

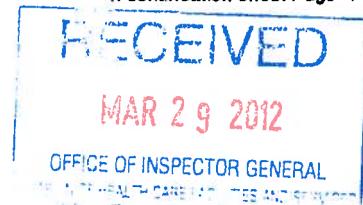
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/23/2012
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was initiated on 02/21/12 and concluded on 02/23/12. Deficiencies were cited with the highest scope and severity at an "E". The facility had the opportunity to correct the deficiencies before remedies would recommended for imposition. A Life Safety Code survey was conducted on 02/22/12 and found the facility meeting the requirements with no deficiencies cited.	F 000			
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. 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 provide an ongoing program of one (1) to one (1) activity programs based on the comprehensive assessment, interests and well-being of seven (7) of twenty-three (23) sampled residents (Residents #2, #3, #6, #8, #13, #15 and #23). Residents, unable to plan their own activities and received the same one (1) on one (1) activity programs regardless of their interests, cognition, and/or physical abilities. In addition, the Activity Director depended on the activity assistants to develop the daily activities for residents receiving 1:1 visits without specific activities planned by the	F 248	1. CORRECTIVE ACTION FOR RESIDENTS AFFECTED BY THIS PRACTICE: Staff involved in providing 1:1 activities for the residents identified were re-educated on 02-23-12 by the Activity Director. Additional training is scheduled as indicated under section 3 below. Residents #2, 3, 6, 13 and 15 were reassessed on March 19, 2012. Resident #3 will receive individualized 1:1s as developed by the Activity Director. Residents #2, 6 and 13 were also reassessed and will be encouraged to become involved in small group activities and will receive 1:1s when not able to attend small groups. Resident #15 was assessed using a new population assessment tool and it was determined that she is high functioning, younger than most of our residents and will no longer require 1:1s. She is attending morning group activities and walks around the facility and engages in conversation with her peers and staff and goes for walks in our courtyard.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X *Lucie J. Butterfield* TITLE: X Admin (X6) DATE: X 3-29-12

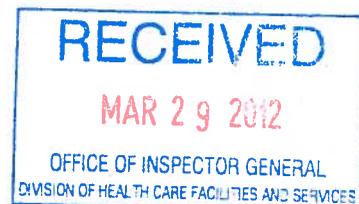
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 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 248	Continued From page 1 Activity Director based on residents' likes and interests. The findings include: Review of the facility's policies for Activities, undated, revealed 1:1 activities were to be completed three (3) times a week. If the resident does not receive 1:1, staff were to document that those residents received a wheelchair ride, a devotional, TV and a talk. When doing 1:1, activity assistants were to show creativity and rotate what residents were shown. Turn on residents' TV and radios unless the resident requests you not to turn them on. Read a devotional to the ladies in the Women's Day Room and take residents to the North Nursing Station to watch the fish and the bird. Make sure you chart this. You are to do a social hour daily at 4:00 PM, then turn on the radio. Do not read to the residents every day during social hour. When charting on a resident you will need to concentrate and write down as many numbers as possible. Interview with the Activity Director (AD), on 02/23/12 at 3:15 PM, revealed the facility utilized activity assistants to lead activities on each nursing unit. She stated she developed a monthly calendar with 1:1 on a daily basis. On the back of the calendar, the activity assistants were to document what was done with each resident. She stated the facility used numbers as codes for different activities, so the more numbers you listed, the more activities you	F 248	Resident # 8 is no longer a resident at Friendship Manor and Resident #23 was a former resident that had passed away on February 10, 2012, about ten days before the first day of our survey. Activity care plans for Residents #8 and #15 are located in the resident's charts. 2. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED WERE IDENTIFIED: All residents receiving 1:1 activities have the potential of being affected. All residents will be offered an individualized activity care plan that meets the resident's interests and the physical, mental, and psychosocial well-being of the residents. 3. MEASURES OR SYSTEMIC CHANGES TO PREVENT RECURRENCE: The activity department was provided additional 1:1 training by consultant, Jackie Laskee, and was held for <u>All</u> activity staff on March 19, 2012. The Activities Director will personally develop a non-repetitive 1:1 activity plan for all residents requiring 1:1 activities. The activity documentation sheet, for each resident receiving 1:1 activities, will be reviewed weekly by the Activity Director.	



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F 248	<p>Continued From page 2</p> <p>completed with the resident during 1:1 visits. She stated she had a list of activities specifically planned for each resident, however, she did not provide evidence of the list. She stated "Social Hour" activities were not planned and the activity assistants could do what they wanted to do. She stated she was not aware of activities not being completed as planned; however, she was aware that the activity assistants were repeating the same activities for all residents in the facility receiving 1:1 visits. She stated residents were gathered in the lounges and televisions were turned on several times a day.</p> <p>Observation of Resident #13, on 02/21/12 at 3:30 PM, 4:00 PM and 4:30 PM, and on 02/22/12 at 8:05 AM and 9:15 AM, revealed the resident sitting in a chair in the room with the television on. At each visit, the resident would become excited and reach out. The resident did not seem engaged with the television. The television was on at each observation. There were no observations of the resident actively involved in activities.</p> <p>Review of the clinical record for Resident #13, revealed the facility admitted the resident on 10/03/11 with diagnoses of Dementia and Hypertension. The facility completed a significant change Minimum Data Set (MDS) assessment on 01/03/12 which revealed the facility assessed Resident #13 as not interviewable. The facility and Hospice developed a care plan which included spiritual care, poetry, art and music. The MDS assessment indicated the resident enjoyed music, fresh air, pets, church and groups</p>	F 248	<p>The Activity Director will personally provide 1:1 activities for six residents, representing each wing, that require 1:1 in room activities. This will allow her to be on the floor to observe and assist her staff during 1:1s.</p> <p>4. HOW CORRECTIVE ACTIONS WILL BE MONITORED:</p> <p>Six 1:1 residents will be reviewed by the administrator each week for 6 weeks and then monthly thereafter to verify that 1:1s are individualized and non repetitious. The sample will include two residents from each wing. The finding will be presented to and reviewed at our monthly QA meeting. After 3 months the QA committee will determine, based on information presented to the committee the duration of reviews and number of residents to be sampled.</p> <p style="text-align: right;">3-30-12</p>



