

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

PRINTED: 03/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/18/2015
NAME OF PROVIDER OR SUPPLIER HIGHLANDS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205		
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F 000	INITIAL COMMENTS An Abbreviated Survey was initiated on 02/17/15 and concluded on 02/18/15 to investigate KY22841. The Division of Health Care substantiated the allegation and deficiencies were cited.	F 000	To the best of my knowledge and belief, as an agent of Highlands Health and Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.		
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to resolve grievances for three (3) of three (3) Resident Council Meetings reviewed regarding food, cleanliness of the facility and toilets. The facility received concerns during the Resident Council meetings; however, the outcome of the facility's actions were not shared with the Resident Council members and some concerns were not addressed at all, this included three (3) of three (3) rooms observed. (Room 125, 228 and 232). The findings include: Interview with the Administrator, on 02/18/15 at 10:00 AM, revealed the facility had no policy that addressed grievances. He stated there was a form, Customer Concern Form, that the facility encouraged families and residents to fill out and turn in to management. There were forms	F 166	Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.		

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

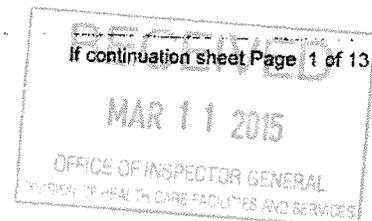
TITLE

(X6) DATE

X Rose Thurman

X Administrator X 3/11/15

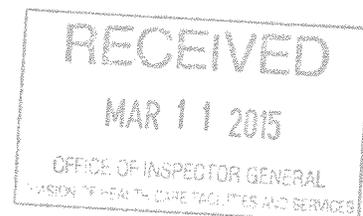
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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



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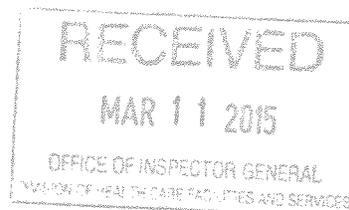
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F 166	<p>Continued From page 1 available on the units. He indicated many concerns were not necessarily grievances.</p> <p>Review of the Customer Concern Form, undated, requested information on the concern and the actions taken by the resident/family to resolve the concern. The form also included what the facility needed to do to resolve the concern and how and when the concern was resolved. The form had a place for the Administrator to sign and date. There was no documentation on the form to define what a grievance was.</p> <p>1. Observation of Resident #1, on 02/17/15 at 3:40 PM, revealed the resident was reclining in the bed and dressed. The call light was within reach. The resident had snacks on the overbed table and was alert and oriented.</p> <p>Review of the clinical record for Resident #1, revealed the facility admitted the resident with diagnoses of Hypertension, Atrial Fibrillation, and Diabetes. The facility completed an admission Minimum Data Set (MDS) assessment, on 02/04/15, which revealed the resident was cognitively intact, had no behaviors, was extensive assistance with bed mobility, transfers, dressing, hygiene and bathing. The resident was continent and had no range of motion deficits.</p> <p>Review of the comprehensive care plan for Resident #1, revealed the resident was planning to return home after therapy was completed. The resident had a pain management plan related to an old back injury. The resident was Diabetic and noncompliant with meals and the Dietician and Dietary Manager were to assure the resident was served dishes the resident liked.</p>	F 166	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 was interviewed by the Dietary Manager and Registered Dietician on 2/18/15 to determine the resident's specific diet requests. The specific requests are being met for resident on a daily basis, with follow up with Resident #1 by the Dietary Manager on a weekly basis. (Resident #1 discharged to home as planned on 3/3/15). The Activity Director met with the Resident Council, that included Resident #2 and Resident #3 on 3/10/15 to outline the detail of the revised process that will be used in the recording of concerns voiced in Resident Council, as well as the mechanism of follow-up to the voiced concerns to the council members. (detail of the process specified in requirement 3 below). All Resident Council Members that included Resident #2 and #3 acknowledged understanding and agreement of the process. The Ombudsman was present during this meeting on 3/10/15.</p> <p>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.</p>		



