Nurse, verified the last inservice related to perineal care was done February 2012.	N 144			
N 193	902 KAR 20:300-7(4)(c)1. Section 7. Resident Assessment (4) Comprehensive care plans. (c) The services provided or arranged by the facility shall: 1. Meet professional standards of quality; and This requirement is not met as evidenced by: Based on interview, record review and review of facility's policy, it was determined the facility failed	N 193	N193 1) Resident #12 physician and family were notified on 1/11/13 by the director of nurses that the urinalysis was ordered for 12/14/12 but was not completed until 12/20/12. No new orders were noted. Medical director was notified on 1/11/13 of the lab being completed late for resident #12 by the director of nurses. No new orders were noted.		

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N 193	<p>Continued From page 11</p> <p>to ensure the services provided by the facility met professional standards of quality for one (1) of fifteen (15) sampled residents (Resident #12). The facility failed to ensure a Physician's order was followed for Resident #12. A Physician's order was given on 12/03/12 to repeat a urinalysis three (3) days after completion of the antibiotic, which would have been 12/14/12. However, there was no documented evidence the urinalysis was collected until 12/20/12.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Labs" revealed the facility was to follow all Physician's orders as given per the Physician.</p> <p>Review of the clinical record revealed the facility admitted Resident #12 on 07/01/12 with diagnoses which include Hypothyroidism, Diabetes, Hypertension, Hyperlipdemia, Anemia and Asthma.</p> <p>Review of the Physician's Order, dated 12/03/12 revealed Resident #12 was to have a urinalysis collected on 12/03/12 and a follow up urinalysis three (3) days after completion of the antibiotic, Levaquin 500 Milligram (mg) twice daily for five (5) days. The antibiotic was completed on 12/11/12, and the follow up urinalysis should have been collected on 12/14/12. However, further record review revealed the urinalysis was not collected until 12/20/12.</p> <p>Review of Resident #12's Medication Administration Record (MAR) for December 2012 revealed Resident #12 completed the antibiotic as ordered on 12/11/12.</p> <p>Review of the lab report revealed no documented</p>	N 193	<p>2) A 100% one time audit will be completed by 2/11/13 to identify any labs ordered that were not completed per physician's order. This audit will be completed by the director of nurses, assistant director of nurses, education manager and/or regional nurse consultant. This will include a look back of lab orders from 12/1/12 through 2/8/13. Any issue identified will be immediately corrected.</p> <p>Regional nurse consultant to re-educate director of nurses, assistant director of nurses, and education manager regarding following physician orders for labs, lab processes, and meeting professional standards of care by 1/30/13.</p> <p>3) Education manager to re-educate all licensed nurses regarding professional standards of care, following physician orders for labs and lab process by 2/11/13.</p> <p>Director of nurses, assistant director of nurses, and/or education manager to audit 10 records each week for 6 weeks beginning week of 2/11/13 to ensure all labs completed per physician orders.</p> <p>Assistant director of nurses to audit lab binder weekly for 4 weeks to ensure all lab orders are noted and a lab slip is completed timely.</p> <p>Regional nurse consultant to audit 10 records monthly for 3 months beginning week of 2/11/13 to ensure all labs are completed per physician orders.</p> <p>4) Quality Improvement Team consisting of the administrator, medical director, director of nurses, education manager, activities/dietary manager, social services manager, and MDS coordinator) will meet weekly for 4 weeks beginning week of 2/4/13; then 2 times per month for 2 months; and then monthly ongoing to review all audit findings and make recommendations for follow-up. This will be ongoing until corrected.</p> <p>5) Date of compliance: 2/15/13</p>	

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N 193	Continued From page 12 evidence the urinalysis was collected on 12/20/12. Interview with the Assistance Director of Nursing (ADON), on 01/11/13 at 5:30 PM, revealed she kept a lab log binder with daily labs that were to be obtained. The third shift nurse or whoever was on duty was responsible for checking the log to ensure lab specimens were obtained. The ADON revealed the follow up urinalysis for Resident #12 was not obtained as ordered, it got overlooked and should have been collected as ordered on 12/14/13.	N 193		
N 194	902 KAR 20:300-7(4)(c)2. Section 7. Resident Assessment (4) Comprehensive care plans. (c) The services provided or arranged by the facility shall: 2. 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 review of facility's policy, it was determined the facility failed to ensure services were provided by the facility in accordance with each resident's written plan of care for one (1) of fifteen (15) sampled residents (Resident #8) Observations during the survey revealed a bottle of No Rinse Body Wash Shampoo and Incontinence Cleanser Spray and baby powder accessible to Resident #8 who had a history of placing toiletries in his/her mouth. The findings include:	N 194	N194 1) Resident #8 did not have any issue with putting toiletries in his mouth during the survey. Resident condition is unchanged. Resident #8 physician and family were notified by the director of nurses that the toiletries were accessible to resident during the period of 1/8/13 through 1/11/13. No new orders were noted. Medical director was made aware that the toiletries were available to the resident but the resident did not get them during the period of 1/8/13 though 1/11/13. No new ordered were noted. 2) A one time audit of all residents was made by the administrator, director of nurses, assistant director of nurses, and education manager on 1/14/13 to identify if care was provided to each resident per their individualized plan of care, if toiletries was on resident sinks and to identify any issue with toiletries being left at bedside that should not have been. Any issues identified were immediately corrected. A one time audit of 15 residents will be completed by the director of nurses, assistant director of nurses and the education manager by 2/5/13 to identify any resident not being supervised per their plan of care to prevent accidents and injuries; that all assistive devices are correct and to identify any resident that is not supervised.	