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F 248	<p>Continued From page 3 of people.</p> <p>Review of the activity attendance record for 1:1 visits, revealed Resident #13's 1:1 activities were listening to a devotional, had lotion applied, received a spray of scent and saw the rabbit or the bird in their cage at each visit for twenty-three (23) times during the month of February 2012. There was no evidence of any other activity provided for the resident.</p> <p>Review of the medical record for Resident #23, revealed the facility admitted the resident with diagnoses of a Fractured Hip and Hypertension. The facility completed an admission MDS assessment on 01/19/12 which revealed the resident was alert and able to make care decisions. The MDS revealed the resident enjoyed church, news, magazines, the outdoors and music.</p> <p>Review of the Activity attendance record for Resident #23 for February 2012, revealed the resident received daily 1:1 activity visits which consisted of hearing a devotional, looking at the rabbit, petting a stuffed animal and receiving a spritz of scent at every visit for ten (10) of ten (10) days.</p> <p>Further interview with the AD, on 02/23/12 at 3:15 PM, revealed she had attempted to take confused residents to group activities; however, she was told by the nurses that Resident #13 was too confused. She stated confused residents are</p>	F 248	

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F 248	<p>Continued From page 4</p> <p>not always appropriate for a group activity and she only had one (1) small group activity a week. She thought residents that were confused normally received 1:1 visits. She stated she did not routinely supervise the activity assistants to evaluate what they were doing with residents.</p> <p>Review of Resident #2's clinical record revealed the facility assessed the resident on the Minimum Data Set (MDS), dated 12/29/11, with a cognition score of 9 and moderately impaired. The facility assessed the resident with full functional range of motion to the upper extremities and no behavior. The Admission/Activity assessment, dated 07/14/03, revealed the resident liked animals, enjoys watching the news on the television, being read too, listening to country music, playing card games, playing with puzzles and completing crossword puzzles.</p> <p>Resident #2's care plan revealed the following interventions: Provide simple activities such as beading and reading magazines. Have the resident sit by the nurses station or in the television room where she can be involved in conversation. Take the resident to Devotional activities when up or have him/her sit near other residents at the nurses station. Assist with country music on the radio, assist with television likes news and movies, pet visits, provide with one to one three times a week.</p> <p>Observation, on 02/21/12 at 3:25 PM and 4:45 PM, revealed Resident #2 lying in bed in the Resident's room staring out the window. No music or television was turned on.</p>	F 248			



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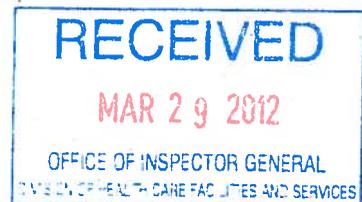
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F 248	Continued From page 5 Observation, on 02/22/12 at 7:55 AM, revealed Resident #2 sitting up in the Geri chair in the television room. No other residents were in the television room, however, five residents were noted sitting around the nursing station. Observation, on 02/22/12 at 9:00 AM, revealed Residents #2 lying in bed. The activity assistant was at the bedside with a rabbit in a cage and was reading a devotional. The activities assistant asked the resident to smell the lotion and placed a stuffed animal close to the resident's face. The resident's eyes became wide and repeatedly said "why you doing that". Continued observation of Resident #2, on 02/22/12 at 10:00 AM, 11:35 AM, and 2:00 PM, revealed the resident lying in the bed staring into space, with no music or television or activity taking place. Interview with the Activities Director (AD), on 02/23/12 at 3:35 PM, revealed the purpose of the activities department was to provide likes and dislikes according to the residents' mental status and health. The AD revealed she did not know that one on one activities should be individualized, just that it had to be done. The AD revealed she did make rounds once a day to ensure activities are being provided, but stated it was not sufficient. The AD revealed she was aware that Resident #2 enjoyed going to morning activities, talking, and watching television. The	F 248	



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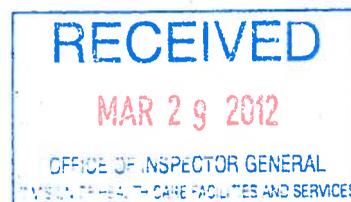
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F 248	Continued From page 6 AD revealed she was not aware activities were not being provided for Resident #2 according to their likes and preferences. Review of the medical record for Resident #3, revealed the facility admitted the resident on 01/03/12 with diagnoses of Neurogenic Bladder with an indwelling Catheter, Dementia and Parkinson's Disease. The facility assessed the resident with Impaired cognition. The facility completed an admission Minimum Data Set (MDS) assessment on 01/10/12 which revealed the resident had no behaviors, and a full functional range of motion to the upper extremities. The Admission/Activity assessment also revealed Resident #3 enjoyed keeping up with the news, going outside for fresh air, and participating in religious services. Review of the facility activity calendar documentation for January 2012 and February 2012 revealed Resident #3 did not attend or participate in any scheduled calendar events. Resident #3's care plan revealed the following interventions: Provide clock and calendar in the residents room, provide communion in room weekly, provide resident with one on one visits three (3) times per week, encourage to go outside when the weather permits, read devotionals and offer reading material. Observation, on 02/21/12 at 3:30 PM, revealed Resident #3 lying in an air mattress bed. At 4:09 PM, the resident was at the 300 unit nursing	F 248			



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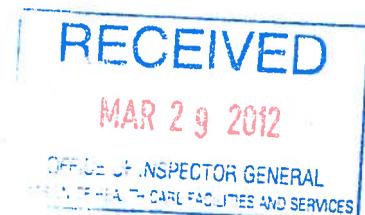
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F 248	Continued From page 7 station sitting up in a wheel chair next to other facility residents. The resident was not engaged in conversation. Observation, on 02/22/12 at 8:00 AM, revealed Resident #3 at the 300 unit nursing station sitting up in a wheelchair and at 9:51 AM the resident was in the therapy room working with therapy staff and the resident was escorted back to the 300 unit nursing station by therapy staff. At 5:00 PM, the resident was visiting with family in his/her room. Interview, on 02/23/12 at 4:45 PM, with Resident #3's spouse revealed she visits 2-3 times a day and revealed the resident did not watch television but enjoyed working around the house and doing lawn work before the resident was admitted to the facility but noticed the resident recently had become quieter. Review of the medical record for Resident #6, revealed the facility admitted the resident on 01/20/12 with diagnoses of Dementia, Hypertension, and Osteoporosis. The admission MDS assessment was completed on 01/27/12, and revealed the resident was severely cognitively impaired. The MDS revealed the resident preferred activities involving music, animals, being outside, and reading. The facility developed a care plan for the resident for activities to include music, television, feel and smell stimulation, magazines, and encouragement to attend group activities. Review of the one-to-one (1:1) activity attendance	F 248		