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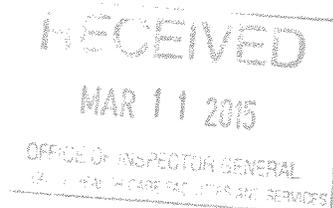
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F 166	Continued From page 2 Interview with Resident #1, on 02/17/15 at 3:40 PM, revealed the resident had discussed with the Dietician alternate breakfast foods. The resident stated a request was made to the Dietician for Cheerios in the morning with breakfast and a creamed soup (tomato, mushroom or celery) with lunch and dinner. The resident stated the food was terrible and if there was a creamed soup on the tray, at least there would be something to eat. The resident reported bouts of nausea and creamed soup helped to resolve the nausea. The resident stated the diet requests were never implemented. Interview with the Food Service Manager, on 02/18/15 at 3:50 PM, revealed he was not aware Resident #1 wanted specific foods on the meal trays. He stated it would be no problem and the Dietician did not let him know the resident had requests. 2. Review of the clinical record for Resident #2, revealed the facility admitted the resident with diagnoses of Chronic Obstructive Pulmonary Disease, Fracture Femur and Fractured Humerus. The facility completed an annual MDS assessment on the resident on 01/11/15 which revealed the resident was intact cognitively, required limited assistance for transfers, walking, dressing and bathing. The resident had occasional episodes of incontinence. Interview with Resident #2, on 02/18/15 at 9:06 AM, revealed the resident attended the Resident Council Meetings and was the current President. The resident stated the facility did not answer to the grievances brought up during the council meetings. The resident indicated the facility	F 166	What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? The Regional Vice President re-educated the Administrator, Director of Nursing, Assistant Directors of Nursing, Activity Director and Dietary Manager on 3/10/15 in regards to the policy on Resident Council that includes: The Activity Director or Social Service Director that is conducting the monthly and/or ad hoc Resident Council meetings will be responsible for providing assistance and communicating to department managers the written requests/questions that result from Resident Council meetings. The department manager is to address the concern and document actions/resolutions on the written report. The written communication will then be shared with the Resident Council by the Activity Director, Social Services Director, or assigned Department Director at the invitation of the council to ensure understanding and satisfaction. This process will be part of the normal Resident Council process on an on-going basis. The Administrator re-educated all department managers, that included but not limited to the Activity Director, Social Services, Director of Nursing and Dietary Manager on this process during the morning start-up meeting on 3/11/15.	



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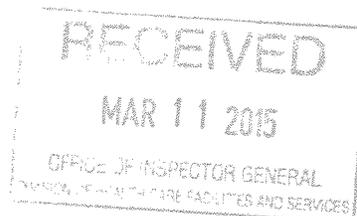
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F 166	<p>Continued From page 3</p> <p>would tell the group a problem was resolved or live with it. The resident stated nothing changed when the group voiced concerns.</p> <p>3. Review of the clinical record for Resident #3, revealed the facility admitted the resident with diagnoses of Diabetes, Liver Disorder, and Leukocytosis. The facility completed an annual MDS assessment on 02/20/15 which revealed the resident was cognitively intact and had no behaviors. The resident required limited assistance with bed mobility, transfers, walking, dressing, and bathing. The resident was continent.</p> <p>Interview with Resident #3, on 02/18/15 at 9:32 AM, revealed the resident attended the Resident Council Meetings. The resident indicated the facility rarely resolved a complaint or told the residents that a specific complaint had been resolved. The resident stated the facility would say a grievance was resolved, however, residents were not told how. The resident stated housekeeping had so many problems with lack of supplies and failure to clean, however, all the grievances filed during the council meetings were never answered or to the council's thinking never resolved.</p> <p>4. Review of the Resident Council Meeting minutes, for 12/30/14, revealed residents voiced concerns that their rooms were not being cleaned especially the bathrooms. The residents were concerned regarding gnats in the facility. They talked about the facility being short staffed on nurse aides and food portions being too small. In addition, the residents wanted the dietary staff educated on meal tickets.</p>	F 166	<p>How will the facility monitor performance to ensure solutions are sustained? Resident Council review of concerns and follow-up will become a routine component of the facility monthly Quality Assurance Process Improvement (QAPI) meeting that is led by the facility Administrator and includes the Director of Nursing, Assistant Director of Nursing, Dietary Manager, Activity Director, Social Services, Medical Director, Pharmacy Consultant, Staff Development Coordinator, Medical Records Director. The QAPI agenda shall include discussion of Resident Council review of concerns and follow-up on an on-going basis. This will validate that all concerns had the appropriate documented resident follow-up. Any instance of non-compliance would trigger the development of action plan interventions to correct.</p>	3/12/15	