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N 194	Continued From page 13 Review of Resident #8's clinical record revealed diagnoses which included Mental Retardation and Psychosis. Review of the Minimum Data Set (MDS) Assessment dated 12/14/12 revealed the facility assessed the resident as having severe impairment in cognitive skills. Review of the Comprehensive Plan of Care, dated 10/09/12, revealed Resident #8 had the inability to sense the need to urinate related to cognitive impairment. The approaches included keeping personal hygiene items locked in the top drawer including periwash, lotion, and deodorant. Further review revealed a problem, dated 10/02/12, which stated the resident had impaired cognition and required assistance with decision making. The approaches included assuring the dresser drawer was locked with personal items to include periwash, lotions, and deodorant. Observation of Resident #8, on 01/09/13 at 9:00 AM, revealed the resident was in his/her room sitting straight up in a recliner chair watching television. Further observation revealed there was a basket by the sink across the room which contained a bottle of baby powder with a label which stated, keep out of the reach of children and a bottle of No Rinse Body Wash Shampoo and Incontinence Cleanser Spray with a label which stated; contains Benzethonium Chloride 0.1%, external use only, if swallowed get medical help or call poison control immediately. Observation of Resident #8, on 01/10/13 at 9:15 AM, revealed the resident was in his/her room sitting in a recliner chair. It was noted there was a bottle of baby powder and a bottle of No Rinse Body Wash Shampoo and Incontinence Cleanser Spray on the floor to the left side of the recliner chair within the resident's reach. Interview, on	N 194	A one time audit of all accident and incident reports form a period of 1/1/13 through 2/8/13 to be completed by regional nurse consultant, director of nurses, assistant director of nurses or education manager to identify any accident and incident that occurred due to not following the individualized plan of care and/or due to an issue with resident supervision. This will be completed by 2/11/13 and that the physician and family were notified. Director of nurses, assistant director of nurses, education manager or social services manager to audit all care plans by 2/12/13 to identify that care plan meets resident's individual needs and is correct. Any issue identified will be immediately corrected. 3) Director of nurses, assistant director of nurses, or education manager to audit care being provided to at least 10 residents each week for 6 weeks; then 2 residents per week for 2 months to ensure the plan of care is followed, that no toiletries are available if identified as an issue. Administrator and education manager to complete a walk through 1 time daily; 5 days a week; for 4 weeks beginning week of 2/4/13 through all resident rooms to ensure residents are being supervised; that toiletries are not on sink; and that assistive devices are in place per plan of care; and that no chemical is available to resident, if care plan prohibits this. Education manager will re-educate all nursing staff regarding supervision of residents to prevent accidents and injuries, following the plan of care, ensuring toiletries are off the sink. AccuNurse system, specifically for resident #8 plan of care regarding chemicals at bed side is available. Director of nurses to audit 5 records weekly for 4 weeks beginning 2/11/13 to ensure care plan meets the resident needs and has been updated with any changes and that the care plan is being followed.	

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N 194	<p>Continued From page 14</p> <p>01/10/13 at 9:15 AM, with the Director of Nursing (DON) who entered the room at the surveyors request, revealed the toiletries should have been locked up in the resident's drawer out of sight.</p> <p>Interview, on 01/10/13 at 9:30 AM with Certified Nursing Assistant (CNA) #1, revealed she was assigned to Resident #8. She stated the resident's toiletries were to be locked up in the top drawer; however, these toiletries had been left out by accident. She further stated she checked the resident earlier in the shift and he/she did not need incontinence care at the time and she had not seen any toiletries out in the room. Continued interview revealed the previous shift must have left the top drawer unlocked and she failed to check the toiletries drawer to ensure it was locked when she did rounds. CNA #1 stated the resident could scoot the recliner chair around the room and could reach the sink counter or dresser drawer and obtain toiletries.</p> <p>Interview, on 01/10/13 at 2:10 PM, with Licensed Practical Nurse (LPN) #1 revealed she was assigned to Resident #8. She confirmed that confused residents including Resident #8 were to have their toiletries locked in the bedside table drawer. Further interview revealed the resident could scoot and get to the sink and toiletries were not to be left out on the counter by the sink. She stated the nurses did rounds while administering medications and observed for toiletries being out and she has had to remind the CNAs to lock up toiletries.</p> <p>Interview, on 01/10/13 at 3:30 PM, with LPN #3 revealed she worked the west hall where Resident #8 resided. She stated some residents had to have toiletries locked and secured and the nurses should check to ensure this was done</p>	N 194	<p>Regional nurse consultant to audit at least 10 records monthly to ensure the care plan is correct, being followed and that toiletries are being stored properly and not on the sink. This is to begin the week of 2/1/13 for 3 months.</p> <p>4) Quality Improvement Team consisting of the administrator, medical director, director of nurses, education manager, activities/dietary manager, social services manager, and MDS coordinator) will meet weekly for 4 weeks beginning week of 2/4/13; then 2 times per month for 2 months; and then monthly ongoing to review all audit findings and make recommendations for follow-up. This will be ongoing until corrected.</p> <p>5) Date of compliance: 2/15/13</p>	

