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FORM APPROVED
OMB NO. 0938-0391

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

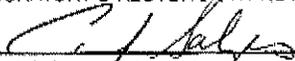
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2014
NAME OF PROVIDER OR SUPPLIER BOYD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Standard Recertification Survey was conducted 01/07/14 through 01/09/14. Deficiencies were cited with the highest Scope and Severity of an "E".	F 000	To the best of my knowledge and belief as an agent of Boyd Nursing and Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Observations revealed numerous boxes of resident supplies were stored directly on the floor including boxes of Attends (Incontinence briefs) which were open with the Attends containers directly touching the floor in the medical records room. The findings include: Observations conducted on 01/08/14 at 9:40 AM, in the medical records room revealed numerous cardboard boxes on the floor. One (1) box of Prevail Large Briefs was open and the individual packets containing the Incontinence briefs were touching the floor. In addition, two (2) boxes of X-Large Prevail briefs were touching the floor and two (2) boxes labeled as mixed merchandise were directly touching the floor.	F 253	It is the policy of Boyd Nursing and Rehabilitation Center to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Central Supply Coordinator appropriately stored all nursing supplies in the central supply room by 01/09/14. Any identified supplies that had made contact with the floor were disposed of appropriately. On 01/28/14 by the Staff Development Coordinator an environmental audit was conducted throughout the facility to determine if all supplies were stored appropriately and not making contact with the floor. Any identified areas of concern were corrected. Central Supply Coordinator was educated by the Administrator on proper storage of nursing supplies to maintain sanitary conditions on 01/10/14. All staff will be educated on 02/10/14 by the Administrator concerning proper storage of nursing supplies to maintain sanitary conditions. Central Supply Coordinator will conduct daily, Monday - Friday, audits (copy attached) for proper storage of nursing supplies for four weeks.	

FEB 12 2014

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

TITLE

(X6) DATE



Administrator

2-12-14

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	Continued From page 1 An interview conducted, on 01/09/14 at 3:50 PM, with the Medical Records Coordinator revealed the medical supplies were delivered on Tuesday (01/07/14) of that week. She related the supplies were normally transferred from Medical Records to the Central Supply area where they were un-packed and stored in the clean utility room. She stated she had not been available to transfer the medical supplies to Central Supply and she did not know who opened the Prevail Large Briefs container and left the medical supplies touching the floor. Further interview revealed this was not their usual practice and she would correct the situation immediately. An interview conducted, on 01/09/14 at 8:30 PM, with the Administrator, who supervised the medical records department revealed, storing medical supplies on the floor was not their usual practice. She stated, they tried to get everything unpacked as soon as possible within twenty-four (24) hours and stored appropriately.	F 253	Thereafter the SDC and/or Maintenance Supervisor will monitor these areas during weekly environmental rounds (audits attached) to ensure that environmental issues are addressed timely. The results of these rounds will be reviewed weekly in Focus Committee meeting and forwarded to monthly CQI Committee meeting for further monitoring and continued compliance.	02/10/14
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. 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 that it was free of medication error rates of five percent (5%) or greater. Observation of medication pass revealed there were two (2) errors out of	F 332	It is the policy of Boyd Nursing and Rehabilitation Center to ensure that the facility is free of medication error rates of five percent or greater. CMA #1 was educated by the Director of Nursing on 01/31/14 concerning the proper procedure for oral inhalation administration. Administrator and Director of Nursing reviewed policy "Specific Medication Administration Procedures/Oral Inhalation Administration on 01/30/14. No changes were made to this policy.	