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F 248	<p>Continued From page 8</p> <p>records for Resident #8 revealed the facility scheduled 1:1 visits which included: read a devotional, apply a spray or lotion, pet a rabbit or bird, and see a toy doll or toy blocks for every visit for five (5) of seven (7) days in January and ten (10) of seventeen (17) days in February.</p> <p>Observation of Resident #8, on 02/21/12 at 3:25 PM and on 02/22/12 at 11:00 AM, 3:45 PM and on 02/23/12 at 10:05 AM, revealed the resident sitting in a wheel chair at the nurse's station. Observations, on 02/22/12 at 9:35 AM and 10:15 AM, revealed the resident sitting in a wheelchair in the women's lounge. The resident was not engaged in any activity.</p> <p>Review of the medical record for Resident #8 revealed the facility admitted the resident on 12/02/11 with diagnoses of Dementia and Hypertension. A significant change MDS assessment was completed by the facility on 12/09/11. The facility assessed the resident was cognitively impaired. The MDS revealed the resident preferred activities involving reading, music, animals, and groups, however the resident did not attend any group activities. The facility did not provide evidence of an activity care plan.</p> <p>Review of the activity attendance for 1:1 activities for Resident #8 revealed the resident was read a devotional, a spray or lotion was applied, and a stuffed animal was shown to the resident at each visit for fifteen (15) of twenty-two (22) days in January and eleven (11) of seventeen (17) days in February.</p> <p>Observation, on 02/21/12 at 3:35 PM, revealed Resident #8 lying in bed. Observations, on</p>	F 248	



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F 248	Continued From page 9 02/22/12 at 2:15 PM, 3:00 PM, 3:40 PM and on 02/23/12 at 1:00 PM, revealed the resident lying in bed. Observations, on 02/22/12 at 9:00 AM, 9:45 AM, 10:20 AM, 11:00 AM, 1:05 PM and on 02/23/12 at 10:15 AM and 10:55 AM, revealed the resident sitting in a wheelchair in the men's lounge watching television. Review of Resident #15's clinical record revealed the facility admitted the resident on 07/13/11 with a diagnosis of Dementia with Behavior Disorders. The admission MDS assessment completed on 07/28/11, revealed the resident preferred reading, group activities, and being outside. The quarterly (MDS) completed on 01/10/12 revealed the facility assessed the resident as severely cognitively impaired. The facility did not provide evidence of an activity care plan. Review of the 1:1 activity attendance record for Resident #15 revealed 1:1 visits consisted of reading a devotional, spray or apply lotion, and petting a stuffed animal on every visit for fifteen (15) of twenty-two (22) days in January and eleven (11) of seventeen (17) days in February. Observation of Resident #15, on 02/23/12 at 10:00 AM and 12:55 PM, revealed the resident walking in the facility. At 11:05 AM and 1:37 PM the resident was observed in the women's lounge watching television, not engaged with other residents or facility staff. The resident was not observed to attend any group activity. Interview with the Activities Director (AD,) on 02/23/12 at 3:40 PM, revealed the AD did not supervise the activity assistants as they knew what to do for the residents. She stated the	F 248			



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F 248	Continued From page 10 assistants do not tell her what they do for the residents, saying they just mark it, referring to writing the activity on the progress notes. She stated she had developed a list of activities for each resident, however she did not provide any evidence of a list.	F 248		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum	F 272	F 272 1. CORRECTIVE ACTION FOR RESIDENTS AFFECTED BY THIS PRACTICE: The MDS for Resident #2 has been corrected and transmitted indicating the unhealed pressure ulcer. The care plan was updated on February 28, 2012. 2. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED WERE IDENTIFIED: It is Friendship Manor's goal to produce an accurate MDS and care plan for all residents. To insure that no other resident was missed, all skin assessments for <u>all</u> residents will be reviewed for the presence of any skin issue and will look for corresponding documentation in the MDS and care plans. Skin assessments, MDSs and care plans will be reviewed by, Cheryl Baetzel RN, Vicki Swann RN, Jean Shepherd RN and Helen Grimes DON by March 30, 2012.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/23/2012
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40058	
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F 272	<p>Continued From page 11 Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the Weekly Wound Documentation Form, it was determined the facility failed to accurately assess and identify a pressure area for one (1) of the twenty-three (23) sampled residents (Resident #2). Resident #2's Minimum Data Set (MDS) did not contain information regarding a pressure ulcer present when the MDS was completed.</p> <p>The findings include:</p> <p>The facility did not provide a policy for resident assessments.</p> <p>Review of the quarterly MDS assessment, dated 12/29/11, revealed the facility assessed Resident #2 as having no unhealed pressure areas. Review of the weekly wound documentation form revealed a Stage II pressure area was first observed to the sacrum of Resident #2 on 11/22/11.</p> <p>Observation of the skin assessment for Resident #2, on 02/22/12 at 11:35 AM, revealed a Stage II</p>	F 272	<p>3. MEASURES OR SYSTEMIC CHANGES TO PREVENT RECURRENCE:</p> <p>Each MDS coordinator will be given a, written, weekly update from the skin nurse of all skin issues. A policy and procedure for this communication will be produced and presented to skin nurse and MDS nurses by March 30, 2012. Education for those involved will be provided by Cheryl Baetzel RN.</p> <p>4. HOW CORRECTIVE ACTIONS WILL BE MONITORED:</p> <p>All MDSs brought to our weekly care plan meeting will be QA'd by Cheryl Baetzel to ensure skin assessments are represented on the MDS and care plan. The Director of Nursing will continue to review 2 MDSs a week for accuracy of assessments. Results will be presented to the QA committee who will determine future need for monitoring the MDSs.</p>
			3-30-12



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F 272	<p>Continued From page 12</p> <p>pressure area to the Residents sacrum, measuring 1.5 centimeter (cm) x 2.0 cm x 0.2 cm.</p> <p>Interview with Registered Nurse (RN) #1, on 02/23/12 at 2:27 PM, revealed Resident #2 had chronic pressure area with a recent reopen. The RN revealed Resident #2 was first identified with recurrent areas in November. The RN revealed the MDS nurse did not complete a skin assessment, but discussed with the nurses if actual problems existed.</p> <p>Interview with MDS Coordinator #1, on 02/23/12 at 5:05 PM, revealed she did not do an actual skin assessment. The MDS Coordinator revealed she utilized the nurses notes in the computer and the skin assessment sheets to determine if an area needed to be captured on the MDS resident assessment. The MDS Coordinator revealed she did not discuss Resident #2 with the nursing staff and missed the identified skin area on the nursing documentation. The MDS Coordinator revealed she was ultimately responsible to ensure the residents had an accurate assessments, and revealed Resident #2 was not accurately assessed. The MDS Coordinator revealed accurate assessment are important to ensure payment and to provide holistic nursing care.</p> <p>Interview with the Director of Nursing (DON), on 02/23/12 at 6:05 PM, revealed the DON compared 1 or 2 residents a week with the facility assessed MDS. However, the DON revealed she was looking at the functionality of the resident and not the skin to ensure pressure areas are accurately assessed and captured on the MDS.</p>	F 272		