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N 194	Continued From page 15 during rounds. She stated, "to be honest", she had to clean up after the night shift CNAs who repeatedly left toiletries out. Further Interview with the DON, on 01/11/13 at 3:30 PM, revealed one of the ways they ensured the care plans were followed was to have the management team use the CNA Assignment Sheets as a reference when doing rounds. She stated the CNA Assignment Sheets had specific interventions to be followed for each resident including safety devices and Resident #8's Assignment Sheet included an intervention for the toiletries to be locked up. She indicated staff needed to be more diligent with ensuring Resident #8's toiletries were locked up.	N 194		
N 219	902 KAR 20:300-8(7)(a) Section 8. Quality of Care (7) Accidents. The facility shall ensure that: (a) The resident environment remains as free of accident hazards as is possible; and This requirement is not met as evidenced by: Based on observation, interview, record review, and review of facility's policy, it was determined the facility failed to ensure the resident environment remains as free of accident hazards as is possible. Observation on initial tour on 01/08/13 revealed toiletries in residents' rooms by the sinks accessible to wandering residents. In addition, observation during the survey revealed a bottle of No Rinse Body Wash Shampoo and Incontinence Cleanser Spray and baby powder accessible to Resident #8 who had	N 219	N219 1) Resident #8 did not have any issue with putting toiletries in his mouth during the survey. Resident condition is unchanged. Resident #8 physician and family were notified by the director of nurses that the toiletries were accessible to resident during the period of 1/8/13 through 1/11/13. No new orders were noted. Medical director was made aware that the toiletries were available to the resident but the resident did not get them during the period of 1/8/13 through 1/11/13. No new orders were noted. 2) A one time audit of all residents was made by the administrator, director of nurses, assistant director of nurses, and education manager on 1/14/13 to identify if care was provided to each resident per their individualized plan of care, if toiletries was on resident sinks and to identify any issue with toiletries being left at bedside that should not have been. Any issues identified were immediately corrected.	

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N 219	Continued From page 16 a history of placing toiletries in his/her mouth. The findings include: Review of the facility's "Personal Care Items Policy", undated, revealed personal care items should be bagged and kept in resident's room to include lotions, shampoos, conditioners, toothpaste, mouthwash, etc. and all residents were provided with a bedside chest which could be used for resident's personal storage. 1. Observation during initial tour, on 01/08/13 at 10:00 AM, revealed toiletries were in the following resident rooms accessible to wandering residents: Room 2 and Room 6 had baby powder on the bedside tables with a label which stated keep out of the reach of children. Room 24 had Vanilla Citrus White Tea Lotion on the bedside table with no lid with a label which stated keep out of the reach of children. Room 25 had baby powder with a label which stated keep out of the reach of children and No Rinse Body Wash Shampoo and Incontinence Care Spray which stated, keep out of the reach of children and if swallowed get medical help or contact poison control immediately in a basket at the sink. Room 29 had Aloe Vera Lotion in the window with a label which stated keep out of the reach of children. Room 39 had Classic Splash Aftershave and Old Spice Deodorant on the bedside table both with a label which stated keep out of the reach of	N 219	A one time audit of 15 residents will be completed by the director of nurses, assistant director of nurses and the education manager by 2/5/13 to identify any resident not being supervised per their plan of care to prevent accidents and injuries; that all assistive devices are correct and to identify any resident that is not supervised. A one time audit of all accident and incident reports form a period of 1/1/13 though 2/8/13 to be completed by regional nurse consultant, director of nurses, assistant director of nurses or education manager to identify any accident and incident that occurred due to not following the individualized plan of care and/or due to an issue with resident supervision. This will be completed by 2/11/13 and that the physician and family were notified. Director of nurses, assistant director of nurses, education manager or social services manager to audit all care plans by 2/12/13 to identify that care plan meets resident's individual needs and is correct. Any issue identified will be immediately corrected. 3) Director of nurses, assistant director of nurses, or education manager to audit care being provided to at least 10 residents each week for 6 weeks; then 2 residents per week for 2 months to ensure the plan of care is followed, that no toiletries are available if identified as an issue. Administrator and education manager to complete a walk through 1 time daily; 5 days a week; for 4 weeks beginning week of 2/4/13 through all resident rooms to ensure residents are being supervised; that toiletries are not on sink; and that assistive devices are in place per plan of care; and that no chemical is available to resident, if care plan prohibits this.		

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N 219	<p>Continued From page 17</p> <p>children.</p> <p>Room 32 had Calazime Lotion on the bedside table with a label which stated keep out of the reach of children.</p> <p>Interview, on 01/08/13 at 11:15 AM, with Licensed Practical Nurse (LPN) #1, who was working the west hall, revealed toiletries were to be placed in a bath basin and stored inside bedside tables and kept out of the sight of wandering residents. She stated there were five (5) wandering residents on the west hall.</p> <p>(interview with the Director of Nursing (DON), on 01/09/13 at 10:30 AM, revealed toiletries should be kept in residents' drawers out of sight of wandering residents and the management team did rounds to ensure these items were in place. She stated there were eight (8) wandering and confused residents in the building who were able to wander into others rooms.</p> <p>2. Review of Resident #8's medical record revealed diagnoses which included Mental Retardation and Psychosis. Review of the Minimum Data Set (MDS) Assessment dated 12/14/12, revealed the facility assessed the resident as having severe impairment in cognitive skills for decision making.</p> <p>Review of the Accident/Incident Report with a date and time of incident as 03/17/12 at 5:30 PM, revealed Resident #8 had a spray bottle labeled Personal Cleanser and had it in his/her mouth sucking on it. According to the Report, Poison Control was notified and the resident was given milk and house supplement to drink and placed on every fifteen (15) minute checks with vital signs every hour for twelve (12) hours.</p>	N 219	<p>Education manger will re-educate all nursing staff regarding supervision of residents to prevent accidents and injuries, following the plan of care, ensuring toiletries are off the sink. AccuNurse system, specifically for resident #8 plan of care regarding chemicals at bed side is available.</p> <p>Director of nurses to audit 5 records weekly for 4 weeks beginning 2/11/13 to ensure care plan meets the resident needs and has been updated with any changes and that the care plan is being followed.</p> <p>Regional nurse consultant to audit at least 10 records monthly to ensure the care plan is correct, being followed and that toiletries are being stored properly and not on the sink. This is to begin the week of 2/11/13 for 3 months.</p> <p>4) Quality Improvement Team consisting of the administrator, medical director, director of nurses, education manger, activities/dietary manager, social services manager, and MDS coordinator) will meet weekly for 4 weeks beginning week of 2/4/13; then 2 times per month for 2 months; and then monthly ongoing to revicw all audit findings and make recommendations for follow-up. This will be ongoing until corrected.</p> <p>5) Date of compliance: 2/15/13</p>	

