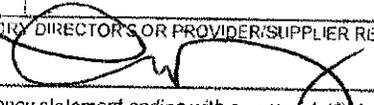


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/14/2012
NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000	The following constitutes Lexington Country Place's plan of correction for the deficiencies cited and will serve as the facility's credible allegation that substantial compliance will be achieved by January 21, 2013. The submission of this plan of correction is not an admission on the part of the facility that a deficiency exists or that the facility necessarily agrees with the accuracy of the surveyor's findings. Rather, it is being submitted as required by law. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	1/21/13	
F 157 SS=G	<p>A Recertification Survey was conducted 12/11/12 through 12/14/12. Deficiencies were cited with the highest Scope and Severity of a "G".</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	
		EXECUTIVE DIRECTOR		1/11/13	

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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 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policies, it was determined the facility failed to ensure the Physician was notified when there was a change in a resident's physical health and a need to alter treatment for one (1) of sixteen (16) sampled residents (Resident #5).</p> <p>Resident #5 had poor fluid intake from admission on 10/04/12; however, there was no documented evidence the Physician or the Registered Dietician (RD) were notified of this resident's poor fluid intake. In addition, the results of laboratory data obtained on 10/08/12 for a Complete Blood Count (CBC) and Comprehensive Metabolic Panel (CMP) were faxed to the facility on 10/08/12 at 6:04 PM; however, there was no documented evidence the Physician was notified of the laboratory values until 10/09/12, although the values were abnormal. On 10/09/12 orders were received to send Resident #5 to the hospital emergency room for evaluation related to abnormal labs and lethargy. Resident #5 was admitted to the hospital on 10/09/12 with diagnoses including Severe Dehydration and Acute Kidney Failure.</p> <p>In addition, there was no documented evidence the Physician and Registered Dietician (RD) were notified of Resident #5's weight loss of thirteen and four-tenths pounds (13.4 pounds) from 11/06/12 to 12/05/12 which was a significant weight loss of seven and one-half percent (7.5 %) in one (1) month.</p> <p>The findings include:</p>	F 157	<p>How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents would have the potential to be affected by this deficient practice. All monthly weights are current and are being compared to the prior month by the RD to identify any significant changes. The RD is assessing food and fluid intakes for those patients exhibiting a significant change, with the physician being notified by nursing for any recommended order changes. All lab orders for the current month were reviewed by the Unit Coordinators (UC's) for timely draw results and proper notification to the physician for potential new orders and as of 1/9/13 no issues were identified.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>The Unit Coordinators (UC's) will obtain daily reports of fluid and food intakes from CareTracker (clinical documentation software) Monday through Friday and bring them to the morning clinical meeting the following day for review with the Director of Nursing (DON) and RD. Saturday and</p>		

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F 157	Continued From page 2 Review of the facility's policy entitled, "Hydration/Fluid Management", dated 01/05/11, revealed the Physician was to be notified when there was a significant change in the resident's fluid intake or output. Review of Resident #5's medical record revealed the facility admitted the resident, on 10/04/12, with diagnoses which included Cerebrovascular Accident (CVA), Hypertension, Atrial Fibrillation and Congestive Heart Failure. Resident #5 was also admitted with a current diagnosis of Pneumonia with Physician's Orders for Levaquin (antibiotic medication) 500 milligrams (mgs) every day for five (5) days. Further review of the Physician's Orders, upon admission, revealed orders for Lasix (diuretic medication) forty (40) mgs every day. Review of the Intake/Output Chart Detail Report revealed the following: On 10/05/12, 480 mls of fluids were consumed for the twenty-four (24) hours. Further review of the Physician's Orders, dated 10/05/12, revealed orders to obtain a Complete Blood Count (CBC) and Comprehensive Metabolic Panel (CMP) on 10/08/12. On 10/06/12, 240 mls of fluids were consumed for breakfast; however, there was no documentation of fluids consumed for lunch and supper. On 10/07/12, 840 mls of fluids were consumed for the 24 hours.	F 157	Sunday reports will be reviewed at the Monday clinical meeting. Any significant changes identified will be addressed by the RD, DON, and/ or Unit Coordinators and the physician notified as needed. The DON will maintain a log (exhibit A) to serve as an audit tool to identify those residents with significant changes. This log will also verify that the RD and physician have been notified and that follow-up orders and any other pertinent data have been obtained. Nursing staff will be re-educated by the DON on 1/13/13, 1/15/13, and 1/16/13 in regards to appropriate documentation of food and fluid intakes, the proper reporting of poor intakes to the nursing supervisor, and the signs and symptoms of dehydration. Licensed nursing staff will be re-educated by the DON on 1/13/13, 1/15/13, and 1/16/13 regarding timely physician and RD notification and proper documentation related to significant changes, including decreased intake, weight loss and abnormal labs. The DON will designate one individual SRNA on 1/14/13 to obtain weekly and monthly weights. This individual will be educated by the DON on the proper protocol for obtaining re-weights, identifying significant changes, and the immediate reporting of significant		

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F 157	<p>Continued From page 3</p> <p>On 10/08/12, 720 mls of fluids were consumed for the 24 hours.</p> <p>Review of the Nurse's Notes from admission, 10/04/12 until 10/08/12, revealed there was no documented evidence the Physician was notified of the resident's low fluid intakes.</p> <p>Review of the Laboratory Report for the CMP and Blood Urea Nitrogen (BUN) drawn 10/08/12 revealed the BUN was High at 73 (reference 1-24), and the creatinine was High at 2.3 (reference 0.6-1.5). Further review revealed the Laboratory Report was faxed to the facility on 10/08/12, at 6:04 PM; however, there was no documented evidence the Physician or Nurse Practitioner were notified of the laboratory results until 10/09/12, although the laboratory data was abnormal.</p> <p>Review of the Physician's Orders, dated 10/09/12 at 10:30 AM, revealed orders to hold the resident's Lasix (diuretic medication) and Lisinopril (Hypertensive medication), start Lactated Ringer intravenous (IV) at 40 mls per hour for one (1) liter, and obtain a Basic Metabolic Panel (BMP) on 10/10/12, 10/11/12 and 10/12/12.</p> <p>Review of the Nurse's Notes, dated 10/09/12 at 12:00 PM, revealed Resident #5 complained of nausea, and tremors were noted to the resident's bilateral hands. The Nurse Practitioner was notified and orders were received to send the resident to the emergency room related to the abnormal labs and tremors. Resident #5 was sent to the hospital and admitted.</p>	F 157	<p>changes to the appropriate Unit Coordinator. The Unit Coordinators shall be responsible for verifying that all weekly and monthly weights have been obtained, and that the RD and physician have been notified of any significant changes as necessary. The DON will monitor this system weekly as part of the Nutritional At-Risk Meeting attended by the DON, RD, Unit Coordinators and Speech Therapist (as needed if therapy is indicated). Clinical documentation reviewed at this meeting will include resident nutritional intake, review of lab results, physician notification, RD notification, and resident weights. Audit tools (Exhibits A, B, C, & D) will be completed to ensure that all of this information has been reviewed.</p> <p>Nursing staff will be re-educated by the DON on 1/13/13, 1/15/13, and 1/16/13 in regards to appropriate documentation of food and fluid intakes, reporting of poor intakes to nursing supervisor.</p> <p>Licensed nursing staff shall be re-educated by the DON on 1/13/13, 1/15/13, and 1/16/13 regarding timely physician and RD notification and documentation of significant changes, which would include decreased intake, weight loss or abnormal labs.</p>		

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F 157	<p>Continued From page 4</p> <p>Review of the Hospital Discharge Summary, dated 10/13/12, revealed the admitting diagnoses included Severe Dehydration and Acute Kidney Failure. Further review revealed upon arriving at the emergency room the resident was found to have a BUN of 86 (high) and creatinine of 3.1 (high). Per the Summary, the resident was admitted and started on IV hydration and a Renal Consult was obtained. Further review of the Summary revealed the resident's laboratory values improved after hydration with laboratory values within normal range before discharge from the hospital. The BUN was noted to be 28 and the creatinine level was 1.</p> <p>Interview, on 12/13/12 at 11:30 AM, with State Registered Nurse Aide (SRNA) #7, revealed she worked the day shift on the Unit where the resident resided, and she was assigned to the resident a lot recently. Further interview revealed SRNA #7 did not remember having to report to the nurse's that this resident was not eating or drinking well. She stated if the residents were not eating and drinking well she would let the nurses know.</p> <p>Interview, on 12/13/12 at 3:30 PM, with SRNA #6 revealed she worked the evening shift on the Unit where Resident #5 resided and was assigned to the resident at times. She stated the resident refused dinner a lot, although she could not remember how the resident's intake was in October 2012. She stated the SRNAs notified the nurses when the residents had poor intakes.</p> <p>Interview, on 12/13/12 at 11:30 AM and at 12:30 PM, with the Unit Coordinator on Resident #5's Unit revealed after reviewing the Intake/Output</p>	F 157	<p>For each new admission, a baseline weight will be obtained within 24 hours, and subsequent weights obtained weekly for four (4) weeks. Thereafter, weights will be scheduled either weekly or monthly, or as ordered by the physician. Food and fluid intakes will be documented upon admission.</p> <p>Any new admissions or readmissions from the previous day will be evaluated and discussed at the morning clinical stand-up meeting attended by the DON, RD and Unit Coordinators. The RD will complete a nutritional assessment within 72 hours of admission/readmission and will update the initial plan of care if indicated.</p> <p>The RD assessment and care plan update will be included on the log maintained by the DON for verification of completion.</p> <p>The Unit Coordinators will maintain a log (Exhibit E) for each unit that will serve as an audit tool to verify that all lab orders were submitted, specimens were obtained, results received, the physician was notified promptly, and that there was return notification with documentation of either "no new orders" or documentation of the new orders.</p>	

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F 157 | Continued From page 5
Detail Report, Resident #5 was consuming a low percentage 10/05/12 through 10/08/12. However, after reviewing the Nurses's Notes from admission 10/04/12 through 10/09/12, she stated there was only two (2) notes related to decreased intake and she did not see documentation of notification to the Physician or Dietitian related to the low intake. She stated the nurses did not routinely monitor food and fluid intakes and were not required to ensure residents met their estimated fluid requirement. Continued interview revealed they depended on the SRNAs to report when a resident had decreased intakes. The Unit Coordinator stated the Physician and Dietitian should have been notified of the decreased intakes. Further interview revealed it was important to immediately notify the Physician for abnormal labs received and the nurses were to look for faxes during their shift. She indicated the laboratory results for the CBC and CMP drawn 10/08/12 should have been called in to the Physician when the results were faxed to the facility on 10/08/12.

Phone interview, on 12/14/12 at 2:00 PM, with Registered Nurse (RN) #1, who was assigned to the resident on 10/05/12 and 10/08/12, revealed the SRNAs were to let the nurses know when a resident consumed less than fifty (50) percent and the nurses were to encourage the residents to eat and drink. She stated there was no protocol as to when the Physician or Dietitian was to be notified of decreased intakes but she would notify the Physician if there were a few shifts or a few days of low intakes, depending on the circumstances. She stated the nurses were responsible for monitoring intakes when there was a concern; however, she did not routinely

F 157 | The Unit Coordinators will be responsible to bring the logs to the morning clinical stand-up meeting for review by the DON. Licensed nurses will be re-educated by the DON on 1/13/13, 1/15/13, and 1/16/13 in regards to this process and the timely physician notification and follow-up of abnormal labs.

How will the facility monitor its performance to ensure solutions are sustained?