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F 166	Continued From page 4 Review of the Department Manager Response Form from the Director of Nursing, undated, related to the 12/30/14 Resident Council meeting, revealed the facility was currently hiring nurses and nurse aides. The response did not provide information on how the staff shortage would be managed until other staff were hired. Review of the Department Manager Response Form from the Director of Housekeeping, related to the Resident Council meeting on 12/30/14, revealed the facility was out of paper towels for one (1) day due to a late shipment. She went to another building to get supplies. There was no evidence located regarding the complaint that resident rooms were not being cleaned and how the concern was resolved. There was no evidence located addressing the gnats in the facility. Review of the Resident Council Meeting minutes, for 01/13/15, revealed residents voiced concerns again about short staffing for nurse aides. There was no evidence located to show nursing responded to the complaints voiced during the 01/13/15 Resident Council meeting. The same response was given by the Housekeeping Director as the response from the 12/30/14 complaints. The response stated the facility ran out of paper towels for one (1) day and paper towels were taken from another facility to cover. There was no evidence provided that addressed the residents' concerns regarding soiled floors, soiled toilets and soiled shower rooms. Observations of Rooms 232, 228 and Room 125, on 02/17/15 at 4:21 PM, revealed the floors were soiled with dried substances and debris. In addition, the toilets in Rooms 232, 228 and 125	F 166			