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N 219	Continued From page 18 Review of the Progress Notes, dated 03/17/12 at 6:30 PM, completed by LPN #2, revealed the Poison Control Center was notified and stated Secura Personal Cleanser was not dangerous even if two (2) to three (3) ounces were consumed. Phone Interview with LPN #2, on 01/11/13 at 3:05 PM, revealed a CNA who no longer worked at the facility had notified her the resident had a periwash spray bottle in his/her mouth and staff was not aware if the resident had swallowed any. She stated she called the Physician and the Poison Control Center. Further interview revealed she notified the previous Director of Nursing (DON) who told her to ensure the resident's toiletries were out of reach. Review of the Comprehensive Plan of Care, dated 10/09/12, revealed the resident had the inability to sense the need to urinate related to cognitive impairment. The interventions included keeping personal hygiene items locked in the top drawer including periwash, lotion, and deodorant. Further review revealed a problem, dated 10/02/12, which stated the resident had impaired cognition with short and long term memory loss and required assistance with decision making. The interventions included assuring the dresser drawer was locked with personal items to include periwash, lotions, and deodorant. Observation of Resident #8, on 01/09/13 at 9:00 AM, revealed the resident was in his/her room sitting in a recliner chair watching television. There was a basket by the sink across the room which contained a bottle of baby powder with a label which stated to keep out of the reach of children. The basket also contained a bottle of	N 219		

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N 219	<p>Continued From page 19</p> <p>No Rinse Body Wash Shampoo and Incontinence Cleanser Spray with a label which stated the product contained Benzethonium Chloride 0.1%, external use only, if swallowed get medical help or call poison control immediately.</p> <p>Further observation of Resident #8, on 01/10/13 at 9:15 AM, revealed the resident was in his/her room sitting in a recliner chair. There was a bottle of baby powder and a bottle of No Rinse Body Wash Shampoo and Incontinence Cleanser Spray on the floor to the left side of the recliner chair within the resident's reach. Interview, on 01/10/13 at 9:15 AM, with the DON who immediately entered the room at the surveyors request, revealed the toiletries should have been locked up in the resident's drawer out of sight.</p> <p>Interview, on 01/10/13 at 9:30 AM, with Certified Nursing Assistant (CNA) #1 revealed she was assigned to the resident. She stated Resident #8's toiletries were to be locked up in the top drawer; however, these toiletries had been left out by accident. She stated she checked the resident earlier in the shift and he/she did not need incontinence care at the time and she had not seen any toiletries out in the room. She further stated the previous shift must have left the top drawer unlocked and she failed to check the toiletries drawer to ensure it was locked when she did rounds. She stated the resident could scoot the recliner chair around the room and could reach the sink counter or dresser drawer and obtain toiletries.</p> <p>Interview, on 01/10/13 at 2:10 PM, with LPN #1 revealed she was assigned to Resident #8. She stated confused residents including Resident #8 were to have their toiletries locked in the bedside table drawer. She further stated the resident</p>	N 219		