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F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and the facility's Procedure for MDS/Care Plan Process, it was determined the facility failed to develop a comprehensive care plan for one (1) of the twenty-three (23) sampled residents (#7). The facility did not develop a care plan to address Resident #7's need for oxygen therapy.</p> <p>This is a repeat deficiency</p> <p>The findings include:</p>	F 279	<p>F 279</p> <p>1. CORRECTIVE ACTION FOR RESIDENTS AFFECTED BY THIS PRACTICE:</p> <p>Resident #7 has been care planned for oxygen therapy. LPN #5 identified as failing to modify the care plan was counseled by the DON on March 13, 2012.</p> <p>2. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED WERE IDENTIFIED:</p> <p>All residents have the potential for a nurse not to update a care plan for a new order, therefore all nurses will be re-educated as indicated below. A review of all residents with orders for oxygen was completed by March 15, 2012. MDS nurses will review all care plans by March 30, 2012, to insure that all physician orders requiring care plans are present in the care plan and the CNA care plan. Any issues found will be corrected immediately and will be reported to the DON.</p>	

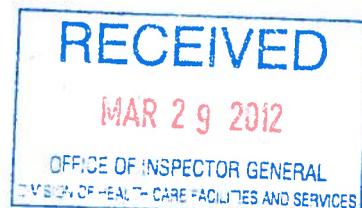


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F 279	Continued From page 14 Review of the facility's procedure for MDS/Care Plan Process revealed a Comprehensive Care Plan was to be completed within seven (7) days of a comprehensive assessment. All disciplines are responsible for entering their plan of care into the computer. Charge nurses are responsible to revise care plans as changes occur to include new diagnoses, skin problems, and acute illnesses. They must revise the existing hard copy on the chart. 1. The facility admitted Resident #7 on 10/5/11 with a diagnoses of chronic obstructive pulmonary disease (COPD) and long term use of steroids. The facility assessed Resident #7 on Minimum Data Set, dated 10/18/11, as requiring oxygen therapy while a resident. Observations on, 02/21/12 at 4:45 PM; 02/22/12 at 9:20 AM, 9:55 AM, 2:00 PM, and 3:30 PM, revealed Resident #7 in their room with oxygen in place. Observations on 02/21/12 at 3:25 PM, 5:30 PM, and 5:50 PM; 02/22/12 at 7:55 AM and 11:30 AM revealed the resident out of the room and self propelling a wheelchair in the facility without oxygen in place. Interview with Certified Nursing Assistant (CNA) #4, on 02/23/12 at 1:50 PM, revealed Resident #7 is not on the CNA care plan for oxygen therapy or to transfer with oxygen. The CNA revealed the nurses were responsible for the oxygen and she notified the nurse if the Resident became short of air.	F 279	3. MEASURES OR SYSTEMIC CHANGES TO PREVENT RECURRENCE: Nurses were re-educated on one of the following days, March 15, 20, 21, 22 or the 23rd by our Director of Nursing and Staff Development Nurse. Education covered the importance of care planning. Training included the need to care plan physician orders for some meds, treatments and therapies such as oxygen therapy which should include type of oxygen, amount, monitoring and use of oxygen outside of the resident's room. The DON and our MDS nurses will review <u>all</u> new orders or any change of current orders each weekday, to insure that the order, if needed, has been correctly care planned. 4. HOW CORRECTIVE ACTIONS WILL BE MONITORED: Our computer system generates a message for each new order. The DON and MDS nurses will review those orders and will then check with the charge nurse or just pick up the chart to insure that appropriate orders have been care planned. The DON and 2 of the MDS nurses, doing the daily reviews, are part of our monthly QA Committee. They will report their finding to the committee. Based on their finding the QA committee will determine if additional education is needed to ensure continued compliance.	

3-30-12



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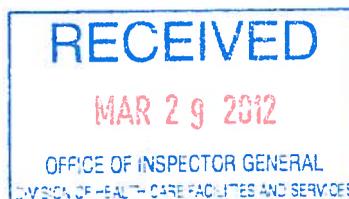
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F 279	Continued From page 15 Interview with Licensed Practical Nurse (LPN) #5 North Hall Charge nurse, on 02/23/12 at 2:15 PM, revealed she was not aware the resident did not have a care plan for oxygen therapy, and did not think of developing a care plan to address this need. The Charge nurse revealed inconsistent care could potentially result in the Residents oxygen saturation dropping below 90 percent. Interview with the Minimum Data Set (MDS) Coordinator, on 02/23/12 at 4:50 PM revealed she had missed the use of oxygen therapy during development of the comprehensive care plan. The MDS Coordinator revealed she used the triggered areas in the care area assessment on the MDS, physician orders, treatment administration record, progress notes, and the Resident's diagnoses to develop the care plan. The MDS Coordinator revealed a potential problem would be the nursing staff not monitor the resident for respiratory problems related to oxygen therapy. The MDS Coordinator revealed the care plan drove the nursing care and helped to evaluate the effectiveness of treatments. The MDS Coordinator revealed she was responsible to develop the initial care plan, but stated both nursing and MDS was responsible to ensure they being developed.	F 279			
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.	F 309			

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F 309	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to follow Physician's orders for three (3) of twenty (23) sampled residents (Resident #3, 2 and 7). Resident #3 had a Physician's order for wound care that was not followed correctly. In addition, the facility failed to follow Physician's orders to maintain oxygen saturation at 90% or greater for Residents # 2 and #7. The findings include: Review of the facility's M.D. Order Policy, (undated), revealed MD orders are to be followed according to the direction of the physician. Interview with the Director of Nursing (DON), on 02/23/12 at 4:30 PM, revealed nurses were required to follow physician orders for resident care. She stated nursing could not change the orders for pressure ulcer care or oxygen therapy without physician orders. She stated she did not have a routine for supervising the nurses to ensure their skills were proficient. 1. Clinical record review for Resident #3 revealed the facility received a Physician's order, on 11/17/11, to cleanse the resident's bilateral heels and bilateral great toe wounds with Normal Saline (Sodium Chloride). Interview with Registered Nurse (RN) #1, on	F 309	F 309 1. CORRECTIVE ACTION FOR RESIDENTS AFFECTED BY THIS PRACTICE: RN #1, LPN #4 and LPN #5 involved with residents #3, #2 and #7 were re-educated on March 13th by DON and Staff Development Nurse. Resident #3 is receiving wound care exactly as order by the physician. Residents #2 and #7 are receiving oxygen and O2 stats are being monitored every shift to provide oxygen as ordered by the physician. 2. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED WERE IDENTIFIED: All residents were identified as having the potential to be affected, therefore all nursing staff will required to be re-educated as indicated below. 3. MEASURES OR SYSTEMIC CHANGES TO PREVENT RECURRENCE: On March 15, 20, 21, 22 and 23, 2012 nurses were re-educated and tested for competency in how to transcribe and carry out physicians orders. Education also included care planning, wound care and oxygen administration. Education was provided by our DON and Infection Control Nurse.	