As stated previously, the DON will maintain a log from the morning clinical stand-up that will validate that fluid and food intakes have been reviewed and followed up on as indicated, as well as log maintenance in regards to weight monitoring with the appropriate follow-up as indicated. These logs, along with documentation from the weekly Nutritional At-Risk meeting will be discussed at the monthly interdisciplinary CQI meeting that includes, but is not limited to, the Administrator, DON, Medical Director, Consulting Pharmacist, Medical Records Consultant, RD, Social Services, Unit Coordinators, MDS Nurses, wound nurse, and Food and

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F 157	<p>Continued From page 6</p> <p>monitor intakes because she did not have access to this information in the computer and would need to ask the Unit Coordinator for access. Continued interview revealed the Unit Coordinator monitored the meal intakes on the computer on a regular basis.</p> <p>Phone interview, on 12/14/12 at 2:30 PM, with Licensed Practical Nurse (LPN) #4, who was assigned to the resident on the day shift and evening shifts on 10/06/12 and 10/07/12, revealed she could not remember the specifics of how much Resident #5 was eating and drinking in October 2012, but she did not remember low intakes with Resident #5. Further interview revealed the nurses did not consistently monitor food/fluid intake documentation, but if there was a concern she could ask the Unit Coordinator for access to the information on the computer.</p> <p>Interview, on 12/13/12 at 3:45 PM, with LPN #5 revealed he had admitted Resident #5 on 10/04/12 and was also assigned to the resident on 10/05/12 and 10/08/12. He stated the SRNAs picked up the meal trays and were to report to the nurse if the residents had a low food/fluid intake. He further stated if a resident was eating 25% or less for 48-72 hours, or consumed less than 50% of the tray for two (2) days he would notify the Physician. Continued interview revealed he did not notify the Physician of Resident 5's low intakes or he would have documented the notification in the chart. Continued interview revealed he had notified the Physician of the results of the PT/INR (Prothrombin Time/International Normalized Ratio) (test used to monitor the effectiveness of anti-coagulation medications) on 10/08/12 at 5:05 PM as per his</p>	F 157	Beverage Director, on an on-going basis to ensure effectiveness of the system and corrective action will be taken as necessary.		

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F 157	<p>Continued From page 7</p> <p>documentation on the Laboratory Report. According to the Laboratory Report for the PT/INR obtained on 10/08/12, the Report was faxed to the facility on 10/08/12 at 4:35 PM. Further interview revealed "for whatever reason" he did not receive the results of the labs over the fax machine for the CBC and CMP which was drawn 10/08/12 with results faxed to the facility on 10/08/12 at 6:04 PM. He stated the Laboratory Reports came in over the fax at different times and he always checked the machine several times a shift. Continued interview revealed if he had received the Laboratory Report for the CBC and CMP on 10/08/12, he would have notified the Physician immediately because of the abnormal BUN and Creatinine which was very high, and documented the notification in the Nurse's Notes as well as on the Laboratory Report. He further stated he did not necessarily check the "Lab Book" on the unit to see which labs were due back and when.</p> <p>Interview, on 12/14/12 at 3:00 PM, with the Attending Physician revealed Resident #5 did have low intakes on admission, especially considering he/she was receiving Lasix. He stated Resident #5 was being over diuresed and the dehydration was more a function of the Lasix than the intakes. Further interview revealed the nurses should have alerted the Physician of the low intakes, especially considering the resident was on a large dose of Lasix. He further stated the chart would reflect if he or the Nurse Practitioner, who worked with him had been notified, and there would have been new Physician's Orders if they had been notified of the intakes. Continued interview revealed he would anticipate quicker response to the Physician</p>	F 157			

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F 157	<p>Continued From page 8</p> <p>related to the abnormal laboratory results for the CBC and CMP as the values were high, and there would have been new Physician's Orders related to the labs.</p> <p>Interview and review of the intakes from 10/04/12 through 10/08/12 with the Registered Dietitian (RD), on 12/14/12 at 3:15 PM, revealed she should have been notified of the low intakes and if she had been notified she would have documented the notification in the chart as well as made recommendations for "Ensure" as a supplement at least one (1) time a day as well as an afternoon snack. She further stated she would have either done a calorie count or checked the meal intakes each meal for several days. Further interview revealed Lasix 40 mg a day was a high dose for a small person, which placed this resident at risk for dehydration; and, also the Levaquin (an antibiotic) would decrease the appetite.</p> <p>Interview, on 12/14/12 at 4:20 PM, with the Director of Nursing (DON) revealed there was no one currently looking at what was input in the system for food and fluid intake on a regular basis, and staff relied on the weights to monitor; however, they needed to be more proactive. Further interview revealed the staff nurses did not have access to look back past the current day to see intakes and were unable to run a report currently because the computer blocked their access. After review of the medical record, she stated the Physician should have been notified of the low intakes for the time period 10/04/12 through 10/08/12. Further interview revealed the laboratory results for the CBC and CMP drawn on 10/08/12 should have been called into the</p>	F 157		

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NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504		
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F 157	<p>Continued From page 9</p> <p>Physician on the evening shift of 10/08/12 when the results were faxed to the facility and new orders would have been received that evening instead of waiting until 10/09/12.</p> <p>2. Review of the Nutrition Management Program Policy, dated 06/03/10, revealed the nursing staff would notify Dietary Services if there was a weight loss of 5% more in one (1) month. The nurse would also review the resident's intake and notify the Physician.</p> <p>Review of the Weight Management Policy, dated 06/03/10, revealed a greater than 5% weight loss in one month would be considered severe. Further review revealed if there was an actual 5% or more weight loss in one month, nursing would notify the Physician, and dietary.</p> <p>Review of Resident #5's medical record revealed the "Weight Calendar" indicated a weight of 177.7 pounds on 11/06/12 and a weight of 164.3 pounds on 12/05/12. This was a significant weight loss of 7.5 % in one (1) month; however, there was no documented evidence of a re-weigh until 12/13/12. The resident's weight on 12/13/12 was 160.4 pounds, showing a further weight loss. However, there was no documented evidence the Physician or the RD was notified of the weight loss. Observation, by the surveyor, of a weight obtained on 12/14/12 at 5:00 PM in a weight chair revealed a weight of 161.6 pounds.</p> <p>Review of the Nutrition Note dated, 11/08/12, revealed the resident's average intakes were; breakfast 96%, lunch 82%, and dinner 89%.</p> <p>However, review of the Monthly Nutrition at Risk</p>	F 157			

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NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504		
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F 157	<p>Continued From page 10</p> <p>Note, dated 11/29/12, revealed the resident's meal intakes included 57% of breakfasts, 67% of lunches and 68% of supper with decreased intake values since the prior nutrition Note. Further review revealed Resident #5's weight was stable since admission at 177.7 pounds and the resident had an order for Lasix which may cause weight fluctuations. Continued review revealed the resident had two (2) recent orders for antibiotics related to a Urinary Tract Infection (Macrobid) for ten (10) days written 11/13/12 and Cipro for ten (10) days written 11/23/12 which may cause a decrease in appetite.</p> <p>Interview, on 12/13/12 at 11:30 AM, with the Unit Coordinator (UC), revealed different SRNAs obtained weights with either a weight chair or a "Hoyer" (mechanical) lift. She stated when the SRNAs obtained the weights they documented the results in the weight book, and the licensed nurses then transcribed the weight from the weight book to the medical record on the "Weight Calendar". She further stated if a weight discrepancy was noted, a re-weight would need to be done immediately, and the Physician notified at that time, if there was a weight gain or loss. Continued interview revealed a re-weight should have been done immediately on 12/05/12 instead of waiting eight days (8) for the re-weight. She stated she was unaware of Resident #5's weight loss although she was aware the resident was not eating well. She further stated there was a Nutrition at Risk meeting each Thursday where the Interdisciplinary Team (IDT) discussed weights and she was unsure if this resident had been discussed in the meetings. After reviewing the medical record, the UC stated there was no notification to the RD or the Physician related to</p>	F 157			

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F 157	Continued From page 11 the weight loss although they should have been notified. Interview, on 12/14/12 at 3:00 PM, with Kentucky Medication Aide (KMA) #1, revealed she normally got all the weights on the Unit where Resident #5 resided, although she did get some help at times from the SRNAs. She stated when she obtained the weights she turned them into the Unit Coordinator and was told by the Unit Coordinator when re-weights were needed. Continued interview revealed she had obtained the last few weights on Resident #5 including the 12/05/12 weight and the 11/06/12 weight and had documented them in the weight book. She stated she had not been asked to get a re-weight. She further stated there had been times when she was told to document the weights in the medical record on the Weight Calendar. Further interview revealed KMA #1 had documented the resident's weights on the weight calendar for the 11/06/12 and the 12/05/12 weights. Interview, on 12/14/12 at 3:15 PM, with the RD revealed re-weights were to be done the same day if there was a discrepancy; however, this did not always happen which caused lag time. She stated this had been talked about in the Nutrition at Risk (NAR) meetings and she had no concerns with the other two (2) units. Continued interview revealed she had been notified by one of her staff that Resident #5 was not eating well and she had notified the Nurse Practitioner and recommended Periactin which was ordered 11/12 to increase the resident's appetite; however, she was unaware that the resident had actual weight loss from 11/12 to 12/12. She stated she would need to review the chart in order to make further	F 157			

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F 157	Continued From page 12 recommendations. Review of the Physician's Orders, dated 11/30/12, revealed orders for Periactin 40 mg three (3) times a day. Interview, on 12/14/12 at 4:20 PM and 5:30 PM, with the Director of Nursing (DON), revealed a re-weight for Resident #5 should have been obtained within twenty-four (24) hours. She further stated she had reviewed the medical record and there was no documentation the Physician had been notified of the weight loss from 11/06/12 to 12/05/12, or of the weight loss after the re-weight on 12/13/12. Interview, on 12/14/12 at 3:00 PM, with the Attending Physician for Resident #5, revealed a thirteen (13) pound weight loss in one month was a lot for that time period, and may have been due to the diuretic the resident was receiving. He stated he was unsure if he or the Nurse Practitioner he worked with was notified of the weight loss; however, he stated if there was no new orders and staff did not document the Physician was notified, he probably was not notified.	F 157		
F 221 SS-D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 221	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #9 is the only resident found to be affected by this deficient practice. A physical restraint assessment was completed by the Unit Coordinator on 12/20/12 that supported the need for the	1/21/13

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F 221	<p>Continued From page 13</p> <p>and review of the facility's policy, it was determined the facility failed to identify a lap buddy as a restraint for one (1) of sixteen (16) sampled residents (Resident #9). The facility did not complete a pre-evaluation of Resident #9's lap buddy to establish if the device was used for positioning or was a restraint. However, the resident was unable to remove the lap buddy upon command when the device was first initiated, as well as currently.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Physical Restraints", dated 11/06/01, revealed a Physical Restraint Assessment would be completed when the use of any physical restraint device was necessary. In addition, the policy stated the resident or responsible party would sign a written informed consent that would specify the type, reason and potential risks of using the restraint. Further review revealed when in use, restraints would be released at a minimum of every two hours (2) and, this release would be noted on the Restraint Flow Sheet.</p> <p>Record review revealed the facility admitted Resident #9 on 06/17/11, with diagnoses which included Dementia, Hypertension, Delirium, Dysphagia, Abnormal Gait, Anemia, Hypertrophy, Weakness, and Anxiety.</p> <p>Review of Resident #9's Quarterly Minimum Data Set (MDS) Assessment, dated 10/19/12, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 00. The BIM score of zero (00) indicated severe cognitive impairment.</p> <p>Review of Section P of the MDS dated, 10/19/12,</p>	F 221	<p>physical restraint currently in use. An informed consent which included risks versus benefits and which was signed by the responsible party was obtained by the Unit Coordinator on 12/18/12. A clarification order was obtained on 12/20/12 stating the need for the restraint to be released every two (2) hours. The MDS was updated on 1/9/13 to reflect the use of the restraint. This resident's care plan was updated on 12/20/12 to reflect the use of the restraint and the need to release it every two (2) hours.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents with any type of positioning or enabling device would have the potential to be affected by this deficient practice. A meeting was held on 12/20/12 involving the DON, Unit Coordinators and Regional Health Director. Each resident with any type of positioning or enabling device was reviewed on or before 1/2/13 to determine its type and need. For those that were determined to meet the definition of a restraint, supporting documentation was made to verify that</p>	