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N 219	Continued From page 20 could scoot and get to the sink and toiletries were not to be left out on the counter by the sink. Continued interview revealed the nurses did rounds while administering medications and observed for toiletries being out and she has had to remind the CNAs to lock up toiletries. Interview, on 01/10/13 at 3:30 PM, with LPN #3 revealed she also worked the west hall where Resident #8 resided. She stated some residents had to have toiletries locked and secured and the nurses should check to ensure this was done. She stated she had to clean up after the night shift CNAs who repeatedly left toiletries out. Further interview with the DON, on 01/11/13 at 3:30 PM, revealed the management team used the CNA Assignment Sheets which had specific interventions to be followed for each resident to do rounds and ensure safety devices were in place as well as other interventions such as toiletries locked. She stated she was unaware until this survey of Resident #8's history of placing toiletries in his/her mouth and indicated staff needed to be more diligent with ensuring the resident's toiletries were locked up.	N 219			
N 276	902 KAR 20:300-10(5) Section 10. Dietary Services (5) Therapeutic diets. Therapeutic diets must be prescribed by the attending physician. This requirement is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide food of the appropriate nutritive content as prescribed by the Physician for one (1) of fifteen (15) sampled residents (Resident #6). The facility failed to serve Resident #6 the Physician's	N 276	N276 1) Resident #6 physician and family were notified immediately that resident had received tomato based soup although she had an order for "no tomato products". No new orders were noted. Resident #6 diet order was changed per the physician and no longer has an order for "no tomato products". The medical director was notified of resident and that she had received tomato based soup and had an order for "no tomato products". No new orders were noted.		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100412	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/11/2013
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION C		STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069		
(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) COMPLETE DATE
N 276	<p>Continued From page 21</p> <p>ordered diet as the resident was observed to have tomato-based vegetable soup on the evening meal tray on 01/09/13, in spite of the Physician's order for "no tomato products".</p> <p>The findings include:</p> <p>Review of the clinical record revealed the facility admitted Resident #6 on 10/11/12 with diagnoses which included End Stage Renal Disease. Review of the Physician's Order, dated 12/06/12, revealed the following dietary restrictions: No tomato products, no orange juice, no oranges, no potatoes, and no bananas.</p> <p>Observation of the evening meal service, on 01/09/13 at 5:55 PM, revealed Resident #6 was served the meal tray in the resident's room. Continued observation revealed the meal included what appeared to be a tomato-based vegetable soup. Review of the meal ticket revealed no dietary restrictions were printed on the ticket.</p> <p>Interview with the Consultant Dietician, on 01/09/13 at 6:00 PM, revealed dietary restrictions ordered by the Physician should be on the tray ticket.</p> <p>During interview on 01/09/13 at 6:05 PM, the Dietary Manager confirmed Resident #6's dietary restrictions, based on the Physician's order. She stated Resident #6 should not have received the vegetable soup, which was tomato-based. She further stated the restrictions should have been on the tray ticket, and the food checked for accuracy, first by the cook, then by the aide. Continued interview revealed she could not say why the restrictions were not noted on the tray ticket, but acknowledged there was no way for</p>	N 276	<p>2) Dietary manager to audit all diet orders by 2/4/13 to identify that dietary department is serving all diets per the prescribed physician's order. Any issue identified will be immediately corrected.</p> <p>Administrator, director of nurses, assistant director of nurses, education manager, and/or dietary manager will complete a one time audit of every tray served at one meal by 2/7/13 to identify any issue with tray card directions, resident diet order, and what is served to resident. Any issues with tray card not matching physician prescribed diet order and resident receiving the physician prescribed diet order will be immediately corrected.</p> <p>3) The education manager will re-educate all staff regarding following physician orders for prescribed diet, to compare tray card with the food on the tray to ensure that it is correctly served and that all resident receive care and diet per the physician order. This will be completed by 2/11/13.</p> <p>Dietary manager will re-educate all dietary staff regarding procedures to ensure that physician prescribed therapeutic diet is recorded in the dietary department and served to the resident as ordered. This will be completed by 2/11/13.</p> <p>Director of nurses, assistant director of nurses, charge nurse, and dietary manger to audit at least 10 trays a day; for 5 days each week for 4 weeks to ensure that diet is served correctly per physicians order and that the tray card is correct.</p> <p>Dietitian to complete a monthly audit of 10 records and trays to ensure that physician order is reflected on the tray card and that prescribed diet is being served.</p>	

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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION C		STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069		
(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) COMPLETE DATE
N 276	Continued From page 22 the cook or the aide to know the wrong food was served without an accurate tray ticket. Interview with the Director of Nursing (DON), on 01/11/13 at 4:40 PM, revealed she had investigated the incident and had determined the nursing staff had failed to send the proper communication to the kitchen regarding the dietary restrictions for Resident #6. She further stated the restrictions had been discussed in an interdisciplinary team meeting attended by the Dietary Manager, and an opportunity to identify and correct the error was missed.	N 276	4) Quality Improvement Team consisting of the administrator, medical director, director of nurses, education manger, activitics/dietary manager, social services manager, and MDS coordinator) will meet weekly for 4 weeks beginning week of 2/4/13; then 2 times per month for 2 months; and then monthly ongoing to review all audit findings and make recommendations for follow-up. This will be ongoing until corrected. 5) Date of compliance: 2/15/13	
N 313	902 KAR 20:300-14(4) Section 14, Pharmacy Services (4) Labeling of drugs and biologicals. The facility shall label drugs and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date. This requirement is not met as evidenced by: Based on observation, interview and review of facility's policy, it was determined the facility failed to ensure all medications were labeled, to include the expiration date, in accordance with currently accepted professional principles. In addition, medications were not stored appropriately according to facility policy. Observation of the medication refrigerator on the East Hall revealed a multi-dose vial of Tuberculin serum had been opened more than thirty (30) days prior. Also, food items were noted stored in the refrigerator with the medications. The findings include: Review of facility's policy titled "Storage and Expiration Dating of Drugs, Biologicals, Syringes	N 313	N313 1) No specific resident was identified. All residents have the potential to be affected. 2) Director of nurses and education manager to audit medication rooms 2 times a week for 4 weeks beginning week of 2/4/13 to ensure that all narcotics are stored and counted per state and federal laws. Director of nurses and education manager to audit all medication rooms 2 times a week beginning week of 2/4/13 to ensure temperature of the medication refrigrators are within appropriate parameters to store medications. Education manager to re-educate all licensed nursing staff regarding following state and federal laws for storage of and locking of narcotics. This will be completed by 2/10/13. Education manager to re-educate licensed nurses regarding medication storage temperatures be kept at manufacturers recommendations; this will be completed by 2/11/13.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100412	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/11/2013
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION C		STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069		
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N 313	Continued From page 23 and Needles", dated 12/01/07, revealed the following: "Once any drug or biological package is opened, the facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications." Continued review of the policy revealed food was not to be kept in the refrigerator where drugs were stored. Observation of the medication refrigerator on the East Hall, on 01/03/13 at 5:00 PM, revealed an open vial of Tuberculin serum was dated 11/21/12. Continued observation of manufacturer's label revealed the medication should be discarded thirty (30) days after opening. Further observation of the refrigerator revealed three (3) cups of chocolate milk were stored in with the medications. During interview at the time of the observation, the Nurse Educator confirmed the vial of Tuberculin serum had been opened longer than thirty (30) days, and should have been discarded. Continued interview revealed all food products should have been stored in the pantry refrigerator. Interview with the Regional Nurse Consultant, on 01/08/13 at 6:05 PM, revealed opened medication vials typically should be discarded after thirty (30) days, or after twenty-eight (28) days for insulin. She also stated food was not to be stored in the medication refrigerator.	N 313	Regional nurse consultant will re-educate the director of nurses, assistant director of nurses, and education manager regarding the storage of biologicals, dating opened medications, noted to be stored in refrigerator; and following manufacturers recommendations for all opened medications by 2/11/13. Pharmacy representative to audit both medication rooms and medication refrigerators for expired or undated opened medications by 2/11/13. Director of nurses to audit all medication refrigerators 2 times a week for 4 weeks, beginning week of 2/4/13, to ensure all medications are dated if opened and discarded per manufacturers recommendation, and that there is no food items present. Education manager to audit once a week for 4 weeks beginning week of 2/4/13 medication and treatment carts to ensure opened liquids are dated and discarded per manufacturer's recommendations. 4) Quality Improvement Team consisting of the administrator, medical director, director of nurses, education manger, activities/dietary manager, social services manager, and MDS coordinator) will meet weekly for 4 weeks beginning week of 2/4/13; then 2 times per month for 2 months; and then monthly ongoing to review all audit findings and make recommendations for follow-up. This will be ongoing until corrected. 5) Date of compliance: 2/15/13	