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F 309	Continued From page 17 02/23/12 at 1:15 PM, revealed he used wound cleanser spray instead of the NS irrigation solution as ordered by the physician. RN #1 said he had been told it was okay to use the wound cleanser instead of the NS, but would call the pharmacy to confirm. He did not verbalize the need to call the physician to clarify the wound care orders. The RN was aware the physician's order was to use NS. Observation of the East Wing treatment cart, on 02/23/12 at 11:30 AM, revealed two (2) containers of Sodium Chloride irrigation solution for Resident #3 were opened and not labeled with the opening date. The containers of irrigation solution were partially used and had a delivery date of 01/17/12. Hanging on the side of the treatment cart were three (3) opened bottles of wound cleanser, not labeled with residents name or open date. 2. The facility admitted Resident #2 with the following diagnoses: Stroke; Subarachnoid Hemorrhage; and Chronic Airway Obstruction. The facility assessed the resident, on 12/29/11, as requiring oxygen therapy. Physician orders, dated 02/10/12, revealed oxygen should be at 2 liter per minute per nasal cannula, and may titrate the flow rate to keep saturation greater than 90 percent. Observation of Resident #2, on 02/21/12 at 4:45 PM and 5:30 PM, revealed the resident sitting up in a Geri-chair in the dining room eating lunch with no oxygen in place. Observation, on 02/22/12 at 7:55 AM, revealed the resident sitting	F 309	Care plans for oxygen use will be required to include frequency of monitoring oxygen stats. A new policy will be written stating that oxygen stats will be recorded at a minimum of once every shift on all residents currently utilizing oxygen therapy. The policy and procedure will be written and education given at the meetings mentioned above. Physicians orders will now be reviewed and signed by a second nurse to insure accuracy. The DON and MDS nurses will audit all physician orders on a daily basis. Our computer system generates a message for each new order entered into the system. Each order will be reviewed to ensure appropriate orders are carried over to the care plan. 4. HOW CORRECTIVE ACTIONS WILL BE MONITORED: The DON and MDS nurses will audit all physician orders on a daily basis. Each order will be reviewed to ensure appropriate orders are carried over to the care plan as the physician ordered. The DON will summarize findings to the Monthly QA meeting. Quarterly the QA committee will determine if more training is required.		



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F 309	Continued From page 18 In the television room with no oxygen in place. Observation, on 02/22/12 at 12:00 PM, revealed Registered Nurse (RN) #1 removing the residents oxygen and leaving it in the room, then transporting the resident to the dining room with no oxygen in place. Observation, on 02/23/12 at 11:20 AM, revealed a nursing assistant transported Resident #2 to the dining room without oxygen and leaving them unattended without oxygen in place. Upon request, the Minimum Data Set (MDS) Coordinator obtained a oxygen saturation of the resident in the dining room, on 02/23/12 at 11:35 AM, which revealed an oxygen saturation of 89 percent and dropped to 84 percent when the resident began talking. Observation of the MDS Coordinator, on 02/23/12 at 11:40 AM, revealed the nurse brought the residents oxygen concentrator into the dining area and applied oxygen at 2 liters per minute per nasal cannula. The oxygen saturation rose to 93 percent. Interview with RN #3, on 02/23/12 at 3:00 PM, revealed Resident #2 should be on oxygen at 2 liters and the nurse may titrate to keep the oxygen saturation above 94 percent. The RN revealed the oxygen saturation was checked before the resident was assisted out of bed and after the resident was returned to bed, although this information was not recorded. The RN revealed a potential for hypoxia and oxygen deprivation to the tissues. Interview with RN #1 East wing charge nurse, on	F 309	A sample of six residents requiring a treatment will be monitored 1 time a week for 4 weeks and there after once a month. Monitoring will evaluate if the procedure is being performed as ordered by the physician. Monitoring will be done by Vicki Swann MDS RN, Jean Shepard MDS RN, and Sheila Townsend (Staff Development Nurse). After Sheila Townsend reports findings to the QA committee, the committee will determine, on a monthly basis, further requirements for monitoring, either increasing or decreasing the scope and frequency of observations.	3-30-12	



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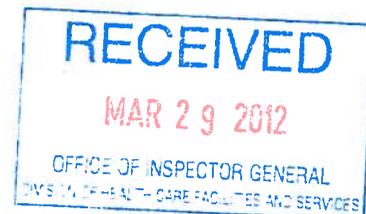
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F 309	<p>Continued From page 19</p> <p>02/23/12 at 2:27 PM, revealed there was no set monitoring system for oxygen saturation of the residents with oxygen. The RN revealed a potential problem was the oxygen level to desaturate. The RN revealed the resident's geri-chair was not adapted for the use of a portable tank, but was easily able to find a cylinder caring case in the storage closet on observation during the interview. The RN revealed Resident #2 should be wearing oxygen when out of bed. RN #1 revealed each nurse was responsible to monitor the oxygen saturation, and stated the Resident had never been assessed for the need for portable oxygen.</p> <p>3. Record review revealed the facility admitted Resident #7 with the following diagnoses: Chronic Obstructive Pulmonary Disease (COPD) and long term steroid use. The Facility assessed the Resident, on 10/18/11, as requiring oxygen therapy while a resident at the facility and oriented to person, place and time on 01/03/12. Physician orders, dated 02/10/12, revealed an order for oxygen at 3.5 liters per minute per nasal cannula to maintain oxygen saturation greater than or equal to 90 percent.</p> <p>Observation, on 02/21/12 at 3:25 PM, 5:30 PM, and 5:50 PM; 02/22/12 at 7:55 AM and 11:30 AM, revealed the resident sitting up in the wheelchair self propelling around the facility with no oxygen in place.</p> <p>Interview with the Resident, on 02/22/12 at 9:55 AM, revealed the resident was never offered a portable oxygen tank. The Resident stated sometimes feeling short of air and had to return</p>	F 309			



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F 309	<p>Continued From page 20 to the room to get some oxygen and feel better.</p> <p>Observation of Resident #7 in the dining room without oxygen in place, on 02/23/12 at 12:30 PM, revealed the Licensed Practical Nurse (LPN) #5 North Hall charge nurse checked the oxygen saturation with a result of 81 percent. LPN #5 escorted resident back to their room and reapplied oxygen. The LPN asked the resident if they wanted to eat in their room, and the resident replied they did not. The LPN informed the resident they could put the oxygen concentrator in the dining room, and the resident replied it was all right, they did not need it. The oxygen saturation was rechecked and had increased to 90 percent.</p> <p>Observation of Resident #7 in a bingo activity with no oxygen in place, on 2/23/12 at 2:05 PM revealed LPN #4 checked the oxygen saturation with a result of 88 percent.</p> <p>Interview with LPN #4, on 02/23/12 at 2:07 PM, revealed she was not aware if the resident had a care plan or if the resident had specific physician orders regarding oxygen or oxygen saturation. The LPN revealed a potential for the resident to have increased confusion and an overall decline with low oxygen saturations. The LPN revealed the facility did provide portable oxygen tanks; however, the resident's wheelchair had not been adapted to fit the oxygen tank. The LPN revealed the Resident was very mobile and did not like to be strapped to the large oxygen concentrator that was kept in the room.</p>	F 309	