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F 221	<p>Continued From page 14</p> <p>indicated Resident #9 was not being restrained by manual, physical, or mechanical device.</p> <p>Review of Resident #9's comprehensive plan of care, dated 05/02/12, revealed there were no plans of care to address positioning devices or restraint usage.</p> <p>Review of the Physician's orders, dated 07/07/11, revealed Resident #9 was to have a lap buddy utilized at all times when sitting in the wheelchair. Further review revealed the order continued on to state the order for the lap buddy was requested by the family, and approved by the Director of Nursing (DON). Review of the current Physician's orders revealed no stipulation to release the lap buddy every two (2) hours.</p> <p>Review of Resident #9's Treatment Administration Record (TAR), dated December 2012, revealed the lap buddy placement was to be checked every shift by the nurse responsible for treatments. This form did not reveal any documented evidence that the lap buddy was released every two (2) hours.</p> <p>Review of Resident #9's Occupational Therapy Treatment Notes revealed the lap buddy was placed on 07/07/11, by Occupational Therapist #1. This Note stated at the time of placement of the lap buddy, Resident #9 initialed removal of the lap buddy, but was unable to successfully remove.</p> <p>Review of an additional Occupational Therapy note for Resident #9, dated 07/08/12, revealed he/she continued to be unable to remove the lap buddy. Furthermore, the note stated the lap</p>	F 221	<p>least restrictive devices are being used and that signed consents, appropriate orders verified and care plans updated.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Education will be provided to licensed nurses by the DON on 1/13/13, 1/15/13, and 1/16/13 regarding the non-emergency use and emergency use of physical restraints. Any non-emergency use of a physical restraint shall require an interdisciplinary assessment of the resident by nursing and therapy and will require approval by the DON to ensure adherence to the restraint policy and that the least restrictive device is utilized.</p> <p>Unit Coordinators will be responsible for obtaining signed consents from the responsible party to include risk versus benefits and verifying appropriate physician orders including release instructions, implementation of care plans regarding restraint use, and establishing a means to document release of restraints as ordered (Exhibit F).</p>		

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F 221 | Continued From page 15
buddy placement decreased Resident #9 from reaching forward or trying to bend down.

Observations, on 12/12/12 at 9:10 AM, at 10:00 AM, and at 12:00 PM; and, on 12/13/12 at 8:30 AM, at 9:30 AM, and at 10:30 AM revealed Resident #9 was sitting in the wheelchair with his/her lap buddy in place.

Observation, on 12/13/12 at 8:55 AM, revealed Resident #9 was taken to his/her room by Unit Coordinator #1 and asked to release his/her lap buddy. There was no response or effort from Resident #9 to remove the lap buddy. Further observation revealed Unit Coordinator #1 continued to ask Resident #9 to release his/her lap buddy, but Resident #9 did not follow this command. Resident #9 was unable to release the lap buddy on command.

Interview with State Registered Nursing Assistant (SRNA) #2, on 12/12/12 at 3:05 PM, revealed Resident #9 was released from the lap buddy every two (2) hours when checked for incontinence, but she further revealed this release was not documented. She was unaware the lap buddy needed to be released every two (2) hours, and had never documented when she released it. She also stated Resident #9 could not remove the lap buddy.

Interview with SRNA #3, on 12/12/12 at 3:07 PM, revealed Resident #9's lap buddy was released every two (2) hours when Resident #9 was checked for incontinence. She also stated Resident #9 could not remove the lap buddy.

Interview with Licensed Practical Nurse (LPN) #1,

F 221 | Nursing staff will be educated by DON on 1/13/13, 1/15/13, and 1/16/13 on proper restraint release and documentation.

How will the facility monitor its performance to ensure solutions are sustained?

A monthly restraint meeting will be held with Unit Coordinators, the DON, and other departments as indicated; (i.e. therapy, social services, activities) to review all restraints and positioning devices for appropriate orders, signed consents, reduction opportunities, care plan revision, and restraint assessments and will be documented (Exhibits G & H).

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F 221	<p>Continued From page 16</p> <p>on 12/12/12 at 3:20 PM, revealed the lap buddy was placed over a year ago after a request from The resident's spouse. LPN #1 stated Resident #9 could remove his/her lap buddy at times, but not on command. LPN #1 reported the lap buddy was released every two (2) hours related to toileting. She was unaware of any orders to release the lap buddy and did not believe the release of the lap buddy was documented. She did not consider the lap buddy a restraint because it was used for trunk control and positioning. She further stated she did not believe it restricted the resident's movement because he/she was not able to walk.</p> <p>Continued interview with LPN #1, on 12/13/12 at 9:00 AM, revealed the SRNAs could apply the lap buddy, but the SRNAs did not have to release the lap buddy at certain intervals.</p> <p>Interview with Unit Coordinator #1, on 12/13/12 at 8:40 AM, revealed she was responsible for ensuring Physical Restraint Assessments were conducted when restraints were in place. She stated she believed Therapy had completed the initial Physical Restraint Assessment on Resident #9's lap buddy. However, she reported she had conducted the quarterly Physical Restraint Assessments related to Resident #9's lap buddy. In her opinion, she had evaluated the lap buddy to be solely a positioning device and not a physical restraint. Continued interview revealed Resident #9's Responsible Party would have needed to have signed consent prior to the placement of the lap buddy. She also stated the lap buddy would need to be released every two (2) hours, but reported these releases were not documented. She stated Resident #9 could not</p>	F 221			

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F 221	Continued From page 17 release the lap buddy on command. Upon reviewing Resident #9's medical chart, Unit Coordinator #1 was unable to locate an initial Physical Restraint Assessment, consent for the placement of the lap buddy, or plan of care related to the use of the lap buddy. She further stated she had no idea how this was missed. Interview with the MDS Coordinator, on 12/13/12 at 9:00 AM, revealed she was aware Resident #9 had a lap buddy in place while in the wheelchair daily. She reported the Unit Coordinator completed the assessments to determine if a device such as a lap buddy was a restraint. She stated the Unit Coordinator had indicated the lap buddy used for Resident #9 was not a restraint. The MDS Coordinator stated she believed a restraint would have to limit movement of arms or legs, not just the trunk of the body. Interview with Occupational Therapist #1, on 12/13/12 at 9:21 AM, revealed she had placed the lap buddy initially on Resident #9 per family request as a safety positioning device. The goal of the lap buddy was to prevent Resident #9 from leaning down and picking things up off the floor. Furthermore, she stated she believed the nurses were responsible for initial and quarterly restraint assessments. She stated she did not complete risk verses benefits consent with the responsible party prior to placement of the lap buddy. She stated she did not feel the lap buddy was a restraint so consent would not have been completed. Interview with the Director of Nursing, on 12/13/12 at 10:36 AM, revealed the process for the application of a safety device was to conduct	F 221			

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F 221	Continued From page 18 a team meeting (interdepartmental) and determine if the device was a restraint or strictly a positioner prior to approval. Also, she stated pre-evaluation as well as quarterly ongoing evaluations would be conducted. She reported the team meeting as well as the pre-evaluation should be documented in Resident #9's medical chart, but she was unable to locate this documentation. She reported Resident #9 could remove the lap buddy at times, but could not remove the lap buddy on command. In addition, she stated the lap buddy placement required a consent to be signed that informed the responsible party of the risk verses benefits. However, she could not present documented evidence a pre-evaluation or consent form was completed prior to the placement of the lap buddy.	F 221		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #9 is the only resident to have been identified as being affected by the deficient practice. The comprehensive care plan for Resident #9 was updated on 12/20/12 to include the use of the physical restraint/ lab buddy. How will the facility identify other residents having the potential to be affected by the same deficient practice?	1/21/13

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F 280	<p>Continued From page 19 each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy it was determined the facility failed to ensure the comprehensive plan of care was revised to include necessary revisions for one (1) of sixteen (16) sampled Residents (Resident #9). Resident #9's plan of care was not revised per facility policy, to include the use of a lap buddy.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Process for Care Plan Development and Communication", revised 01/10/08, revealed the facility would develop a plan of care specific to each resident to promote the resident's highest practical level of function. In addition, the policy stated the care plan would be a continual process and changes would be made as needed to meet the needs of the resident.</p> <p>Record review revealed the facility admitted Resident #9 on 06/17/11, with diagnoses which included Dementia, Hypertension, Hyperlipidemia, Delirium, Dysphagia, Abnormal Gait, Anemia, Hypertrophy, Weakness and Anxiety.</p> <p>Review of the Physician's orders dated, 07/07/11,</p>	F 280	<p>A complete audit of all care plans will be performed by the Unit Coordinators and MDS nurses by 1/18/13 to ensure that all individualized care needs have been addressed and current orders are reflected (Exhibit I). The results of this audit will be provided to the DON to ensure follow-up of any resident needs that had not been addressed.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Licensed nurses will be educated by the DON on 1/13/13, 1/15/13, and 1/16/13 on care planning and updating care plans. Education will be provided to Unit Coordinators and MDS nurses by the DON 1/13/13, 1/15/13, and 1/16/13 regarding care plan accuracy and updates with new orders and quarterly assessments. The Medical Records Consultant shall audit on a weekly basis those care plans that are scheduled for Care Plan Meetings/ updates for the week (Exhibit I). Results will be provided to the DON for follow-up. The DON shall make the Unit Coordinators/ MDS Nurses responsible for the care plan updates.</p>		

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NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504		
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F 280	<p>Continued From page 20</p> <p>revealed Resident #9 was to have a lap buddy utilized at all times while in the wheelchair. The Physician's Order continued on to state the device was requested by the family, and approved by the Director of Nursing (DON).</p> <p>Review of Resident #9's Occupational Therapy Treatment Notes revealed the lap buddy was placed, on 07/07/11, by Occupational Therapist #1.</p> <p>Review of Resident #9's Quarterly Minimum Data Set (MDS) Assessment, dated 10/19/12, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 00. This score indicated severe cognitive impairment. Review of Section P of the MDS indicated Resident #9 was not being restrained by a manual, physical, or mechanical device.</p> <p>Review of Resident #9's comprehensive plan of care, dated 05/02/12, revealed there was no plan of care addressing the use of a lap buddy.</p> <p>Observations, on 12/12/12 at 9:10 AM; 10:00 AM; 12:00 PM, and on 12/13/12 at 8:30 AM; 9:30 AM, and at 10:30 AM revealed Resident #9 was up in his/her wheelchair with the lap buddy in place.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 12/12/12 at 3:20 PM, revealed the resident's lap buddy was placed over a year ago after a request from the resident's spouse due to positioning in his/her wheelchair.</p> <p>Continued interview with LPN #1, on 12/13/12 at 9:00 AM, revealed upon review of the comprehensive plan of care, she had no</p>	F 280	<p>How will the facility monitor its performance to ensure solutions are sustained?</p> <p>Review of care plan auditing will be taken to monthly CQI meetings on an on-going basis. Additional action plans would then be developed if problems were identified with the system.</p>		

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F 280 Continued From page 21

documented evidence Resident #9 was care planned for the use of a lap buddy. She was unsure as to why the lap buddy had not been included in Resident #9's plan of care.