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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

185336

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - MAIN BUILDING 01
B. WING _____

(X3) DATE SURVEY
COMPLETED

01/10/2013

NAME OF PROVIDER OR SUPPLIER

SPRINGFIELD NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

420 EAST GRUNDY AVENUE
SPRINGFIELD, KY 40069

(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

K 000

INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 1968

SURVEY UNDER: 2000 Existing

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: One (1) story, Type (111)

SMOKE COMPARTMENTS: Three (3) smoke compartments

FIRE ALARM: Complete fire alarm system with smoke detectors

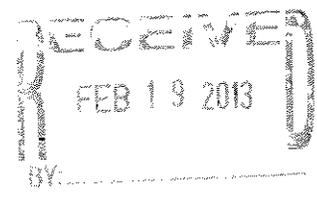
SPRINKLER SYSTEM: Complete automatic dry sprinkler system.

GENERATOR: Type II generator. Fuel source is Natural Gas with a letter of reliability.

A standard Life Safety Code survey was conducted on 01/10/13. Springfield Nursing and Rehab was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for seventy (70) beds with a census of fifty six (56) on the day of the survey.

The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)

K 000



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

Susan Palmer

TITLE

Administrator

(X6) DATE

2/19/13

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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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000 Continued From page 1

K 025 SS=E Deficiencies were cited with the highest deficiency identified at F level.
NFPA 101 LIFE SAFETY CODE STANDARD

Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, residents, staff and visitors. The facility is certified for seventy (70) beds with a census of fifty six (56) on the day of the survey.

The findings include:

Observations, on 01/10/13 between 12:00 PM and 1:00 PM, with the Maintenance Director revealed the smoke barriers, extending above the ceiling had penetrations of pipes and wires. The penetrations were not filled with a material rated

K 000 K025 SS=E

K 025 NFPA 101 Life Safety Code Standard
Smoke Barrier Penetrations

- 1) No specific residents were cited in the statement of deficiency as having been affected; however, on the date of this inspection the census was 56.
- 2) An audit was completed by the Maintenance Manager on 1/15/2013 to identify any other areas of smoke penetration in the attic. No other areas were noted.
- 3) Maintenance Manager fixed the smoke barrier, extending above the ceiling located on the east hall by the nursing station that had penetrations of pipes and wires. The penetrations have been filled with a material rated equal to the partition and now can resist the passage of smoke. This work was completed on 1/15/13. Maintenance manager checked all areas of the attic to ensure that no other areas needed repairs regarding smoke penetrations. No other areas were identified. This work was completed on 1/15/13.

The administrator re-educated the maintenance manager on 1/15/13 regarding the need for ongoing inspections of the attic to check and repair smoke barrier penetrations issues and repair, as identified. Documentation of inspections and action taken will be completed and maintained by the maintenance manager by utilizing the TELS system.

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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069
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K 025 Continued From page 2
equal to the partition and could not resist the passage of smoke. The location of the smoke partition with the penetrations was in the East Hall by the Nurse's Station.

Interview, on 01/10/13 between 12:00 PM and 1:00 PM, with the Maintenance Director revealed he was not aware of the penetrations.

Interview, on 01/10/13 at 4:00 PM, with the Administrator revealed she was aware of the requirements for smoke barriers but not aware of the penetrations.

Reference: NFPA 101 (2000 Edition).

8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:

(a) The space between the penetrating item and the smoke barrier shall

1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or
2. Be protected by an approved device designed for the specific purpose.

(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall

1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or

K 025 Administrator to audit the TELS system (electronic documentation system) weekly ongoing to verify that inspections are occurring and that all smoke barriers are in place per state and federal regulations. This weekly audit will begin the week of 1/29/2013.

4. QA team consisting of at least the Administrator, DON, ADON, Maintenance Director and Medical Director to meet weekly x 4 weeks beginning the week of 2/4/2013, then at least monthly ongoing, to review audit findings and revise plan as needed.

5. Date of Completion: 2/22/13

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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069	

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K 025 Continued From page 3
2. Be protected by an approved device designed for the specific purpose.
(c) Where designs take transmission of vibration into consideration, any vibration isolation shall
1. Be made on either side of the smoke barrier, or
2. Be made by an approved device designed for the specific purpose.

K 029 SS=F NFPA 101 LIFE SAFETY CODE STANDARD
One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is certified for seventy (70) beds with a census of fifty six (56) on the day of the survey. The facility failed to provide self-closing devices for doors protecting hazardous areas.