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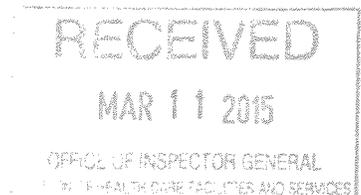
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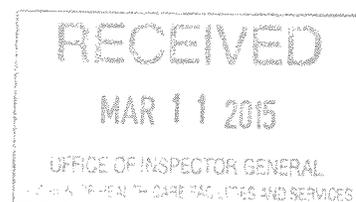
F 166	<p>Continued From page 5 were soiled with dried brown substances.</p> <p>Review of the Resident Council Meeting minutes, for 02/10/15, revealed residents voiced a concern about short staffing for nurses again. They stated they were not receiving medications as ordered by their physicians. They also commented that some of the nurses hired did not know what they were doing. In addition, residents were still concerned that their bathrooms were not not being cleaned, rooms were not dusted and paper towels were not being stocked in the bathrooms.</p> <p>Review of the Department Manager Response Form from the Director of Nursing for the Resident Council meeting on 02/10/15, revealed nurses had been hired to eliminate staff overtime. She revealed a new staffing system was in the process and would eliminate alot of staffing concerns. There was no evidence provided that addressed the residents' concerns regarding what the residents felt was a lack of knowledge by the new nurses hired and any resolution to the concerns regarding not receiving medications as ordered by their physician.</p> <p>There was no evidence located to show the Director of Housekeeping addressed concerns voiced by the residents at the 02/10/15 Resident Council meeting. The Director had since resigned and a new Director started on 02/18/15.</p> <p>Interview with the Activity Director, on 02/18/15 at 1:31 PM, revealed she notified residents about the location of complaint forms so they could write down their concerns. She stated she wrote down complaints voiced during the Resident Council meetings and passed the information on to the appropriate department manager. She</p>	F 166		
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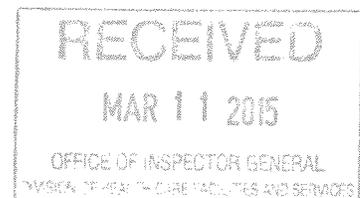
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F 166	<p>Continued From page 6</p> <p>stated the Dietary Manager did not answer these complaints in writing back to the council. She stated he managed his department complaints on his own. She stated she did not know residents were to receive answers to grievances other than they were fixed.</p> <p>Interview with the Food Service Manager, on 02/18/15 at 3:50 PM, revealed the food was very good and an alternate was available in the form of leftovers from a prior meal. He stated the residents could also get a sandwich. He stated he could not provide other foods and had not discussed the complaint with the resident council or provided the council with a written response to the complaints.</p> <p>Interview with Social Services, on 02/18/15 at 10:40 AM, revealed she was aware of the complaints regarding Resident #1's care. She stated many complaints were not grievances and were not documented. She stated she instructed residents and families to fill out a Customer Concern Form and turn it in to her. She stated she had heard complaints regarding dirty bathrooms and resident rooms; however, she did not write those issues up and report them. She stated she did not ensure the complaints she took were followed up on with the residents or the council.</p> <p>Interview with the Administrator, on 02/18/15 at 2:16 PM, revealed he was not aware the concerns voiced by the Resident Council members were not followed-up or discussed during the council meeting. He stated the concerns were resolved and residents were notified they were resolved. He stated he was not aware those concerns continued to be a problem.</p>	F 166			



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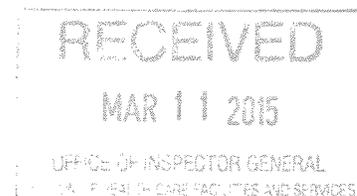
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F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policy, it was determined the facility failed to ensure one (1) of three (3) sampled residents (Resident #1) was administered seven (7) of fourteen (14) medications ordered by the physician.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Medication Ordering and Receiving from the Pharmacy, undated, revealed medications were received from the dispensing pharmacy on a timely basis. Medication orders were written on a medication order form. If the medications were needed before the next regular delivery, the facility would fax the orders and call the pharmacy. Timely delivery of new orders was required so that medication administration was not delayed. The emergency kit was used when the resident needed a medication prior to pharmacy delivery.</p> <p>Observation of Resident #1, on 02/17/15 at 3:20 PM, revealed the resident was reclined on the</p>	F 309			