Interview with Unit Coordinator #1, on 12/13/12 at 8:40 AM, revealed Resident #9 should have had a plan of care to address the current and ongoing use of a lap buddy. Upon reviewing Resident #9's medical chart, Unit Coordinator #1 was unable to locate a plan of care related to the use of a lap buddy. She further stated she had no idea how this was missed.

Interview with the MDS Coordinator, on 12/13/12 at 9:00 AM, revealed she was aware Resident #9 had a lap buddy in place while in the wheelchair daily. The MDS Coordinator stated Resident #9 should have a current plan of care addressing the need for a lap buddy, but upon review of the medical chart she was unable to locate documented evidence of a current plan of care related to the lap buddy. The MDS Coordinator then reviewed the ongoing computer plan of care for Resident #9, and still could not find documented evidence that the lap buddy had been included in his/her comprehensive plan of care. The MDS Coordinator reported the lap buddy usage should have been included in Resident #9's plan of care, and she did not know why the lap buddy was not mentioned in Resident #9's comprehensive plan of care.

Interview with Occupational Therapist #1, on 12/13/12 at 9:21 AM revealed she had placed the lap buddy on Resident #9 per family request as a safety positioning device. The goal of the lap buddy was to prevent Resident #9 from leaning

F 280

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F 280 Continued From page 22
down and picking things up off the floor. Furthermore, she stated she believed the nurses were responsible for care plans.

Interview with the Director of Nursing, on 12/13/12 at 10:36 AM, revealed the MDS Coordinator and/or Unit Coordinator should have transcribed the order for the lap buddy into Resident #9's plan of care. She stated this had been missed and should have been caught before now.

F 280

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS
IS=G

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 the facility's policies, it was determined the facility failed to ensure the Plan of Care was sufficient to meet the needs of newly admitted residents for one (1) of sixteen (16) sampled residents (Resident #5).

Resident #5 had poor fluid intake from admission on 10/04/12; however, there was no documented evidence the facility implemented their "Process for Care Plan Development and Communication Policy". Although the resident had risk factors for dehydration including poor fluid intake, was receiving a diuretic medication, and was admitted to the facility with a diagnosis of Pneumonia in which she/he was receiving antibiotic medication, there was no documented evidence staff

F 281

What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

Resident #5 is the only resident to have been identified as part of the deficient practice. At this time, Resident #5 remains at the facility. A care plan review and revision was completed on 12/17/12 for Resident #5 to address and include risk factors for dehydration, poor fluid intake, diuretic therapy, treatment for pneumonia, weight loss, as well as all current and pertinent historical diagnoses.

How will the facility identify other residents having the potential to be affected by the same deficient practice?

All residents would have the potential to be affected by the deficient practice.

1/21/13

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F 281	Continued From page 23 identified this resident's risk for decline in hydration status and developed a Plan of Care to promote food and fluid intake. On 10/09/12, the facility transferred Resident #5 to the hospital where she/he was admitted to the hospital with diagnoses of Severe Dehydration and Acute Kidney Failure. The findings include: Review of the facility's policy entitled, "Process for Care Plan Development and Communication", dated 01/10/08, revealed the facility must develop a plan of care specific to each resident which helps to attain or maintain the residents' highest practical level of function. Further review revealed the resident's care plan shall identify the resident's needs, problems, strengths, risk factors and measurable goals. The policy further stated the admitting nurse would develop and initiate a written plan of care for the resident within twenty-four (24) hours of admission which would address Physician's orders and additional assessments/interventions deemed appropriate, and would address high risk areas if they apply to the resident including but not limited to dietary. Review of Resident #5's clinical record revealed the facility admitted the resident on 10/04/12, with diagnoses which included Pneumonia, Cerebrovascular Accident (CVA), Hypertension, Atrial Fibrillation, and Congestive Heart Failure. Review of the Physician's Orders, dated 10/04/12, revealed orders for Lasix (diuretic medication) 40 milligrams (mgs) every day, and Levaquin (antibiotic medication) 500 mgs every day for five (5) days. Review of the Interim Plan of Care, dated 10/05/12, revealed there was no	F 281	The MDS nurses audited initial care plans on 12/17/12 for all newly admitted & readmitted residents for the previous 14 days to ensure that all pertinent admission data, risk factors, and diagnosis had been addressed. Results of this audit were provided to the DON for verification. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? For all new admissions/readmissions from 12/17/12 forward, the Interim Care Plan shall be reviewed the following day at the clinical stand-up meeting on Mondays through Fridays by the Unit Coordinators, DON, MDS and RD. The House RN Supervisor shall be responsible to review the Interim Care Plans for Saturdays and Sundays, with the clinical stand-up team to follow-up on Mondays. The discharge summaries will be reviewed to make sure the Interim Care plan covers current diagnosis, history, risk factors, etc. The DON will maintain a log (Exhibit J) to document completion of Interim care plan reviews. Licensed nurses shall be educated by the DON on 1/13/13, 1/15/13, and 1/16/13 regarding the		

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F 281	<p>Continued From page 24</p> <p>Plan of Care related to this resident's risk of dehydration, even though the resident was receiving a diuretic medication and an antibiotic medication for a diagnosis of Pneumonia.</p> <p>Review of the Intake/Output Chart Detail Report, revealed the following documentation:</p> <p>On 10/05/12, the resident consumed 480 milliliters (mls) of fluids for the twenty four (24) hours. Review of Physician's Orders dated 10/05/12, revealed orders to obtain a Complete Blood Count (CBC) and Comprehensive Metabolic Panel (CMP) on 10/08/12.</p> <p>On 10/06/12, the resident consumed 240 mls of fluids for breakfast, and there was no documentation of fluids consumed for lunch and supper.</p> <p>On 10/07/12, the resident consumed 840 mls of fluids for the 24 hours.</p> <p>On 10/08/12, the resident consumed 720 mls of fluids for the 24 hours.</p> <p>Review of the laboratory data for the CMP drawn 10/08/12 revealed abnormal values for Blood Urea Nitrogen (BUN) at 73 High (reference 1-24), and creatinine at 2.3 High (reference 0.6-1.5).</p> <p>Further review of the Physician's Orders, dated 10/09/12 at 10:30 AM, revealed orders to hold Lasix and Lisinopril (hypertensive medication), start Lactated Ringer intravenous (IV) at 40 mls per hour for one (1) liter, and draw a Basic Metabolic Panel (BMP) on 10/10/12, 10/11/12, and on 10/12/12.</p>	F 281	<p>Interim Care Plan development process.</p> <p>How will the facility monitor its performance to ensure solutions are sustained?</p> <p>The DON will maintain a log (Exhibit J) that will serve as an audit tool for the Initial Care Plan Review that will support reviews of new resident's discharge summaries, risk factors and diagnoses by the clinical stand-up team in the development of the Initial Care Plan. This information will be reviewed at the Monthly interdisciplinary CQI meeting that includes, but is not limited to the Administrator, DON, Medical Director, Consulting Pharmacist, Medical Records Consultant, RD, Social Services, Unit Coordinators, MDS Nurses, wound nurse, and Food and Beverage Director, on an on-going basis to ensure effectiveness of the system and corrective action will be taken as necessary.</p>		

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F 281	<p>Continued From page 25</p> <p>Further review revealed Physician's Orders, dated 10/09/12 at 1:00 PM, to transfer the resident to the emergency room related to abnormal labs and lethargy. Resident #5 was admitted to the hospital.</p> <p>Review of the Hospital Discharge Summary, dated 10/13/12, revealed the admitting diagnoses were Severe Dehydration and Acute Kidney Failure. The resident was admitted to the hospital and started on IV hydration and a Renal Consult was obtained. Per the Summary, upon arriving at the emergency room the resident was found to have a BUN and creatinine of 86 and 3.1 (both values were high). According to the Summary, the resident's laboratory values improved after hydration with laboratory values before discharge from the hospital noted as BUN at 28 and creatinine at 1, both within normal levels.</p> <p>Review of the record revealed there was no documented evidence a Nutritional Assessment which included an estimated fluid requirement was completed until 10/16/12, after the resident was discharged from the hospital. The Nutritional Assessment, dated 10/16/12, revealed the resident's estimated fluid requirements were 2040-2400 milliliters per day.</p> <p>Interview, on 12/13/12 at 11:35 AM and 12:30 PM, with the Unit Coordinator on the Unit, where Resident #5 resided, revealed after reviewing the Intake/Output Chart Detail Report, Resident #5 was consuming a low percentage of food and fluids from 10/05/12 through 10/09/12. Further interview verified that the Report indicated all the</p>	F 281		

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F 281	<p>Continued From page 26</p> <p>fluids consumed for the twenty-four hours was included, not just meals. She stated she or the other nurses did not routinely monitor food and fluid intakes, or check to see if the resident's fluid requirements were met. Continued interview revealed the nurses did a head to toe assessment on each resident each day and checked for signs and symptoms of dehydration; however, the nurses had not recognized this resident as being dehydrated from the assessments per the Nurse's Notes. Further interview revealed it was the staff nurse's responsibility to initiate a nutrition/hydration care plan if a resident was not eating and drinking adequately. She further stated the admitting nurses should have looked at dehydration risk factors for this resident on admission, because the Data Tool Collection the nurse completed dated 10/04/12, indicated the resident had a recent history of weight loss, as well as the resident was on a diuretic medication which would place the resident at risk for dehydration. Continued interview revealed it was her responsibility to audit charts on new admissions to make sure assessments were complete and the medications were transcribed correctly to the Medication Administration Record; however, she did not do an in depth chart review to ensure the Interim Care Plans were accurate.</p> <p>Interview, on 12/14/12 at 3:00 PM, with the Attending Physician revealed Resident #5 did have low fluid intakes on admission, especially considering the dosage of Lasix she/he was receiving. He stated the resident was being over diuresed and the dehydration was more a function of the Lasix medication than the fluid intakes. Further interview revealed the nurses</p>	F 281			

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F 281	<p>Continued From page 27</p> <p>should have alerted the Physician of the low intakes, especially considering the resident was on a large dose of Lasix. The Physician stated the medical record would reflect if he or the Nurse Practitioner who worked with him had been notified, and there would have been new Physician's Orders if they had been notified of the intakes.</p> <p>Interview, on 12/14/12 at 3:15 PM, with the Registered Dietitian (RD) revealed she had seven (7) days from the date of a resident's admission to complete a Nutritional Assessment and assess the resident's estimated fluid requirement. After reviewing the intakes from 10/04/12 through 10/09/12, she stated if she had been notified of the low intakes she would have documented the notification in the medical record as well as made recommendations for "Ensure" as a supplement at least one (1) time a day as well as an afternoon snack, and would have either done a calorie count or checked the meal intakes each meal for several days. Further interview revealed Lasix 40 mg a day was a high dose for a small person which placed this resident at risk for dehydration and also the Levaquin (an antibiotic) would decrease the appetite.</p> <p>interview, on 12/14/12 at 4:20 PM, with the Director of Nursing (DON) revealed the RD was to assess the new admission's caloric count after seven (7) days and she did not interpret the policy as the Nutrition Assessment including the estimated fluid requirement needing to be completed on admission before the seven (7) days. After reviewing Resident #5's medical record, she stated the nurses should have taken the Lasix in consideration, as well as the</p>	F 281		

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F 281	Continued From page 28 Pneumonia and antibiotics and completed a care plan to monitor this resident closely for the potential for dehydration.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well being for one (1) of sixteen (16) sampled residents (Resident #5). The facility failed to ensure their bowel protocol was followed for Resident #5, who had no documented evidence of a bowel movement for seven (7) days from 11/23/12 until 11/30/12. The findings include: Interview, on 12/14/12 at 4:20 PM, with the Director of Nursing (DON) revealed the facility had no written bowel protocol/policy. Review of Resident #5's medical record revealed the facility admitted the resident on 10/04/12 with diagnoses which included Cerebrovascular Accident (CVA) and Pneumonia. Review of the	F 309	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #5 is the only resident to have been identified as being affected by the deficient practice. This resident's bowel patterns are being monitored daily by the Unit Coordinators utilizing CareTracker (clinical documentation software) and there are have been no further issues with bowel elimination noted. This resident has a PRN laxative order. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice. The Unit Coordinators reviewed all residents' bowel elimination patterns on 12/17/12 to identify any residents without a bowel movement for the previous three (3) days. Orders were also checked at this time to ensure a PRN laxative order was obtained if indicated.	1/21/13

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F 309 | Continued From page 29

Admission Minimum Data Set (MDS) Assessment, dated 10/19/12, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 07, indicating the resident was severely impaired in cognitive skills for decision making. Further review revealed the facility assessed the resident as requiring limited assist of two (2) staff for toileting and as being continent of stool.