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F 309	<p>Continued From page 21</p> <p>Interview with LPN #5, on 02/23/12 at 2:15 PM, revealed the resident's oxygen saturation should be kept greater then 90 percent. The LPN revealed the resident wore the oxygen when they were in the room, but took it off to attend activities or meal service. The LPN revealed they had not been monitoring the resident's oxygen saturation when they were off of the oxygen and they had not assessed the Resident for portable oxygen. The LPN revealed she was responsible to ensure the resident maintained the oxygen saturation ordered by the physician.</p> <p>Interview with the Director of Nursing (DON), on 02/23/12 at 6:05 PM, revealed a potential for the residents to sustain respiratory problems by not monitoring their oxygen saturation. The DON revealed she did make rounds in the mornings on the residents, but stated Resident #2 and #7 had always been in their rooms on the oxygen.</p> <p>4. Review of the medical record for Resident #3, revealed the facility admitted the resident on 01/03/12 with diagnoses of Anemia, Neurogenic Bladder with an Indwelling Catheter, Dementia and Parkinson's Disease with an Impaired cognition. The facility completed an admission Minimum Data Set (MDS) assessment on 01/10/12, which revealed the resident required the total care of two (2) persons for bed mobility, toilet use, and personal hygiene. The facility assessment of Resident #3's skin on 02/22/12 at 11:00 AM revealed the resident was at a moderate risk for pressure sores. The nursing notes, dated 01/14/12, indicated the presence of blisters on both heels and the great toes with orders for dressing changes; however, the facility</p>	F 309	



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F 309	Continued From page 22 did not document these pressure sores on the admission MDS assessment completed on 01/10/12.	F 309		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431 F 431	1. CORRECTIVE ACTION FOR RESIDENTS AFFECTED BY THIS PRACTICE: No residents are mentioned as being affected by the deficient practice. Please see section 2. On February 24, 2012 all opened and undated biological wound cleanser solutions were discarded. All solutions currently being used are dated and labeled as dictated by our policies. 2. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED WERE IDENTIFIED: Friendship Manor recognizes that all residents are to be provided care and treatments with properly dated, labeled and stored irrigation solutions and wound cleansers. Therefore, all residents could be affected. 3. MEASURES OR SYSTEMIC CHANGES TO PREVENT RECURRENCE: Our pharmacy consultant provided education to nurses on March 23, 2012 and provided a QA review of all wound carts.	



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F 431	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to store and label irrigation solutions and wound cleansers in accordance with currently accepted professional principles and facility's policies. In one (1) of three (3) treatment carts the facility failed to label with open dates two (2) opened containers of irrigation solution. In addition the irrigation solutions were expired. The facility also failed to label three (3) opened containers of wound cleanser spray with residents' names and the date opened. The containers of wound cleanser were being used for multiple residents and were hanging on the outside of the treatment cart. The findings include: Review of the facility's policy for Labeling and Storage of Medications and Biologicals, Rev. 22, 12-15-06, revealed the medication label at a minimum will include the medication name and strength, the expiration date when applicable, and typically includes the resident's name, route of administration, and appropriate instructions. For medication designed for multiple administrations the label is affixed in a manner to promote administration to the resident for whom it was prescribed. All irrigation solutions are ordered on an individual basis, labeled, and are good for 30 (thirty) days after the seal is opened and dated. All wound cleanser is stored in a locked treatment	F 431	Two Nurses, Heather Downs and Renee Lord have agreed to serve as our Skin Nurses. They will, as part of their duties, QA the wound cart weekly for 4 weeks and then monthly unless the QA committee determines more or less monitoring is needed. The Two nurses will report finding to the Director of Nursing who will pass on the finding to the QA committee. 4. HOW CORRECTIVE ACTIONS WILL BE MONITORED: The Staff Development Director, as part of her QA duties, will inspect all wound carts once per month to ensure the skin nurses are thoroughly inspecting the wound carts. Findings will be brought to the monthly QA committee to help in determining further monitoring and educational needs.	4-02-12	



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F 431	<p>Continued From page 24 cart.</p> <p>Interview with the Director of Nursing (DON), on 02/23/12 at 4:30 PM, revealed opened bottles of biologicals were required to be dated and labeled when opened per facility policy and community wound cleanser were not allowed. She stated all residents with treatments were to have their own supplies labeled with the residents' name and prescription. She indicated supplies must be discarded when expired and the nurse was responsible to check the supplies on the cart.</p> <p>Observation of the East Wing Treatment Cart, on 02/23/12 at 11:30 AM, revealed two (2) containers of opened, expired Sodium Chloride (NS) irrigation solution that was not labeled with the open date for Resident #3. The containers of irrigation solution were partially used and had a delivery date of 01/1/12. Three (3) opened containers of wound cleanser were hanging on the outside of the treatment cart. The wound cleansers were not labeled with the resident's name, instructions for use or the opening date.</p> <p>Interview with Registered Nurse (RN) #1, on 02/23/12 at 1:15 PM, revealed he was not using the expired NS irrigation solution, but was using the wound cleansers that were hanging on the outside of the irrigation cart. RN #1 said he was told by the Pharmacy that he could use the wound cleanser instead of the NS. RN #1 said he would call the Pharmacy to confirm this and would throw away the expired NS. The RN said he was using the wound cleansers on Resident #3, one other unsampled resident with a sacral pressure wound, and on any resident who</p>	F 431		



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F 431	Continued From page 25 sustained a skin tear. The RN was unaware of the facility's policy on labeling and dating irrigation solutions and did not know irrigation solutions were good for only 30 days after the seal was opened. The RN said he would have to review the facility's policy.	F 431			
F 441 SS=E	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.	F 441	F 441 1. CORRECTIVE ACTION FOR RESIDENTS AFFECTED BY THIS PRACTICE: RN #1, RN#3, LPN #6 and CNA #2, staff identified as providing care for residents #2, #3 and #8, were re-educated on March 13, 2012, by Director of Nursing and Infection Control Nurse regarding following our infection control policies. Residents #2, 3 and 8 are receiving dressing changes and skin assessments according to our hand hygiene policies. 2. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED WERE IDENTIFIED: All residents were identified as having the need to receive treatments and skin assessments according to Friendship Manor's policies, therefore all staff are being re-educated as described below.		