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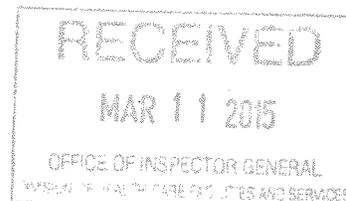
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F 309	<p>Continued From page 8 bed and watching television.</p> <p>Interview with Resident #1, on 02/17/15 at 3:20 PM, revealed the resident had not received medications ordered by the physician for over twenty-four (24) hours after admission to the facility. The resident stated the medications were requested; however, the facility told the resident the medications were not available.</p> <p>Review of the pharmacy's packing slip received on 01/29/15, revealed Resident #1's medications were delivered on 01/29/15. There was no time of delivery documented on the slip.</p> <p>Review of the clinical record for Resident #1, revealed the facility admitted the resident on 01/28/15 late in the afternoon with diagnoses of Atrial Fibrillation, Congestive Heart Failure, Hypertension and Diabetes. The facility completed an admission Minimum Data Set (MDS) assessment which revealed the resident was cognitively intact and required extensive assistance with activities of daily living.</p> <p>Review of the Medication Administration Record (MAR) for January 2015, revealed the resident received the medications ordered by the physician on 01/28/15 and received 01/30/15 Lipitor 20 mg, Digoxin 0.125 mg, Diltiazem HCL ER 350 mg, Lasix 40 mg, Glipizide 5 mg, Lisinopril 5 mg, Metoprolol 100 mg, Loratidine-D 24 Hr. An Albuterol inhaler was ordered by the physician on 01/29/15; however, the medication was not started until 02/01/15.</p> <p>Review of the emergency medication box, revealed the following medications were stocked as a par level at the facility Lisinopril 5 mg,</p>	F 309	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All current medication orders for Resident #1 were re-verified by the Director of Nursing on 2/18/15 to ensure that all medications were readily available for Resident #1 and being administered as ordered.</p> <p>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.</p> <p>What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? Education was provided to all licensed nursing staff by the Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator in regards to 1) medication orders process with pharmacy 2) pharmacy follow-up for delayed order delivery 3) Emergency Medication box contents and availability for use beginning on 2/19/15 and continuing through 3/11/15 to include all licensed nurses. Nursing education also included that any identified issue with the timely receipt of medications for administration be reported to the Director of Nursing or Assistant Director of Nursing immediately. In addition, the Administrator, the Director of Nursing and Assistant Director of Nursing are meeting with the Consultant Pharmacist to review the process of timely pharmacy notification and delivery of prescribed medications.</p>		



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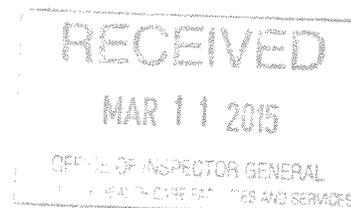
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NAME OF PROVIDER OR SUPPLIER HIGHLANDS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205	
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F 309	Continued From page 9 Digoxin 0.125 mg, Diltiazem 360 mg, Metoprolol 100 mg, Lasix 40 mg, Norco 10-325 mg. Attempts on 02/18/15 to interview the Pharmacy Consultant by telephone were not successful. Interview with Licensed Practical Nurse (LPN) #2, on 01/18/15 at 11:51 AM, revealed medications were generally delivered around 4:00 PM. She stated the emergency medication box was not used unless necessary; however, medications were available in the emergency box if a resident's medications had not arrived from the pharmacy. Interview with LPN #3, on 02/18/15 at 1:11 PM, revealed the pharmacy normally delivered medications around 4:00 PM. If there was a problem with the delivery, the emergency medication box was available and had many of the routine medications ordered by physicians. The medications should have been taken out of the box and administered to the resident rather than waiting several days. She stated increased blood pressure and heart rate would be a complication for a resident with heart disease. Interview with the Director of Nursing, on 02/18/15 at 3:06 PM, revealed nurses were trained to call the pharmacy if medications were not delivered timely. She stated the nurse could notify her and she would call the pharmacy or have a nurse go to the pharmacy and pick up the medications. She indicated the physician's orders were faxed to the pharmacy at 4:00 AM on 01/29/15 and was not aware of the delayed start of Resident #1's medications. She stated the nurses should have used medications from the emergency medication box to prevent a delay and	F 309	How will the facility monitor performance to ensure solutions are sustained? Review of new admission orders as well as any new physician orders are reviewed each morning in the Clinical Start Up meeting that is led by the Director of Nursing or Assistant Director of Nursing on weekdays and includes members of the clinical management team (RN Supervisors, Staff Development Coordinator, Medical Records Director, MDS Coordinator). The Nursing Supervisor is responsible for the review of new admission orders and any new physician order on weekends, with a comprehensive review of Friday-Sunday being reviewed again at the Monday meeting. As part of these reviews, the validation that medications were received and administered timely will be included. The Clinical Start Up meeting shall continue on an on-going basis. Any identified issue with the timely receipt of medications will be reviewed in the monthly QAPI meeting to determine additional interventions that may be warranted.	3/12/15