Review of the Bowel and Bladder Chart Detail Report revealed Resident #5 had a bowel movement on 11/23/12; however, the next bowel movement was noted to be on 11/30/12 which was seven (7) days later. Review of the Medication Administration Record (MAR), dated November 2012 and the Nurse's Notes for the dates of 11/24/12 through 11/30/12 revealed no documented evidence of a PRN (as needed) laxative being administered.

Interview, on 12/13/12 at 12:30 PM, with the Unit Coordinator (UC) for the Unit where Resident #5 resided, revealed the nurses had no computer access in which to monitor bowel movements. She stated the computer automatically printed a list every day indicating which residents had not had a bowel movement for three (3) days and she gave the list to the staff nurses. Further interview revealed the staff nurses were to administer PRN bowel medication or notify the Physician to obtain an order. She stated she did not review the bowel movements, but relied on the computer to print the list. She further stated she did not keep the list. The UC was unsure why Resident #5 had not had a bowel movement for 7 days.

Interview, on 12/14/12 at 1:00 PM, with Licensed

F 309 | **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?**

On Mondays through Fridays, the Unit Coordinators will obtain bowel elimination reports from Care Tracker and bring them to the morning clinical standup meeting to assess for any resident that is approaching 3 days without documentation of a bowel movement. The House Supervisor RN will be responsible on Saturdays and Sundays to audit for those entering the 3 day window. The DON will also review weekend activity on Mondays.

Nursing staff will be educated 1/13/13, 1/15/13, and 1/16/13 by the DON on the bowel elimination protocol and will include documentation of bowel movements, proper reporting criteria, the need for PRN medications, and physician notification.

The DON shall monitor ongoing compliance utilizing an audit tool (Exhibit K).

How will the facility monitor its performance to ensure solutions are sustained?

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NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504		
(X4) IIC 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	
F 309	Continued From page 30 Practical Nurse (LPN) #7 who worked on the unit where Resident #5 resided, revealed she received a list daily of residents who had not had a bowel movement in three (3) days from the UC. She stated the day shift nurse was to administer an oral laxative, if no results, the evening shift nurse was to administer a suppository, and if no results, the night shift was to administer a "Fleets Enema". Interview, on 12/14/12 at 5:05 PM, with LPN #5 who worked the evening shift and was often assigned to Resident #5, confirmed that the staff nurses had no access to the computer to monitor bowel movements and the nurses received a list of residents who needed medications for constipation. Interview, on 12/14/12 at 4:20 PM, with the Director of Nursing (DON) revealed the UC looked at bowel movements for residents on their units every morning from the computer, and if a resident had not had a bowel movement in three (3) days, they were to receive a "PRN" medication or the Physician was to be notified for an order. She stated she agreed it looked as though Resident #5 had gone more than three (days) without a bowel movement per record review.	F 309	be taken to monthly CQI meetings on an on-going basis. Additional action plans would then be developed if problems were identified with the system.		
F 325 SS-D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition	F 325	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #5 is the only resident to have been identified as part of the deficient practice. At this time, Resident #5 remains at the facility. All labs are	1/21/13	

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F 325	<p>Continued From page 31</p> <p>demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure that a resident maintains acceptable parameters of nutritional status unless the resident's clinical condition demonstrates that this was not possible for one (1) of sixteen (16) sampled residents (Resident #5). Resident #5 sustained a weight loss of 13.4 pounds from 11/06/12 to 12/05/12 which was a significant weight loss of 7.5% in one month. However, there was no documented evidence the facility provided ongoing monitoring of the resident's food/fluid consumption, implemented their Nutrition Program Policy or Weight Management Policy, or notified the Registered Dietitian (RD) and Physician in an attempt to prevent further weight loss.</p> <p>The findings include:</p> <p>Review of the "Nutrition Management Program Policy", dated 06/03/10 revealed the nursing staff would notify Dietary Services if there was a weight loss of 5% more in one (1) month, and the nurse would also review the resident's intake and notify the physician. The care plan was to be modified when indicated to stabilize or improve the nutritional status.</p>	F 325	<p>current and have been reviewed timely by the physician. The resident was assessed by the Registered Dietician (RD) on 12/17/12, who continued to follow weekly and then was reassessed on 1/8/13. The resident's weekly weights and daily intakes are being monitored and reviewed by nursing and the RD weekly, with the physician being notified by nursing of any significant changes.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents would have the potential to be affected by this deficient practice. All monthly weights are current and are being compared to the prior month by the RD to identify any significant changes. The RD is assessing food and fluid intakes for those patients exhibiting a significant change, with the physician being notified by nursing for any recommended order changes. All lab orders for the current month were audited by the Unit Coordinators (UC's) for timely draws, results and proper notification to the physician for potential new orders and as of 1/9/13 no issues were identified.</p>		

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Review of the "Weight Management Policy", dated 06/03/10, revealed a greater than 5% weight loss in one month would be considered severe. Further review revealed if there was an actual 5% or more weight loss in one month, nursing would notify the physician, and dietary. Further review revealed staff would review the resident's intake to determine the percentage of meals eaten, review for changes in usual dietary habits, and review to determine if the weight change was caused by a medical condition. A calorie count was to be initiated and the Nutrition Review Meeting would review significant unplanned weight changes.

Review of Resident #5's medical record revealed the facility admitted the resident on 10/04/12, with diagnoses including Cerebrovascular Accident (CVA), Congestive Heart Failure (CHF), and Pneumonia. Review of the Admission Minimum Data Set (MDS) Assessment, dated 10/19/12, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 07, which indicated the resident was severely impaired in cognitive skills for decision making. Further review revealed the facility assessed the resident as requiring supervision and set up help for eating and as having no swallowing problems.

Review of the Comprehensive Plan of Care, dated 10/22/12, revealed the resident was at risk for altered nutrition due to requiring a therapeutic diet and decreased oral intake secondary to cognitive impairment. The goal stated the resident would exhibit adequate nutritional status as indicated by maintaining a stable weight below one hundred and seventy-six (176) pounds, plus

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A complete audit of all care plans will be performed by the Unit Coordinators and MDS nurses by 1/18/13 to ensure all individualized care needs have been addressed and current orders are reflected (Exhibit I). This would include the potential for weight loss or poor intake. The results of this audit shall be provided to the DON to ensure follow-up of any resident needs that had not been addressed.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

The Unit Coordinators (UC's) will obtain daily reports of fluid and food intakes from CareTracker (clinical documentation software) Monday through Friday and bring them to the morning clinical meeting the following day for review with the Director of Nursing (DON) and RD. Saturday and Sunday reports will be reviewed at the Monday clinical meeting. Any significant changes identified will be addressed by the RD, DON, and/or Unit Coordinators and the physician notified as needed. The DON will maintain a log (exhibit A) to serve as an audit tool to identify those

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F 325	<p>Continued From page 33</p> <p>or minus five (5) pounds. The interventions included having weights monitored and obtained routinely, and as needed.</p> <p>Review of the Nutrition Note, date 11/08/12, revealed the resident's average intakes were: breakfast 96%, lunch 82%, and dinner 89%.</p> <p>Review of the Monthly Nutrition at Risk Note, dated 11/29/12, revealed the resident's meal intakes included 57% of breakfast, 67% of lunch and 68% of supper with decreased intake values since the prior nutrition note. Further review revealed the resident's weight was stable since admission at 177.7 pounds and the resident had an order for Lasix which may cause weight fluctuations. Continued review revealed the resident had two (2) recent orders for antibiotics related to a Urinary Tract Infection which included orders for Macrobid for ten (10) days written 11/13/12 and Cipro for ten (10) days written 11/23/12 which may cause a decrease in appetite.</p> <p>Review of the "Weight Calender" indicated a weight of 177.7 pounds on 11/06/12 and a weight of 164.3 pounds on 12/05/12. This was a significant weight loss of 7.5 % in one (1) month; however, there was no documented evidence of a re-weight until 12/13/12. The resident's weight on 12/13/12 was 160.4 pounds, showing further weight loss. Observation by the surveyor of a weight obtained on 12/14/12 at 5:00 PM in a weight chair revealed a weight of 161.6 pounds.</p> <p>Review of the Intake/Output Chart Detail Report revealed a decrease in meal consumption from the 11/29/12 Nutrition at Risk Note. On 12/03/12,</p>	F 325	<p>residents with significant changes. This log will also verify that the RD and physician have been notified and that follow-up orders and any other pertinent data have been obtained. Nursing staff will be re-educated by the DON on 1/13/13, 1/15/13, and 1/16/13 in regards to appropriate documentation of food and fluid intakes, the proper reporting of poor intakes to the nursing supervisor, and the signs and symptoms of dehydration. Licensed nursing staff will be re-educated by the DON on 1/13/13, 1/15/13, and 1/16/13 regarding timely physician and RD notification and proper documentation related to significant changes, including decreased intake, weight loss and abnormal labs.</p> <p>The DON will designate one individual SRNA on 1/14/13 to obtain weekly and monthly weights. This individual will be educated by the DON on the proper protocol for obtaining re-weights, identifying significant changes, and the immediate reporting of significant changes to the appropriate Unit Coordinator. The Unit Coordinators shall be responsible for verifying that all weekly and monthly weights have been obtained, and that the RD and physician have been notified of any significant changes as necessary. The DON will</p>				

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the resident consumed 25% or less for breakfast and lunch and 51-75% of supper. On 12/04/12, the resident consumed 25% or less for breakfast, 26-50% of lunch and 25% or less for supper. On 12/05/12, the resident consumed 26-50% of breakfast, 51-75% of lunch, and 25% or less for supper. On 12/06/12, the resident consumed 25% or less for breakfast, lunch, and supper. On 12/07/12, the resident consumed 25% or less for breakfast and lunch and 76-100% of supper

Record review revealed no documented evidence the Plan of Care was updated to address the significant weight loss and no evidence the facility notified the Physician or the Registered Dietician.

Interview, on 12/13/12 at 11:30 AM, with State Registered Nurse Aide (SRNA) #7 revealed she worked the day shift on the Unit where Resident #5 resided and was often assigned to the resident. She did not remember having to report to the nurses that the resident was not eating or drinking well in the past. She stated the resident was not a good eater in general but would snack in the room and drink from the straw in the water pitcher. Continued interview revealed the SRNAs monitored how much the residents ate and drank at meals and documented it on the Kioske (computer system); however, she stated she was unable to view how much the resident was eating and drinking for prior days per the Kioske.