K 025

K 029 SS=F
NFPA 101 Life Safety Code Standard
Fire Rated Doors and Self Closers

1) No specific residents were cited in the statement of deficiency as having been affected; however, on the date of this inspection the census was 56.

2) No other residents were identified as having been affected; however on the date of this inspection the census was 56.

3) Maintenance Manager has ordered a new 45 minute fire rated door for the oxygen storage room; as well as a 45 minute fire rated door for the office door of the housekeeping supply room. Self closers have been ordered and will be installed as soon as they are available on the following doors that were cited out of compliance: activity room, 2 linen closets, and housekeeping supply room. This work will be completed by 2/20/13. Maintenance manager checked all other enclosed areas to identify any other doors which need self-closers and/or fire rated doors. No other areas were identified.

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K 029 Continued From page 4
The findings include:

Observation, on 01/10/13 between 12:00 PM and 4:00 PM, with the Maintenance Director revealed rooms requiring self-closing or containing a hazardous amount of combustibles did not have self-closing device to keep the door closed. The rooms were identified as:

- 1) Activities Office
- 2) Housekeeping supply
- 3) Closet in Housekeeping Supply (also had unrated door)
- 4) Two (2) Clean linen closets in the Laundry (both had unrated doors)
- 5) The Oxygen Room Door was not rated.

Interview, on 01/10/13 between 12:00 PM and 4:00 PM, with the Maintenance Director revealed they were not aware the doors to these rooms were required to be self-closing.

Interview, on 01/10/13 at 4:00 PM, with the Administrator revealed she was not aware the doors to these rooms were required to be self-closing.

8.4.1.3
Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or

K 029

3) The administrator re-educated the maintenance manager on 1/15/13 regarding the need for rated fire doors and self closers. Maintenance manager will inspect all enclosed areas to ensure all have appropriate rated doors and self closers. Documentation of inspections and action taken will be completed and maintained by the maintenance manager by utilizing the TELS system. This plan of correction for monitoring compliance will be integrated into the facility's quality improvement program where results will be reviewed and monitored by the quality improvement committee for ensuring on-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the Quality Improvement committee will be convened to analyze and recommend any further interventions and actions as deemed appropriate.

4. Date of Completion: 2/22/13

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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069
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K 029	Continued From page 5 automatic-closing in accordance with 7.2.1.8. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than	K 029		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185336	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2013
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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE
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K 029 Continued From page 6
those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.

K 047 SS=D NFPA 101 LIFE SAFETY CODE STANDARD
Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff and visitors. The facility is certified for seventy (70) beds with a census of fifty six (56) on the day of the survey. The facility failed to ensure exits were clearly recognizable with proper exit signage.

The findings include:
Observation, on 01/10/13 at 3:06 PM, with the Maintenance Director revealed the exit doors located in the Kitchen did not have an exit sign above the door making the path of egress clearly recognizable.
Interview, on 01/10/13 at 3:06 PM, with the Maintenance Director revealed he was not aware

K 029 NFPA 101 Life Safety Code Standard Exit Signage
1) No specific residents were cited in the statement of deficiency as having been affected; however, on the date of this inspection the census was 56.
2) No other residents were identified as having been affected; however on the date of this inspection the census was 56.
3) Maintenance Manager has obtained a quote from our electrical vendor; AM Electric Co. to drop electricity into the kitchen in order to install appropriate exit signs at both kitchen doors leading into the hallway and into the dining room. Maintenance manager checked all other enclosed areas to identify any other areas that require exit signs. No other areas were identified. The electrician work will be completed by 2/21/13.
3) The administrator re-educated the maintenance manager on 1/15/13 regarding the need for exit signs in the kitchen area. Maintenance manager will inspect all exit signage to ensure it is in place. This plan of correction for monitoring compliance will be integrated into the facility's quality improvement program where results will be reviewed and monitored by the quality improvement committee for ensuring on-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the Quality Improvement committee will be convened to analyze and recommend any further interventions and actions as deemed appropriate.

5. Date of Completion: 2/22/13

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

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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069
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K 047 Continued From page 7
the exits did not have proper signage.

Interview, on 01/10/13 at 4:00 PM, with the Administrator revealed she was not aware the exits did not have proper signage.

K 047

Reference: NFPA 101 (2000 edition)
7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.

K 050
SS=F NFPA 101 LIFE SAFETY CODE STANDARD

Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2

This STANDARD is not met as evidenced by:
Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at

K050
SS=F
NFPA Life Safety Code Standard
Fire Drills

K 050

1) No specific residents were cited in the statement of deficiency as having been affected; however, on the date of this inspection the census was 56.

2) No other residents were identified as having been affected; however on the date of this inspection the census was 56.

3) Administrator reviewed the fire drill regulations on 1/11/13 for fire drills at unexpected times for all shifts; administrator found that the facility noncompliance was that fire drills at unexpected times are required over a 12 month period must have a 2 hour span of time throughout the different shifts. The maintenance manager was performing fire drills more than required by regulation; however, the time frame with a 2 hour span was the area of noncompliance.

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K 050 Continued From page 8
unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is certified for seventy (70) beds with a census of fifty six (56) on the day of the survey. The facility failed to ensure the fire drills were conducted at unexpected times quarterly.

The findings include:

Review of the Fire Drill records, on 01/10/13 at 2:13 PM, with the Maintenance Director revealed the facility failed to conduct fire drills at unexpected times on third shift. Further fire drill review revealed the facility failed to conduct a fire drill in the third (3rd) quarter on second (2nd) shift.

Interview, on 01/10/13 at 2:13 PM, with the Maintenance Director revealed he was not aware the fire drills were not being conducted as required.