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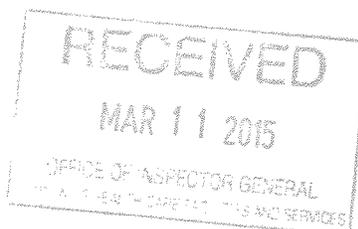
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F 309	Continued From page 10 possible complications from not receiving medications timely.	F 309			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (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	F 441	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No negative outcome was determined to have been identified for Unsampled Resident A. 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.		



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F 441	Continued From page 11 infection. 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 infection control practices for Clostridium Difficile (C-Diff) infection were maintained for one (1) of four (4) unsampled residents (Unsampled Resident A). A nurse performed a blood glucose test for Unsampled Resident A and failed to follow infection control practices thus contaminated the Test Strip bottle. The findings include: Review of the facility's policy regarding Contact Precautions, undated, revealed items taken into the isolation room, were left in the room unless they were able to be disinfected when removed. Observation of Unsampled Resident A, on 02/18/15 at 8:28 AM, revealed the resident was in contact precautions. The resident was in bed on the right side and eyes were closed. Observation of Licensed Practical Nurse (LPN) #2, on 02/18/15 at 8:31 AM, revealed she entered the resident's room after applying gloves. She laid out clean paper towels and placed a bottle of strips used to test blood sugar, alcohol prep pads, and an glucose monitoring device on the towel. She prepared the device and went to the resident's bed, pulled back the covers and tested the blood on the resident's finger. The nurse's	F 441	What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? LPN #2 received immediate 1:1 education by the Director of Nursing Services and Staff Development Coordinator in regards to appropriate infection control measures to be taken when caring for a resident with Clostridium Difficile to include contact isolation precautions on 2/18/15. Additional licensed and certified nursing staff received this same re-education by the Director of Nursing and Staff Development Coordinator beginning on 2/18/15, and continued to capture additional staff through 3/11/15.		



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F 441	<p>Continued From page 12</p> <p>clothing was noted to be in contact with the bed and the resident's linen. After the test was completed, she laid the used lancet and the device back on the paper towel. She sat the test strip bottle on the uncovered dresser top then placed the bottle in her pocket.</p> <p>Interview with LPN #1 after leaving the resident's room, on 02/18/15 at 8:43 AM, revealed she did not need to wear a gown inside the resident's room unless she had direct contact with the resident. She stated she was not aware she touched the bed or the linens while performing the blood test. She stated she did put the test strip bottle in her pocket out of habit. She indicated that the test strip bottle needed to either stay in the room or be disinfected if brought out of the room because it had a paper label not easily cleaned. She stated she had received education on contact precautions from the facility.</p> <p>Interview with the Director of Nursing, on 02/18/15 at 9:02 AM, revealed Unsampled Resident A was in contact precautions for a C. Diff infection. She stated staff were required to wear gowns and gloves when entering the room, especially if they were providing direct care. She stated performing a blood glucose test would be considered direct care. In addition, she stated the test strip bottle should have been left in the room as it was contaminated. The staff had recently been trained on precautions and she was very concerned regarding LPN #2's clothing being contaminated.</p>	F 441	<p>How will the facility monitor performance to ensure solutions are sustained? The nursing clinical leadership that includes the Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator have implemented monthly compliance fairs for all licensed and certified nursing staff that serves the purpose of reinforce education and evaluate competency based on hands-on skills assessment post education, beginning on 3/10/15. Each monthly fair will include an aspect of infection control measures. In addition, the nursing management team will provide additional, resident specific education for any resident identified with isolation needs. Competency results of the monthly health fairs will be reviewed during the monthly QAPI meeting to determine any identified trends for additional educational opportunities that may be warranted.</p>	3/12/15	