Interview, on 12/13/12 at 3:30 PM, with SRNA #6 revealed she worked the evening shift on the Unit and was assigned to the resident at times. She stated the resident refused dinner a lot. She stated the SRNAs documented the food and fluid intake on the Kioske and notified the nurses when

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monitor this system weekly as part of the Nutritional At-Risk Meeting attended by the DON, RD, Unit Coordinators and Speech Therapist (as needed if therapy is indicated). Clinical documentation reviewed at this meeting will include resident nutritional intake, review of lab results, physician notification, RD notification, and resident weights. Audit tools (Exhibits A, B, C, & D) will be completed to ensure that all of this information has been reviewed.

For each new admission, a baseline weight will be obtained within 24 hours, and subsequent weights obtained weekly for four (4) weeks. Thereafter, weights will be scheduled either weekly or monthly, or as ordered by the physician. Food and fluid intakes will be documented upon admission.

All licensed nurses will be educated by the DON on 1/13/13, 1/15/13, and 1/16/13 on care planning and updates to care plans. Education will be provided to Unit Coordinators and MDS nurses by the DON 1/13/13, 1/15/13, and 1/16/13 regarding care plan accuracy and updates with new orders and quarterly assessments. The Medical Records Consultant shall audit on a weekly basis those care plans that are scheduled for

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F 325	<p>Continued From page 35 residents had poor intakes.</p> <p>Interview, on 12/13/12 at 11:35 AM, with the Unit Coordinator (UC) revealed different SRNAs obtained weights and documented the results in the weight book. The licensed nurses were to transcribe the weight from the weight book to the medical record on the "Weight Calender". She further stated if a weight discrepancy was noted, a re-weight was to be obtained immediately, and the Physician notified at that time if the re-weight showed a weight gain or loss. Further interview revealed a re-weight should have been done immediately on 12/05/12 instead of waiting eight days (8) for the re-weight. She stated she was unaware of Resident #5's weight loss although she was aware the resident was not eating well. She stated there was a Nutrition at Risk meeting each Thursday where the Interdisciplinary Team (IDT) discussed weights; however, she was unsure if this resident had been discussed in the meetings and the information from the meetings was not documented in the medical record. After reviewing the medical record, the UC stated there was no notification to the RD or the Physician related to the weight loss although they should have been notified. She stated she or the other nurses did not routinely monitor food and fluid intakes and they depended on the SRNAs to report when a resident had decreased intakes.</p> <p>Phone interview, on 12/14/12 at 2:00 PM, with Registered Nurse (RN) #1, who was often assigned to Resident #5, revealed the SRNAs were to let the nurses know when a resident ate less than fifty (50) percent and the nurses would encourage the residents to eat and drink. She stated there was no protocol as to when the</p>	F 325	<p>Care Plan Meetings/updates for the week (Exhibit I). Results will be provided to the DON for follow-up. The DON shall make the Unit Coordinators/ MDS Nurses responsible for the care plan updates</p> <p>How will the facility monitor its performance to ensure solutions are sustained?</p> <p>As stated previously, the DON will maintain a log from the morning clinical stand-up that will validate that fluid and food intakes have been reviewed and followed up on as indicated, as well as log maintenance in regards to weight monitoring with the appropriate follow-up as indicated. These logs, along with documentation from the weekly Nutritional At-Risk meeting will be discussed at the Monthly interdisciplinary CQI meeting that includes, but is not limited to the Administrator, DON, Medical Director, Consulting Pharmacist, Medical Records Consultant, RD, Social Services, Unit Coordinators, MDS Nurses, wound nurse, and Food and Beverage Director, on an on-going basis for effectiveness of the system and any corrective action taken as necessary.</p>	

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F 325	<p>Continued From page 36</p> <p>Physician or RD was to be notified of intakes and she would notify them depending on the circumstances. Further interview revealed all nurses were responsible for monitoring intakes when there was a concern, but she did not have access to review the resident's intakes in the computer and would need to ask the Unit Coordinator for access when needed. Continued interview revealed the Unit Coordinator monitored the meal intakes on the computer on a regular basis. Further interview revealed she was aware this resident was receiving Pericatin for poor appetite.</p> <p>Phone interview, on 12/14/12 at 2:30 PM, with Licensed Practical Nurse (LPN) #4, who was often assigned to Resident #5, revealed she did not recall low intakes with this resident. Further interview revealed the nurses did not consistently monitor food/fluid intake documentation, but if there was a concern she could ask the Unit Coordinator for access to the information on the computer.</p> <p>Interview, on 12/14/12 at 3:00 PM, with Kentucky Medication Aide (KMA) #1, revealed she usually obtained all the weights on the unit where Resident #5 resided, although she did get help as needed from the SRNAs. She stated once she obtained the weights she turned them into the Unit Coordinator (UC) and the UC informed her when re-weights needed to be obtained. Further interview revealed she had obtained the last few weights on Resident #5 including the 12/05/12 weight and the 11/06/12 weight and had documented them in the weight book. She confirmed she had not been asked to get a re-weight. Further interview revealed there had</p>	F 325	<p>Review of care plan auditing will be taken to monthly CQI meetings on an on-going basis. Additional action plans would then be developed if problems were identified with the system.</p>	

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F 325 Continued From page 37

been times when she was told to document the weights in the medical record on the Weight Calender. Further interview revealed she had documented the weights on the weight calender for the 11/06/12, and the 12/05/12 weights.

Interview, on 12/14/12 at 3:15 PM, with the RD revealed re-weights were to be done the same day if there was a discrepancy; however, this did not always happen which caused lag time. She stated this had been discussed as a concern in the Nutrition at Risk (NAR) meetings. Continued interview revealed she had been notified by one of her staff that Resident #5 was not eating well and she had notified the Nurse Practitioner and recommended Peractin which was ordered November 2012 to increase the resident's appetite. However, she was unaware that the resident had actual weight loss from November 2012 to December 2012. Continued interview revealed she would need to review the chart in order to make further recommendations and update the Nutrition Care Plan. Review of the Physician's Orders, dated 11/30/12, revealed orders for Peractin 40 mg three (3) times a day.

Interview, on 12/14/12 at 3:00 PM, with the Attending Physician revealed a thirteen (13) pound weight loss in one month was a lot for that time period, and may be due to the diuretic the resident was receiving. He stated he was unsure if he or the Nurse Practitioner he worked with was notified of the weight loss; however, he stated if they had been notified there would have been new orders. He further stated if staff did not document the physician notification, he probably was not notified.

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F 325	Continued From page 38 Interview, on 12/14/12 at 4:20 PM and 5:30 PM, with the Director of Nursing (DON) revealed a re-weight should be done within twenty-four (24) hours. She further stated she had reviewed the medical record and there was no documentation that the Physician had been notified of the weight loss from 11/06/12 to 12/05/12, or of the weight loss after the re-weight on 12/13/12. Further interview revealed the staff nurses did not have access to look back past the current day to see intakes and were unable to run a report currently because the computer blocked access. She stated there was no one currently looking at what was input in the system for food and fluid intake on a regular basis, and staff relied on the weights to monitor; however, they needed to be more proactive.	F 325	
F 327 SS-G	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policies, it was determined the facility failed to ensure each resident was provided with sufficient fluid intake to maintain proper hydration and health for one (1) of sixteen (16) sampled residents (Resident #5). Resident #5 had poor intake from admission on 10/04/12; however, there was no documented evidence the facility implemented their "Hydration/Fluid Management Policy". Although the resident had risk factors for dehydration including poor fluid intake, was	F 327	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #5 is the only resident to have been identified as part of the deficient practice. At this time, Resident #5 remains at the facility. All labs are current and have been reviewed timely by the physician. The resident was assessed by the Registered Dietician (RD) on 12/17/12, who continued to follow weekly and then was reassessed on 1/8/13. The resident's weekly weights and daily intakes are being monitored and reviewed by nursing and

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2012
NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504		
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F 327	<p>Continued From page 39</p> <p>receiving a diuretic medication, and was admitted to the facility with a diagnosis of Pneumonia in which she/he was receiving antibiotic medication, there was no documented evidence this resident was identified as at risk for dehydration and no documented evidence a Plan of Care was initiated to promote fluid intake. There was also no documented evidence of a Nutritional Assessment completed on admission to identify this resident's estimated fluid needs. In addition, there was no documented evidence staff provided ongoing monitoring of the resident's fluid intake or notified the Physician or the Registered Dietitian (RD) of this resident's poor fluid intake. On 10/09/12, the facility transferred Resident #5 to the hospital where she/he was admitted to the hospital with diagnoses of Severe Dehydration and Acute Kidney Failure.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled, "Hydration/Fluid Management", dated 01/05/11, revealed each resident's hydration/fluid needs would be determined by the nutritional professional upon admission, the Care Plan interventions related to proper hydration were to be developed according to the resident's needs, staff was to observe fluids provided to the resident to determine if the interventions identified in the Care Plan had been implemented, and the physician was to be notified when there was a significant change in the resident's fluid intake or output.</p> <p>Review of Resident #5's medical record revealed the facility admitted the resident on 10/04/12, with diagnoses which included Pneumonia,</p>	F 327	<p>the RD weekly, with the physician being notified by nursing of any significant changes.</p> <p>A care plan review and revision was completed on 12/17/12 for Resident #5 to address and includes risk factors for dehydration, poor fluid intake, diuretic therapy, treatment for pneumonia, weight loss, as well as all current and pertinent historical diagnoses.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents would have the potential to be affected by the deficient practice. The Unit Coordinators reviewed RD fluid recommendations and 72 hour fluid intakes on 1/8/13 to identify those residents who may require additional interventions or RD or physician consultation.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>The Unit Coordinators (UC's) will obtain daily reports of fluid and food intakes</p>		

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F 327	<p>Continued From page 40</p> <p>Cerebrovascular Accident (CVA), Hypertension, Atrial Fibrillation, and Congestive Heart Failure. Review of the Physician's Orders on admission, dated 10/04/12, revealed orders for Lasix (diuretic medication) 40 milligrams (mgs) every day, and Levaquin (antibiotic medication) 500 mgs every day for five (5) days. Review of the Interim Plan of Care, dated 10/05/12, revealed there was no Plan of Care related to this resident's risk of dehydration on admission, or prior to the resident's hospitalization on 10/09/12 even though the resident was ordered a diuretic medication and an antibiotic medication for a diagnosis of Pneumonia.</p> <p>Review of the Intake/Output Chart Detail Report revealed the following:</p> <p>On 10/05/12, the resident consumed 480 milliliters (mls) of fluids. Review of the Physician's Orders, dated 10/05/12, revealed orders to obtain a Complete Blood Count (CBC) and Comprehensive Metabolic Panel (CMP) on 10/08/12.</p> <p>On 10/06/12, the resident consumed 240 mls of fluids for breakfast, and there was no documentation of fluids consumed for lunch and supper.</p> <p>On 10/07/12, the resident consumed 840 mls of fluids.</p> <p>On 10/08/12, the resident consumed 720 mls of fluids.</p> <p>Review of the laboratory data for the CMP obtained 10/08/12 revealed abnormal values for</p>	F 327	<p>from CareTracker (clinical documentation software) Monday through Friday and bring them to the morning clinical meeting the following day for review with the Director of Nursing (DON) and RD. Saturday and Sunday reports will be reviewed at the Monday clinical meeting. Any significant changes identified will be addressed by the RD, DON, and/ or Unit Coordinators and the physician notified as needed. The DON will maintain a log (exhibit A) to serve as an audit tool to identify those residents with significant changes. This log will also verify that the RD and physician have been notified and that follow-up orders and any other pertinent data have been obtained. Nursing staff will be re-educated by the DON on 1/13/13, 1/15/13, and 1/16/13 in regards to appropriate documentation of food and fluid intakes, the proper reporting of poor intakes to the nursing supervisor, and the signs and symptoms of dehydration. Licensed nursing staff will be re-educated by the DON on 1/13/13, 1/15/13, and 1/16/13 regarding timely physician and RD notification and proper documentation related to significant changes, including decreased intake, weight loss and abnormal labs.</p> <p>The DON will designate one individual</p>	