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F 332	<p>Continued From page 2</p> <p>twenty-six (26) opportunities resulting in a medication error rate of 7.69 percent. Observation revealed improper administration technique for Advair 250/50 Diskus inhaler and Spiriva 18 mcg inhaler for Unsampled Resident A.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Specific Medication Administration Procedures/ Oral Inhalation Administration", revised 02/22/11, revealed the procedure included: remove the cap from the inhaler and the holding chamber or spacer, shake the inhaler, do not shake dry powder inhalers, attach the holding chamber or spacer device to the inhaler, instruct the resident to tilt his/her head back slightly, stand or sit up as straight as possible, and breath out through the mouth, place holding chamber or spacer with inhaler attached to resident's mouth, instruct resident to inhale slowly as you depress the canister to release the medication, breath in and out normally through the holding chamber or spacer for one to three breaths.</p> <p>Review of Unsampled Resident A's medical record revealed diagnoses which included Chronic Obstructive Pulmonary Disease (COPD). Review of the Physician's Orders dated 01/14, revealed orders for Advair 250-50 Diskus one (1) puff per inhalation twice daily for COPD and Spiriva 18 MCG (microgram) Handhaler one (1) cap per inhalation once daily for COPD.</p> <p>Observation, on 01/08/14 at 8:40 AM, revealed Certified Medication Aide (CMA) #1, failed to ask Unsampled Resident A to exhale prior to asking the resident to inhale the Advair Diskus 250/50. Further observation revealed CMA #1 failed to</p>	F 332	<p>All nurses and certified medication aides will be educated on the proper preparation and administration of medication with emphasis on oral inhalation administration, eye drops, etc. by the Pharmacy consultant by 02/05/14.</p> <p>The Staff Development coordinator and/or the RN Supervisor will monitor the proper preparation and administration of medication with emphasis on oral inhalers, eye drops, etc. three times a week for a period of four weeks and weekly thereafter for eight weeks by using the Medication Pass Observation Report and CMT (certified medication tech) competency checkoff for oral inhalation administration when applicable. (copies attached).</p> <p>The Pharmacy Consultant will monitor monthly thereafter. Results obtained will be discussed weekly in Focus meetings. The results will also be forwarded to monthly CQI Committee meeting for further monitoring and continued compliance.</p>	02/05/14

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F 332	<p>Continued From page 3</p> <p>ask Unsampled Resident A to exhale prior to asking the resident to inhale the Spiriva Inhaler 18 mcg (microgram).</p> <p>Interview on 01/08/14 at 9:00 AM with CMA #1, revealed she was supposed to ask the resident to exhale prior to administration of the inhalers; however, did not think the resident would be able to follow the instructions. She acknowledged she should have instructed the resident to exhale prior to administration of the inhalers.</p> <p>Review of the Medication Guide (package insert which came in box with inhaler) for Advair Diskus 250/50, revealed before Inhaling your dose from the Diskus, breath out (exhale) fully while holding the Diskus level and away from your mouth, put mouthpiece to your lips, breath in deeply and quickly through the diskus, remove the diskus from your mouth, hold your breath for about ten (10) seconds or as long as comfortable and breath out slowly.</p> <p>Review of the Instructions for Use (package insert which came in box with inhaler) for Spiriva Handihaler, revealed breathe out completely in one (1) breath, emptying your lungs of any air, do not breathe into your handihaler device, with your next breath, raise your handihaler device to your mouth in a horizontal position, close your lips tightly around the mouthpiece, breathe deeply until your lungs are full, hold your breath for a few seconds, and take the handihaler out of your mouth.</p> <p>Interview with the Director of Nursing (DON), on 01/09/14 at 6:00 PM, revealed the staff development nurse and pharmacy watched medication pass at times. She stated the staff</p>	F 332	

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F 332	Continued From page 4 should follow the insert information that came in the box with the inhalers when administering inhalers.	F 332		
F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p>	F 441	<p>It is the policy of Boyd Nursing and Rehabilitation Center 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. LPN #1 was re-educated on proper infection control techniques to prevent spread of infection while conducting head to toe skin assessments by the Director of Nursing on 01/31/14. Nursing staff will also receive education on proper procedure in conducting head to toe skin assessments by the Director of Nursing and the Staff Development Nurse by 02/05/14. Nursing staff discarded used bedpans and urinals and replaced with new bedpans and urinals placing in plastic bags with resident's name on bag on 01/07/14. Resident B and Resident C outdated tube feeding syringes were properly disposed of on 01/07/14 and new tube feeding syringes replaced by the RN Supervisor.</p>	