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F 441	Continued From page 26 (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, review of the CDC guideline for Hand washing techniques, CDC (Center for Disease Control) Guideline for Hand Hygiene in Health-Care Settings, the facility's policy and procedures for infection control, it was determined the facility failed to maintain an Infection Control Program to prevent the development and transmission of disease and infection. Hand washing was not observed during two (2) dressing changes and a (1) skin assessments for three (3) of twenty-three (23) sampled residents (Residents #2, #3 and #8). The facility treatment cart was brought into the residents room for two (2) of twenty-three (23) sampled residents while the nurse completed wound care. A nurse was observed using her bare hands to turn off the water after washing her hands. This is a repeat deficiency. The findings include: Review of the Infection Control Manual revealed the manual was undated and there was no evidence provided to determine if the manual was reviewed or approved by the Infection Control Committee.	F 441	3. MEASURES OR SYSTEMIC CHANGES TO PREVENT RECURRENCE: All Nurses were re-educated on one of the following days, March 15, 20, 21, 22, or 23rd, 2012 by our DON and our Infection Control Nurse regarding proper hand hygiene and infection control. Inservice will also include placement of wound cart during treatments and on proper use of personal protective equipment On March 23, 2012 CNAs, CMTs and restorative aides will be re-educated by our Infection Control Nurse on infection control with emphasis on proper hand hygiene. Our SD/IC Nurse will provide daily make up sessions for those who could not attend on the 23rd. CNAs not attending one the sessions will be taken off the schedule beginning April 02, 2012.		



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F 441 Continued From page 27

Review of the CDC Guidelines for Hand Hygiene in Health-Care Settings, dated 10/25/02, revealed the following indications for handwashing and hand antisepsis: decontaminate hands before having direct contact with patients; decontaminate hands after contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings; change gloves during patient care if moving from a contaminated body site to a clean body site; decontaminate hands after removing gloves; and decontaminate hands after having contact with inanimate objects in the immediate vicinity of the patient.

Review of the CDC guidelines for How to Handwash, May 2009, revealed a towel should be used to turn off the faucet.

Review of the facility policy on Handwashing/Hand Hygiene, revised 08/08, revealed employees must wash their hands before and after direct contact with resident, after contact with blood, body fluids, secretions, and mucous membranes or non-intact skin and after removing gloves. The facility policy also included employee use of Alcohol-Based Hand Rub if hands were not visibly soiled for the following situations: Before and after direct contact with residents, before moving from a contaminated body site to a clean body site during resident care, after handling used dressings, and contaminated equipment and after removing gloves.

Record review of the facility policy on Wound Care/Treatment Guidelines dated 2007, revealed

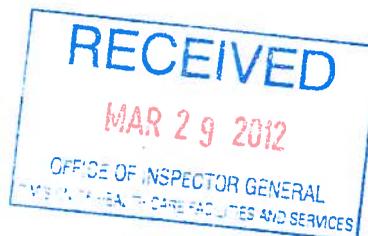
F 441

4. HOW CORRECTIVE ACTIONS WILL BE MONITORED:

Starting on March 19, 2012 a sample of 6 residents requiring skin assessments or dressing changes, to include residents #2, #3 and #8, and residents representing all three units will be monitored 3 times a week for 4 weeks and once a week thereafter. Monitoring will include hand hygiene and cart placement. Monitoring will be done by Vicki Swann MDS RN, Jean Shepard MDS RN, and Sheila Townsend (Infection Control Nurse).

After Sheila Townsend reports findings to the monthly QA committee, the committee will determine, on a monthly basis, further requirements for monitoring and education. Friendship Manor will continue to monitor infection control indefinitely but the QA committee will determine the scope and frequency of observations.

3-30-12



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F 441	Continued From page 28 the cart should be left in the hall and locked. Interview with the Director of Nursing (DON), on 02/23/12 at 4:30 PM, revealed nurses were not allowed to take the treatment cart into a resident's room while doing a wound dressing change treatment. She stated the facility had a policy which specifically stated the treatment cart must remain in the hallway. She indicated nurses were required to thoroughly wash their hands prior to donning gloves to do a treatment and hands were washed and gloves changed anytime the treatment went from a soiled task to a clean task, including changing a soiled resident into clean clothing. She stated nurses were trained to do aseptic dressing changes and prevent the transmission of organisms. She stated infection control measures were indicated during skin assessments with hand washing and glove changes when going from an area of the body considered dirty and an area considered clean. She revealed records of infections were reviewed by the Quality Assurance Committee quarterly. She stated all biologicals on the treatment cart were labeled and dated when opened per facility policy and communal wound cleanser was not allowed. She revealed each resident with a treatment required their own supplies which were to be dated, labeled with the resident's name and the prescription for the use of the item. Observation, on 02/22/12 at 11:00 AM, during Resident #3's wound care and skin assessment revealed Registered Nurse (RN) #1 with gloved hands entered the resident's room and touched the resident's door and privacy curtain. He was not observed washing his hands prior to the	F 441			



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F 441	<p>Continued From page 29</p> <p>dressing change. Upon entering the resident's room, the treatment cart was parked at the foot of the resident's bed with opened dressing supplies and medications for the resident's dressing change. During the dressing change RN #1 was observed opening a drawer on the treatment cart and reaching in to retrieve an unopened dressing supply with the same gloved hands. The RN removed the resident's soiled dressings and placed new dressings to both the resident's feet and toes without removing the soiled gloves, washing his hands and putting on new gloves.</p> <p>Observation, on 02/23/12 at 11:30 AM, revealed RN #1 leaving Resident #3's room without performing hand hygiene and rolling the treatment cart down the 300 unit hall to perform another dressing change with a different resident.</p> <p>Interview, on 02/23/12 at 2:30 PM, with RN #1 revealed the facility had not provided him with any wound care training and he had not been trained to keep the treatment cart in the hall when he provided treatments to the residents. RN #1 stated it was possible to cross-contaminate from resident room to resident room. RN #1 revealed he did not clean the treatment cart in between resident rooms. He further stated he had reached into the treatment cart with dirty gloves and should have removed his gloves and washed his hands. RN #1 acknowledged he had used one pair of gloves for Resident #3's dressing change without washing his hands and stated he should have changed his gloves after taking resident soiled dressings off. The nurse revealed he was not sure what the facility's policy was for hand hygiene and his lack of hand hygiene and glove changes were not good nursing practice.</p>	F 441		