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F 327	<p>Continued From page 41</p> <p>Blood Urea Nitrogen (BUN) at 73 High (reference 1-24), and creatinine at 2.3 High (reference 0.6-1.5).</p> <p>Further review of the Physician's Orders, dated 10/09/12 at 10:30 AM, revealed orders to hold Lasix (diuretic) and Lisinopril (hypertensive medication), start Lactated Ringer intravenous (IV) at 40 mls per hour for one (1) liter, and obtain a Basic Metabolic Panel (BMP) on 10/10/12, 10/11/12, and on 10/12/12.</p> <p>Further review revealed Physician's Orders, dated 10/09/12 at 1:00 PM, to send the resident to the emergency room related to abnormal labs and lethargy.</p> <p>Review of the Hospital Discharge Summary, dated 10/13/12, revealed the admitting diagnoses were Severe Dehydration and Acute Kidney Failure. Further review revealed upon arriving at the emergency room the resident was found to have a BUN and creatinine of 86 and 3.1 (high levels). The patient was admitted and started on intravenous hydration and a Renal Consult was obtained. Per the Summary, the resident's laboratory values improved after IV hydration with laboratory values returning to normal levels, before discharge from the hospital. The labs were noted as BUN at 28 and creatinine at 1.</p> <p>Review of the Nutrition Note written by the RD, dated 10/10/12, revealed the resident was discharged to the hospital prior to a full nutritional assessment being completed. Review of the Nutritional Assessment dated 10/16/12, after the resident was discharged from the hospital revealed the resident's estimated fluid</p>	F 327	<p>SRNA on 1/14/13 to obtain weekly and monthly weights. This Individual will be educated by the DON on the proper protocol for obtaining re-weights, identifying significant changes, and the immediate reporting of significant changes to the appropriate Unit Coordinator. The Unit Coordinators shall be responsible for verifying that all weekly and monthly weights have been obtained, and that the RD and physician have been notified of any significant changes as necessary. The DON will monitor this system weekly as part of the Nutritional At-Risk Meeting attended by the DON, RD, Unit Coordinators and Speech Therapist (as needed if therapy is indicated). Clinical documentation reviewed at this meeting will include resident nutritional intake, review of lab results, physician notification, RD notification, and resident weights. Audit tools (Exhibits A, B, C, & D) will be completed to ensure that all of this information has been reviewed.</p> <p>For each new admission, a baseline weight will be obtained within 24 hours, and subsequent weights obtained weekly for four (4) weeks. Thereafter, weights will be scheduled either weekly or monthly, or as ordered by the physician. Food and fluid intakes will be</p>		

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F 327	<p>Continued From page 42</p> <p>requirements were 2040-2400 mls per day.</p> <p>Interview, on 12/13/12 at 11:30 AM, with State Registered Nurse Aide (SRNA) #7 revealed she worked the day shift on the Unit where Resident #5 resided, and she was assigned to the resident a lot recently. She did not remember having to report to the nurse's that the resident was not eating or drinking well in the past. She stated the SRNAs passed drinks and snacks to all the residents between meals on the day shift at 9:30 AM and 2:00 PM. She further stated the SRNAs monitored how much the residents ate and drank at meals and documented it on the Kioske (computer system); however, she stated she was unable to view how much the resident was eating and drinking for prior days. She further stated if the residents were not eating and drinking well she would let the nurses know.</p> <p>Interview, on 12/13/12 at 3:30 PM, with SRNA #6, revealed she worked the evening shift on Resident #5's Unit and was assigned to the resident at times. She stated the resident refused dinner a lot, although she could not remember how the resident's intake was in 10/12. She stated the SRNAs documented the food and fluid intake on the Kioske and notified the nurses when residents had poor intakes.</p> <p>Interview, on 12/13/12 at 11:35 AM and 12:00 PM, with the Unit Coordinator on Resident #5's Unit, revealed after reviewing the Intake/Output Chart Detail Report, Resident #5 was consuming a low percentage, especially for breakfast and lunch from 10/05/12 through 10/09/12. She stated this Report indicated all the fluids consumed for the twenty-four hours, not just meals. After</p>	F 327	<p>documented upon admision.</p> <p>The Unit Coordinators will maintain a log (Exhibit E) for each unit that will serve as an audit tool to verify that all lab orders were submitted, specimens were obtained, results received, the physician was notified promptly, and that there was return notification with documentation of either "no new orders" or documentation of the new orders.</p> <p>The Unit Coordinators will be responsible to bring the logs to the morning clinical stand-up meeting for review by the DON. Licensed nurses will be re-educated by the DON on 1/13/13, 1/15/13, and 1/16/13 in regards to this process and the timely physician notification and follow-up of abnormal labs.</p> <p>For all new admisions/readmissions from 12/17/12 forward, the Interim Care Plan shall be reviewed the following day at the clinical stand-up meeting on Mondays through Fridays by the Unit Coordinators, DON, MDS and RD. The House RN Supervisor shall be responsible to review the Interim Care Plans for Saturdays and Sundays, with the clinical stand-up team to follow-up on Mondays. The discharge summaries will be reviewed to make sure the</p>	

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F 327	Continued From page 43 reviewing the Nurses's Notes from admission 10/04/12 through 10/09/12, she stated there were only two (2) Notes related to decreased intake and she did not see documentation of notification to the physician or dietician related to low intake. She stated she or the other nurses did not routinely monitor food and fluid intakes and they depended on the SRNAs to report when a resident had decreased intakes. She further stated dietary assessed the estimated fluid intake required per day; however, the nurses were not required to ensure the residents were meeting the fluid requirement. Continued interview revealed the nurses did a head to toe assessment on each resident each day and checked for signs and symptoms of dehydration which was noted on the Nurse's Notes; however, the nurses had not recognized this resident as being dehydrated from the assessments. Further interview revealed it was the staff nurses responsibility to initiate a nutrition/hydration care plan during a situation in which a resident was not eating and drinking well. She further stated the admitting nurses should have looked at dehydration risk factors for this resident on admission because the Data Tool Collection the nurse completed dated 10/04/12, indicated the resident had a recent history of weight loss. Continued interview revealed she was unaware this resident was dehydrated shortly after admission to the facility; however, she did not review hospital discharge summaries. The Unit Coordinator stated it was her responsibility to audit new admits to make sure assessments were complete and the medications were transcribed correctly to the Medication Administration Record; however, she did not do an in depth chart review to ensure the Interim Care Plans were accurate.	F 327	Interim Care plan covers current diagnosis, history, risk factors, etc. The DON will maintain a log (Exhibit J) to document completion of interim care plan reviews. Licensed nurses shall be educated by the DON on 1/13/13, 1/15/13, and 1/16/13 regarding the Interim Care Plan development process. How will the facility monitor its performance to ensure solutions are sustained? As stated previously, the DON will maintain a log from the morning clinical stand-up that will validate that fluid and food intakes have been reviewed and followed up on as indicated, as well as log maintenance in regards to weight monitoring with the appropriate follow-up as indicated. These logs, along with documentation from the weekly Nutritional At-Risk meeting will be discussed at the Monthly interdisciplinary CQI meeting that includes, but is not limited to the Administrator, DON, Medical Director, Consulting Pharmacist, Medical Records Consultant, RD, Social Services, Unit Coordinators, MDS Nurses, wound nurse, and Food and Beverage Director, on an on-going basis for effectiveness of the system and any		

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Continued From page 44

Phone interview, on 12/14/12 at 2:00 PM, with Registered Nurse (RN) #1, who was assigned to Resident #5 on 10/05/12 and 10/08/12 revealed the SRNAs were to let the nurses know when a resident ate less than fifty (50) percent and the nurses would encourage the residents to eat and drink. She stated there was no protocol as to when the Physician or dietitian were to be notified of intakes but if there was a few shifts or a few days of low intakes, she would notify them depending on the circumstances. Further interview revealed all nurses were responsible for monitoring intakes when there was a concern, but she did not have access to this information in the computer and would need to ask the Unit Coordinator for access when needed. She further stated the Unit Coordinator monitored the meal intakes on the computer on a regular basis.

Phone interview, on 12/14/12 at 2:30 PM, with Licensed Practical Nurse (LPN) #4, who was assigned to Resident #5 on the day shift and evening shifts on 10/06/12 and 10/07/12, revealed she could not remember the specifics of how much Resident #5 was eating and drinking in October 2012, but she did not recall low intakes with Resident #5. She stated the nurses did not consistently monitor food/fluid intake documentation, but if there was a concern she could ask the Unit Coordinator for access to the information on the computer.

Interview, on 12/13/12 at 3:45 PM, with LPN #5 revealed he had admitted Resident #5 on 10/04/12 and was also assigned to the resident on 10/05/12 and 10/08/12. He stated the SRNAs picked up the meal trays and were to tell the

F 327

corrective action taken as necessary.

The DON will maintain a log (Exhibit J) that will serve as an audit tool for the Initial Care Plan Review that will support reviews of new resident's discharge summaries, risk factors and diagnoses by the clinical stand-up team in the development of the Initial Care Plan. This information will be reviewed at the Monthly interdisciplinary CQI meeting that includes, but is not limited to the Administrator, DON, Medical Director, Consulting Pharmacist, Medical Records Consultant, RD, Social Services, Unit Coordinators, MDS Nurses, wound nurse, and Food and Beverage Director, on an on-going basis for effectiveness of the system and any corrective action taken as necessary.