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F 441	Continued From page 5 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility's policies, 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 for one (1) of fourteen (14) sampled residents (Resident #1) and two (2) Unsampled Residents (Unsampled Resident B and Unsampled Resident C). The nursing staff used improper hand washing and gloving technique during the skin assessment for Resident #1. Also, initial tour revealed outdated tube feeding syringes on the bedside table for Unsampled Resident B and Unsampled Resident C. In addition, observation on initial tour revealed bedpans, urinals, graduated cylinders and fracture pans which were bagged, but unlabeled hanging on the handrail in a shared bathroom for Room 101 and Room 103. The findings include: 1. According to the facility's "Hand washing/Hand Hygiene" policy, revised 06/10, the facility policy	F 441	Administrator and Director of Nursing reviewed policies "Bedpans/Giving and Removing" and "Urinal/Placement and Removal" on 01/10/14. No changes were made to policies. Director of Nursing reviewed infection control log on 01/07/14 and found no negative outcome secondary to these incidents for Residents #1, B and C. Director of Nursing reviewed infection control log for past three months and found no correlation between infection control log and proper infection control techniques. Process of labeling the bedpan and urinals will be re-educated to nursing staff by the Staff Development Coordinator by 02/05/14. Process of changing out tube feeding syringes every twenty four hours will be re-educated to nursing staff by the Staff Development Coordinator by 02/05/14. All nursing staff will be re-educated by the Staff Development Coordinator on 02/05/14 regarding maintaining 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.	

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F 441	<p>Continued From page 6</p> <p>statement revealed the facility considered hand hygiene the primary means to prevent the spread of infection. Under the Policy Interpretation and Implementation section 5. revealed employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: c. before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice).</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 05/04/10 with diagnoses including: Multiple Sclerosis, Dysphagia, Status Post Gastric Tube (GT) placement, Aphasia, Chronic Obstructive Pulmonary Disease, Mitral Valve Disease, and Contracture of the left hand.</p> <p>An observation conducted, on 01/07/14 at 6:00 PM, during Resident #1's skin assessment, conducted by Licensed Practical Nurse (LPN) #1, revealed the skin assessment from head to toe began while the resident was sitting in his/her wheelchair. LPN #1 began the skin assessment with washing her hands and applying gloves. LPN #1 observed the resident's bilateral upper extremities, back, chest, abdomen, and Gastric Tube site of insertion. The nurse then proceeded to the bilateral lower extremities, removed the resident's shoes and examined the resident's bilateral feet, separating the resident's toes. LPN #1 then transferred the resident to his/her bed and positioned him/her on the bed in the supine position. The nurse opened the resident's incontinence brief, touching the perineal area, rectal area, and left buttock, reapplied the incontinence brief (did not remove gloves and wash hands) and pulled up the residents pajama</p>	F 441	<p>to.</p> <p>The DON, SDC, and RN Supervisor will monitor staff compliance with facility infection control protocols which are designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection daily for four weeks then once for 8 weeks by using the Environmental Survey Resident Rooms and utilizing the skin assessment audit (copies attached). Any staff member deviating from proper protocol will be educated at that time. The Staff Development Coordinator will conduct weekly environmental compliance rounds thereafter. The results will be forwarded to the Focus Committee Meeting. The results will also be forwarded to the monthly CQI Committee Meeting for further monitoring and continued compliance.</p>	02/05/14