Interview, on 01/10/13 at 4:00 PM, with the Administrator revealed she was not aware of the requirements for conducting fire drills.

Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.

K 056 SS=D NFPA 101 LIFE SAFETY CODE STANDARD

If there is an automatic sprinkler system, it is

K 050 4) The administrator re-educated and trained the maintenance manager on 1/15/13 regarding the need for a fire drill calendar/schedule to be developed which would incorporate the 2 hour span of time throughout the 12 month period. A fire drill schedule was developed for 2013 with the 2 hour span included. The maintenance manager will implement the schedule with the first fire drill of 2013 being conducted 1/31/13 the fire drill schedule will be reported to the quality improvement committee where results will be reviewed and monitored by the quality improvement committee for ensuring on-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the Quality Improvement committee will be convened to analyze and recommend any further interventions and actions as deemed appropriate.

5. Date of Completion: 2/22/13

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K 056 Continued From page 9
 installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5

This STANDARD is not met as evidenced by:
 Based on observation and interview, it was determined the facility failed to ensure complete sprinkler coverage, according to NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff and visitors. The facility is certified for seventy (70) beds with a census of fifty six (56) on the day of the survey. The facility failed to ensure sprinklers were not blocked by light fixtures.

The findings include:

Observation, on 01/10/13 at 3:12 PM, with the Maintenance Director revealed three (3) light fixtures installed within twelve (12) inches of a sprinkler head and extending below the deflector on the sprinkler head.

Interview, on 01/10/13 at 3:12 PM, with the Maintenance Director revealed he was unaware

K 056 K056
 SS=D
 NFPA Life Safety Code Standard Sprinkler Coverage

- 1) No specific residents were cited in the statement of deficiency as having been affected; however, on the date of this inspection the census was 56.
- 2) No other residents were identified as having been affected; however on the date of this inspection the census was 56.
- 3) Three sprinkler heads were discovered being located less than 12 inches from the light fixtures. Electrical contractor, AM Electric Co. has provided a quote to complete the necessary changes to move the 3 lights to be 12 inches or greater from each light fixture. The quote has been approved and accepted and the work will be completed by 2/20/13. All sprinkler heads were checked by the maintenance manager and no other issues were found regarding the distance between sprinkler heads and fixtures. This was completed on 1/15/13.

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K 056 Continued From page 10
the sprinkler heads could have no obstructions below the deflector within twelve inches of the sprinkler head.

Interview, on 01/10/13 at 4:00 PM, with the Administrator revealed she was unaware of the requirement.

Reference: NFPA 13 (1999 Edition)

5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.

Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.

Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.

Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:

- (1) Sprinklers installed throughout the premises
- (2) Sprinklers located so as not to exceed maximum protection area per sprinkler
- (3) Sprinklers positioned and located so as to

K 056

3) The administrator re-educated and trained the maintenance manager on 1/15/13 regarding the need for sprinkler heads to be at least 12 inches from fixtures that would impede sprinkler coverage. 4)

This issue will be reported to the quality improvement committee where results will be reviewed and monitored by the quality improvement committee for ensuring on-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the Quality Improvement committee will be convened to analyze and recommend any further interventions and actions as deemed appropriate.

5. Date of Compliance: 2/22/13

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(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - MAIN BUILDING 01
B. WING

(X3) DATE SURVEY
COMPLETED

01/10/2013

NAME OF PROVIDER OR SUPPLIER

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provide satisfactory performance with respect to
activation time and distribution.

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Reference: NFPA 13 (1999 edition)

5-6.3.3 Minimum Distance from Walls. Sprinklers
shall be located a minimum of 4 in. (102 mm)
from a wall.

Reference: NFPA 13 (1999 ed.)
5-5.5.2.2 Sprinklers shall be positioned in
accordance with
the minimum distances and special exceptions of
Sections 5-6
through 5-11 so that they are located sufficiently
away from
obstructions such as truss webs and chords,
pipes, columns,
and fixtures.

Table 5-6.5.1.2 Positioning of Sprinklers to Avoid
Obstructions to Discharge (SSU/SSP)

Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)	Maximum Allowable Distance of Deflector Obstruction (in.)
Less than 1 ft	0
1 ft to less than 1 ft 6 in.	2 1/2
1 ft 6 in. to less than 2 ft	3 1/2
2 ft to less than 2 ft 6 in.	5 1/2
2 ft 6 in. to less than 3 ft	7 1/2
3 ft to less than 3 ft 6 in.	9 1/2
3 ft 6 in. to less than 4 ft	12
4 ft to less than 4 ft 6 in.	14
4 ft 6 in. to less than 5 ft	16 1/2
5 ft and greater	18

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For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m.
Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).

Reference: NFPA 13 (1999 edition)

5-13.8.1. Sprinklers shall be installed under
exterior roofs or canopies exceeding 4 ft (1.2 m)
in width.

Exception: Sprinklers are permitted to be omitted
where the canopy or roof is of noncombustible or
limited combustible construction.

Reference: NFPA 101 (2000 edition)

19.1.6.2 Health care occupancies shall be limited
to the types
of building construction shown in Table 19.1.6.2.
(See 8.2.1.)

Exception: Any building of Type I(443), Type
I(332), Type II(222),
or Type II(111) construction shall be permitted to
include roofing systems
involving combustible supports, decking, or
roofing, provided

that the following criteria are met:

(a) The roof covering meets Class C
requirements in accordance
with NFPA 256, Standard Methods of Fire Tests
of Roof Coverings.

(b) The roof is separated from all occupied
portions of the building
by a noncombustible floor assembly that includes
not less than 2 1/2 in.

(6.4 cm) of concrete or gypsum fill.

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