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F 327	<p>Continued From page 45</p> <p>nurses if the residents had a low food/fluid intake. He stated if a resident was eating 25% or less for 48-72 hours, or consumed less than 50% of the tray for two (2) days he would notify the Physician. LPN #5 stated he did not notify the Physician of Resident #5's low intakes or he would have documented the notification in the chart. Continued interview revealed he had completed this resident's Interim Care Plan on 10/05/12 and should have included a problem with potential for dehydration due to risk factors such as receiving antibiotics for Pneumonia and receiving a diuretic.</p> <p>Interview, on 12/14/12 at 3:00 PM, with the Attending Physician revealed Resident #5 did have low intakes on admission, especially considering she/he was receiving Lasix. He stated the resident was being over diuresed and the dehydration was more a function of the Lasix than the intakes. Continued interview revealed the nurses should have alerted the Physician of the low intakes, especially considering the resident was on a large dose of Lasix. He stated the chart would reflect if he or the Nurse Practitioner who worked with him had been notified, and there would have been new Physician's Orders if they had been notified of the intakes.</p> <p>Interview, on 12/14/12 at 3:15 PM, with the Registered Dietitian (RD), revealed she had seven (7) days from the day of a resident's admission to complete a Nutritional Assessment. After reviewing the intakes from 10/04/12 through 10/08/12, she stated if she had been notified of the low intakes she would have documented the notification in the chart as well as made</p>	F 327		

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F 327	Continued From page 46 recommendations for "Ensure" as a supplement at least one (1) time a day as well as an afternoon snack, and would have either done a calorie count or checked the meal intakes each meal for several days. Continued interview revealed Lasix 40 mg a day was a high dose for a small person which placed this resident at risk for dehydration, and also the Levaquin antibiotic would decrease the appetite. Interview, on 12/14/12 at 4:20 PM, with the Director of Nursing (DON) revealed the RD was to assess the new admissions caloric count after seven (7) days and she did not interpret the policy as the Nutrition Assessment needing to be completed on admission before the seven (7) days. After reviewing Resident #5's food and fluid intakes, she stated the staff should have taken the Lasix in consideration as well as the Pneumonia and antibiotics and completed a care plan to monitor this resident closely for potential for dehydration. She stated there was no one currently looking at what was input in the system for food and fluid intake on a regular basis, and staff relied on the weights to monitor; however, they needed to be more proactive. Further interview revealed the staff nurses did not have access to look back past the current day to see intakes and were unable to run a report currently because the computer blocked access. She further stated the Physician should have been notified of the low intakes for the time period 10/04/12 through 10/08/12.	F 327			
F 371 SS-E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371	The white residue on the plate covers was determined to be calcium or lime buildup caused by the hardness of the water. The foodservice director	1/21/13	

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F 371 Continued From page 47 considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

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 prepare, distribute, and serve foods under sanitary conditions. Observation during initial tour of the kitchen, on the morning of 12/11/12, revealed a stack of plate covers on a shelf. The plate covers had a thick white covering on the outside. Further observation during the breakfast tray line, on 12/11/12, revealed the cook opened the trash can lid with her hands, and without washing her hands, started checking the temperatures of the food on the tray line.

The findings include:

Review of the facility's "Sanitation and Infection Control in Food Service Policy", dated 01/01/01, revealed infection control and sanitation practices were followed to minimize the risk of contamination of food and food borne illnesses.

1. Observation on the initial kitchen tour, on 12/11/12 at 6:00 AM, revealed plate covers which were stacked on a shelf were noted to have a thick white coating on the outside. Interview with the cook at the time of the observation, revealed

F 371 consulted with the facility's dish cleaning chemical supplier on 12/12/12 and obtained a cleaning product that eliminates this residue and which was immediately put into use. This product continues to be used and there have been no further observances of this residue.

To prevent a reoccurrence, the Foodservice Director, RD, or kitchen supervisors will audit plate covers five (5) times per week for six (6) weeks using an audit tool (Exhibit L).

The kitchen staff will be in-serviced on 1/15/13 on the proper procedures for hand washing and dietary sanitation and the wearing and changing of gloves.

To prevent a reoccurrence, the Foodservice Director, RD, or kitchen supervisors will audit the kitchen five (5) times per week for six (6) weeks using an audit tool (Exhibit M).

These audits will be reviewed by the Foodservice Director at the monthly interdisciplinary CQI meetings and any corrective action taken as necessary.

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F 371	Continued From page 48 it was soap residue. Interview with the Dietary Manager, on 12/12/12 at 3:30 PM, revealed he was aware there was a build up of white substance on the plate covers and thought it was due to the hard water. He stated he was unaware the problem could be corrected until questioned by the surveyor. Further observation of the plate covers at the time of the interview revealed the plate covers were no longer covered with white residue and the Dietary Manager stated he had researched and found a way to resolve the problem. 2. Observation during meal preparation, on 12/11/12 at 7:20 AM, revealed the cook removed the trash can lid with her hands and threw away a piece of aluminum foil. She then went to the tray line and cleaned a thermometer with an alcohol pad and took the temperature of the eggs. Interview with the cook at the time of the observation revealed she was unaware she had contaminated her hands by touching the trash can lid. Interview, on 12/12/12 at 3:30 PM, with the Dietary Manager revealed the cook should have washed her hands prior to returning to the tray line after touching the trash can lid. He stated he conducted mock surveys during meal times and observed tray line which included watching for infection control concerns and had not witnessed this type of concern.	F 371			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441	What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	1/21/13	

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F 441 Continued From page 49
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.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review,

F 441 Resident #5 was the only resident identified within the context of this deficiency. There has been no negative outcome as a result of the deficient practice identified.

The bedpans, urinals, and wash basins in resident rooms 204, 205, 214, and 218 were labeled and bagged appropriately on 12/12/12.

How will the facility identify other residents having the potential to be affected by the same deficient practice?

All residents would have the potential to be affected by this deficient practice. All residents currently receiving wound treatments were assessed for the presence of infection on 1/4/13.

On 12/17/12 the Unit Coordinators checked all resident rooms for the presence of any unbagged and/or unlabeled bedpans or urinals.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

All nursing staff will be educated by the DON on 1/13/13, 1/15/13, and 1/16/13

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F 441	<p>Continued From page 50</p> <p>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 sixteen (16) sampled residents (Resident #5). Observation during a dressing change for Resident #5 revealed the nurse used poor infection control technique.</p> <p>In addition, observation during initial tour, on 12/11/12, revealed bed pans, wash basins, and urinals were not labeled with residents' names and were stored on the resident's bathroom floors not bagged.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility's "Clean Dressing Change Policy", dated 06/01/07, revealed the procedure for the dressing change included; put on gloves, assist resident to a comfortable position, remove soiled dressing and gloves, place in bag for disposal, wash hands and put on clean gloves, clean wound as ordered, assess wound, remove gloves, wash hands, put on clean gloves, apply dressing and secure, remove gloves and place in bag for disposal, wash hands, return resident to a comfortable position, discard equipment, and wash hands. <p>Observation, on 12/13/12 from 8:45 AM to 9:30 AM, of a skin assessment and dressing change for Resident #5, revealed Licensed Practical Nurse (LPN) #6 removed the soiled dressing from the resident's left ankle wound, and with the same soiled gloves picked up a bottle of Sea</p>	F 441	<p>on proper infection control practices including hand washing, and the handling, storage and labeling of supplies.</p> <p>Unit Coordinators and RN House Supervisors will inspect each unit five (5) times per week for six (6) weeks using an audit tool (Exhibit N) to ensure compliance and correct any deficient practices noted.</p> <p>All licensed nursing staff will be educated by the DON on 1/13/13, 1/15/13, and 1/16/13 on proper infection control technique for treatments and dressing changes, to include return demonstration. The DON will observe one (1) or more treatments provided by licensed nurses per week for six (6) weeks to observe infection control techniques and document compliance using an audit tool (Exhibit O).</p> <p>How will the facility monitor its performance to ensure solutions are sustained?</p> <p>Review of infection control practices and auditing will be taken to the monthly CQI meetings on an on-going basis. Additional action plans will then be developed if concerns are identified.</p>	

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F 441	<p>Continued From page 51</p> <p>Clens Wound Cleanser and sprayed a dry 4 x 4 guaze pad. The LPN donned new gloves and measured the wound, again picked up the Wound Cleanser with soiled gloves, sprayed a 4 x 4 guaze pad and cleaned the wound. Further observation, revealed the nurse applied the Mepilex and Telfa Dressing, and removed her gloves. Without washing her hands, the nurse opened the dresser drawer and obtained a pair of socks for the resident. After washing her hands, LPN #6 placed the Wound Cleanser back in the bottom drawer of the treatment cart.</p> <p>Interview on 12/13/12 at 10:00 AM with LPN #6, revealed she removed the soiled dressing with one hand and picked up the wound cleanser with the other hand; however, she stated she usually used hand sanitizer to clean her hands after removing a soiled dressing. Continued interview revealed she should have washed her hands after the dressing change was completed, and prior to touching other objects in the room such as the dresser. She verified the Wound Cleanser was used for this resident only. However, further interview revealed the Wound Cleanser bottle had been contaminated during the dressing change and had been placed in the treatment cart where other resident treatment supplies were stored.</p> <p>Interview, on 12/13/12 at 11:05 AM, with the Director of Nursing (DON) revealed the nurse should have washed her hands after removing the soiled dressing and prior to handling the Wound Cleanser, and should have washed hands after the dressing change and prior to handling other items in the room.</p>	F 441		

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F 441 Continued From page 52

2. Review of the facility's policy entitled "Cleaning Commode Pans, urinals, raised toilet Seats and Bedpans", undated, revealed staff was to provide disposable, multiple-use, or single resident equipment labeled with the resident's name.

Observation during initial tour, on 12/11/12 at 8:00 AM, revealed resident rooms #204, #205, #214 and #218, had bedpans, urinals and/or wash basins on the bathroom floors, which were not labeled with the residents' names and they were not bagged.

Interview, on 12/11/12 at 8:30 AM, with State Registered Nurse Assistant (SRNA) #2, revealed bedpans, urinals and wash basins were to be placed in plastic bags and stored.

Interview, on 12/12/12 at 3:00 PM, with SRNA#4 revealed used urinals, bedpans, and wash basins, were to be placed in a plastic bag, due to infection control concerns.

Interview, on 12/12/12 at 3:25 PM, with Unit Manager #2 revealed urinals, bedpans and wash basins were to be placed in a plastic bag, due to infection control. And in addition, the items should have been labeled and should not have been left on the floor.

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 1980 Survey under: NFPA 101 (2000 edition) Facility type: SNF/NF Type of structure: III (000) Smoke Compartment: Seven (7) Fire Alarm: Complete fire alarm with smoke detectors in resident rooms and at smoke barriers. Sprinkler System: Complete sprinkler system one (1) wet and two (2) dry systems. Generator: Type II diesel installed in 1986 A standard Life Safety Code survey was conducted on 12/11/2012. Lexington Country Place was found to not be in compliance with the requirements for participation in Medicare and Medicaid. The census the day of the survey was one hundred (100). The facility is licensed for one hundred ten (110). The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire) with the highest scope and severity (S/S) of a "D".	K 000	The following constitutes Lexington Country Place's plan of correction for the deficiencies cited and will serve as the facility's credible allegation that substantial compliance will be achieved by January 21, 2013. The submission of this plan of correction is not an admission on the part of the facility that a deficiency exists or that the facility necessarily agrees with the accuracy of the surveyor's findings. Rather, it is being submitted as required by law.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical	K 147	The two (2) trash cans that were blocking access to the three (3) electrical panels in the biohazard room were removed on 12/11/12 by the Maintenance Director and have remained unobstructed. Other biohazard and storage rooms containing electrical panels were inspected by the maintenance staff on 12/11/12 for the presence of trash cans	1/21/13

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BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE EXECUTIVE DIRECTOR DATE 1/11/13

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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K 147	<p>Continued From page 1</p> <p>wiring and electrical components were maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, thirty-seven (37) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation, on 12/11/2012 at 11:10 AM, revealed two trash cans blocking access to three (3) electrical panels in the biohazard room in station one (Greenbrier). Storage cannot be located in front, above or to the sides of electrical panels due to fire risk. The observations were confirmed with the Maintenance Director.</p> <p>Interview, on 12/11/2012 at 11:15 AM, with the Maintenance Director, in the biohazard room revealed he was aware of the requirements. Further interview revealed the cleaning staff was aware of the requirements of not placing anything in front of electrical panels.</p> <p>Reference: NFPA 70 (1999 edition) 110-26 Spaces Sufficient access and working space shall be provided and maintained around all electrical to permit ready and safe operation and maintenance of such equipment.</p>	K 147	<p>or other items that could create an obstruction but none were identified.</p> <p>To prevent a reoccurrence, the Maintenance Director or Environmental Services Director will inspect storage rooms containing electrical panels weekly for six (6) weeks using an audit tool (Exhibit P) and remove items as necessary.</p> <p>Any further deficiencies noted will be referred to the facility Quality Assurance committee for corrective action.</p>	