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F 441	<p>Continued From page 7</p> <p>bottoms. LPN #1 touched the bed and curtain, repositioned Resident #1 on his/her left side, removed his/her pajama bottoms, re-opened his/her incontinence brief, examined the right buttock, and touched the rectal area and perineal area. The nurse, then reapplied the incontinence brief, and reapplied the pajama pants, touching the bed sheets, curtain, and door handle. The nurse, then removed the soiled gloves and washed her hands.</p> <p>An interview with LPN #1, on 01/09/14 at 4:00 PM, revealed she had been employed as a staff nurse at the facility for fourteen (14) years. She stated she did not know why she did not wash her hands and change her gloves when going from a dirty to clean area during the skin assessment.</p> <p>An interview with the Director of Nursing, on 01/09/14 at 4:21 PM revealed it was her expectation for all of the nursing staff to change their gloves and wash their hands when going from a clean to dirty to clean area. She related the nurses were In-serviced in the past related to the proper infection control techniques to prevent the spread of infection.</p> <p>2. Review of the facility policy, titled "Bedpan/Giving and Removing", dated 11/01/11, revealed to remove the bedpan, support the lower back and withdraw the pan, cover the pan or urinal before taking it to the bathroom, empty contents into the toilet and flush, rinse bedpan with cool water to remove feces and urine, rinse pan with hot running water, remove gloves, place in plastic bag and return to bedside cabinet or designated area, wash hands before leaving room. This policy did not address labeling the bedpan with the resident's name.</p>	F 441		

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F 441 Continued From page 8 F 441

Review of the facility policy, titled "Urinal/Placement and Removal", dated 11/01/11, revealed when the resident indicates he is finished, remove the urinal, cover the urinal with a cover, empty the urinal in toilet or hopper, clean the urinal and return to bedside storage, remove gloves, and wash hands. This policy did not address labeling the urinal with the resident's name.

Observation, on initial tour on 01/07/14 at 1:30 PM, revealed the bathroom shared by four residents for Room 101 and Room 103, had a bed pan, unlabeled in a plastic bag in the bathroom floor, and a plastic bag hanging on the hand rail which contained two (2) unlabeled fracture pans, an unlabeled urinal, and two (2) unlabeled graduated cylinders.

Interview with Certified Nursing Assistant (CNA) #1, revealed she was assigned to the residents in Room 101, and Room 103, and all four (4) residents were continent. She stated only one (1) of the residents used a bed pan. Continued interview revealed the urinal, bedpans, fracture pans, and graduated cylinders should be labeled with the resident's name before being stored in the plastic bags, and she was unsure which residents were using the items.

Interview with Licensed Practical Nurse (LPN) #2 who was assisting with the tour, revealed she was unaware of who the items belonged to and unsure why they were not labeled with resident names.

Further interview with the Director of Nursing (DON), on 01/09/14 at 6:00 PM, revealed the bed

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F 441 Continued From page 9
pans, urinals, fracture pans and graduated cylinders were to be labeled with the residents name and rinsed and placed in a plastic bag after use.

3. Interview with the Director of Nursing (DON) on 01/09/14 at 6:00 PM, revealed there was no written policy related to changing out tube feeding syringes; however, they were to be changed out every twenty-four (24) hours.

Observation on initial tour on 01/07/14 at 1:40 PM revealed a tube feeding syringe, dated 01/05/14 on the bedside table for Unsampled Resident C. Interview with Licensed Practical Nurse (LPN) #2 who was assisting with the tour, revealed she had noted the tube feeding syringe was outdated earlier today and had opened a new syringe when she administered the resident's medications earlier this morning. However, observation revealed the new syringe was not at the bedside.

Further observation on 01/07/14 at 1:50 PM revealed a tube feeding syringe, dated 01/05/14 on the bedside table for Unsampled Resident B. Interview at the time of observation with LPN #2, revealed she had opened a new syringe today prior to administering the resident's tube feeding. However, observation revealed the new syringe was not at the bedside. She stated she thought the syringes were changed daily on another shift.