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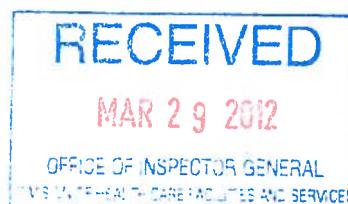
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F 441	<p>Continued From page 30</p> <p>Observation, on 02/22/12 at 2:10 PM, with RN #3 revealed while washing her hands in a resident room she used her bare hands to turn the water off.</p> <p>Interview, on 02/23/12 at 2:40 PM, with RN #3 revealed she could have turned the water off with her bare hands and stated the facility policy was to perform handwashing before and after resident contact and use a paper towel to turn the water off at a sink. RN #3 acknowledged transferring infection to one another by the lack of hand hygiene was a risk to the facility residents and staff.</p> <p>Observation of the dressing change and skin assessment on Resident #2, on 02/22/12 at 11:35 AM, revealed Registered Nurse (RN) #1 entered the room with the treatment cart and parked it to the left of the resident's bed. RN #1 did not wash her hands or use hand sanitizer and applied gloves. The nurse started at the resident's head and worked his way down to the perineal area. The RN removed Resident #2's brief, which was saturated with liquid, and rolled the brief up under the resident. The RN removed the dressing from Resident's sacrum and measured the wound. Without performing hand hygiene or removing the contaminated gloves, the RN stuck his finger into a container of santyl and Bactroban ointment, smeared the contents onto a mepilex dressing and applied it over the wound without cleaning the wound bed. The RN did not perform hand hygiene or change gloves, and proceeded to</p>	F 441	



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F 441	Continued From page 31 perform peri/incontinence care and applied a clean brief. Without changing gloves or performing hand hygiene, the RN applied a clean pair of pants on the resident, assisted the resident to the geri chair utilizing a Hoyer lift. Without changing gloves or performing hand hygiene, the RN removed the resident's oxygen, and transported the resident to the dining room. Interview with RN #1 Charge Nurse for East wing, on 02/23/12 at 2:27 PM, revealed he was responsible to complete the resident's skin assessment. The RN revealed he started performing the skin treatments approximately a month ago. The RN revealed he did not receive training on skin care prior to assuming this responsibility. The RN revealed he had not received training on care of treatment cart. The RN revealed there could be a potential for indirect contact transmission of infection by taking the cart from room to room. The RN revealed he did not clean the cart between residents. The RN revealed hand hygiene and glove changes should have been completed during residents and during procedure. The RN acknowledged a potential for organisms to contaminate the container of ointment, and a potential for cross contamination by not practicing proper hand hygiene during wound care and skin assessments. Interview with the Staff Development/Infection Control Nurse, on 02/23/12 at 5:37 PM, revealed handwashing was covered in every in-service provided by the facility, the last of which was approximately a month ago. The Nurse revealed impromptu surveillance rounds were completed	F 441		



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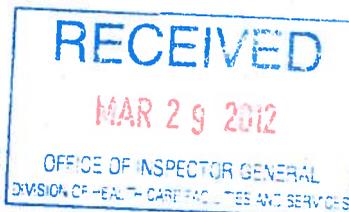
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/23/2012
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 32 using a black light, but she had focused mainly on nursing assistants and not the nurses. The Staff Development/Infection Control nurse revealed the facility no longer had a wound treatment nurse, and training was not provided to the nursing staff on wound care. The Staff Development/Infection Control nurse revealed monitoring for infection control was completed monthly by using the Monitoring Compliance with Infection Control Checklist, which did have an area for wound care observation. The Nurse revealed she had observed a nurse use their finger to retrieve ointment from a container once before, but provided one on one training and not a facility wide in-service. The Staff Development/Infection Control Nurse revealed she had focused so much of her monitoring and training towards the nursing assistants because it was basic nursing on dressing change techniques. The Staff Development/Infection Control Nurse revealed a potential for introducing bacteria to wounds and resident. The nurse revealed the treatment carts should never go into the resident's room. Observation, on 02/23/12 at 1:30 PM, of a skin assessment on Resident #8 revealed Licensed Practical Nurse (LPN) #6 and Certified Nurse Assistant (CNA) #2 did not wash their hands between changing gloves while doing a skin assessment going from clean to dirty. The LPN was observed to assess the resident's body then assess the resident's mouth without washing her hands. The CNA removed the resident's soiled brief and applied a clean brief and topical cream. He then assisted the LPN with maneuvering the resident for the skin assessment. He did not wash his hands when going from soiled to clean.	F 441		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/23/2012
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40058		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 441	Continued From page 33 Interview, on 02/23/12 at 1:40 PM, with LPN #6 revealed hands should be washed when gloves are changed. She stated she did not wash her hands between glove changes and should have. She stated a potential problem could be touching a dirty area followed by touching a clean area. Interview with CNA #2 on, 02/23/12 at 1:42 PM, revealed hands should be washed between changing gloves. The CNA stated he did not wash hands when changing gloves and stated he should have.	F 441			
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure handrails were firmly secured to the walls. The findings include: The facility did not provide a written policy for maintaining the facility. Observation, on 02/22/12 at 4:00 PM and 02/23/12 at 2:00 PM, revealed the handrail outside Rooms # 222, 224, 225, 304 and 317 were loose. Interview with the Director of Maintenance, on 02/23/12 at 10:30 PM, revealed he had no	F 468	F 468	1. CORRECTIVE ACTION FOR RESIDENTS AFFECTED BY THIS PRACTICE: No residents are mentioned as being affected by the deficient practice. Please see section 2. Loose handrails have been repaired. 2. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED WERE IDENTIFIED: Loose handrails could occur anywhere in the building and since handrails are used by many residents, All residents all residents have identified as having the potential to be affected.	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/23/2012
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40058		
(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 468	Continued From page 34 maintenance schedule for inspection of handrails. He stated the facility handrails were checked periodically and no logs were kept on handrail inspections. The Director of Maintenance revealed the system for handrail repair was based on work orders placed by facility staff. Interview with the Administrator, on 02/23/12 at 5:45 PM, revealed he was not aware of any loose hand rails in the facility. The Administrator stated handrails were repaired based on work orders given to the maintenance department. He further stated if something was broken it should be repaired.	F 468	3. MEASURES OR SYSTEMIC CHANGES TO PREVENT RECURRENCE: Don Campbell from the maintenance department will check all rails once a quarter. This will be added to his list of quarterly duties. He will sign off on this inspection as he does on all his other duties. 4. HOW CORRECTIVE ACTIONS WILL BE MONITORED: The Maintenance Director will review Don's work assignment sheet to verify that the inspection has been completed. The Administrator, who is also a member of the QA committee, will ask to see the assignment sheet once a quarter. The Administrator and Human Resource Director, who is a member of the QA committee and who performs some life safety checks for the Administrator, will also randomly check rails, every month, to ensure handrails are secure and will report finding to the monthly QA committee.	3-16-12	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/22/2012
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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1968, 1988</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V Protected.</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Two (2), Type II generators. Fuel source is diesel. One (1), Type II generator. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was conducted on 02/22/12. Friendship Manor was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.