Further interview with the Director of Nursing (DON) on 01/09/14 at 6:00 PM, revealed the night shift was to change out tube feeding syringes every twenty-four (24) hours. She stated she did compliance rounds at least three (3) times weekly, and looked to ensure the tube feeding syringes had been changed out at that time. She

F 441

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NAME OF PROVIDER OR SUPPLIER BOYD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102		
(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	Continued From page 10 stated she had not noticed a concern with outdated tube feeding syringes at the bedside.	F 441	It is the policy of Boyd Nursing and Rehabilitation Center to maintain a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. The auditing process of F-441 will be reviewed by the Director of Nursing by 02/07/14. New forms will be implemented and assigned and redistributed. All nursing administrative staff will be educated by the Director of Nursing by 02/07/14 regarding the revised audit processes which include use of the Environmental Survey conducted weekly by the SDC or the RN Supervisor. The Focus Team consisting of the Administrator, DON, MDSC, SDC, Medical Records Director, Activities Director and Social Services Director will oversee the results of these auditing processes each week during the weekly Focus meeting. The results will be forwarded to the monthly CQI meeting with above members plus Housekeeping/ Laundry Supervisor, Maintenance		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to maintain a Quality Assessment and Assurance Program that developed and implemented appropriate plans of action to	F 520			

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

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NAME OF PROVIDER OR SUPPLIER <p style="text-align: center;">BOYD NURSING & REHABILITATION CENTER</p>	STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102
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F 520 Continued From page 11 correct quality deficiencies. This was evidenced by repeated deficiencies related to the facility's failure to ensure there was an effective infection control program.

The findings include:

Review of the facility policy, entitled "Continuous Quality Improvement Committee", effective 06/01/05, revealed the purpose of the policy was to provide a standardized method of evaluating the facility's performance by reviewing how residents were progressing, the quality of life of the resident, how the facility looks, how well the facility complies with regulations, and the relationship between the facility and the community with the goal of continuous improvement. Further review, revealed the committee should meet at least monthly to review care processes as well as to identify issues of quality assessment and assurance activities and to develop and implement appropriate plans of action to correct identified quality deficiencies.

Based on observation, interview, and record review, it was determined the facility failed to maintain an effective infection control program in order to prevent the development and transmission of disease and infection within the facility. This was a repeat deficiency for the facility which was cited 02/16/13 with the last standard survey for deficiencies related to staff using poor infection control technique with skin assessments.

Review of the facility's Plan of Correction, with a compliance date of 03/29/13, revealed nursing staff were educated on proper procedure for conducting head to toe skin assessments by the

F 520 Supervisor and Dietary Manager for trends, progress or lack thereof. The committee will determine, based on the results of audits received, how long monitoring should continue.

02/07/14

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F 520	Continued From page 12 Director of Nursing (DON) on 02/25/13. The facility alleged the DON, Staff Development Coordinator or Registered Nurse (RN) Supervisor would monitor staff compliance with facility infection control protocols via visual compliance rounds daily Monday through Friday for four (4) weeks, then weekly for eight (8) weeks. Observation during this survey, revealed nursing staff used improper hand washing and gloving technique during the skin assessment for Resident #1. Refer to F-441. Interview, on 01/09/14 at 8:00 PM, with the Administrator revealed the nurses received education related to how to properly conduct head to toe skin assessments after the last standard survey; however, there had been a turnover of nurses. She stated the compliance rounds were done by the DON, Registered Nurse Supervisor, and the Staff Development Nurse, and she was unsure if the compliance rounds continued past twelve (12) weeks. Interview, on 01/09/14 at 8:30 PM, with the Staff Development Nurse, revealed she completed infection control audits weekly to ensure infection control and staff compliance with policies. She stated she audited nurses to perform skin assessments two (2) to three (3) times a week and still had to remind nurses of proper infection control with skin assessments. She stated the facility had inexperienced nurses as well as a turn over of nurses.	F 520			