

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

PRINTED: 03/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/18/2011
NAME OF PROVIDER OR SUPPLIER CALVERT CITY CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029		
(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)	(X6) COMPLETION DATE	
F 000	INITIAL COMMENTS An annual survey and abbreviated surveys (KY #15551, KY #15552 and KY #15930) were conducted 02/15-18/11 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "E". KY #15552 was unsubstantiated with no deficiencies cited. KY #15551 & #15930 were substantiated with no deficiencies cited.	F 000			
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	1) Resident #10 is no longer a resident in the facility therefore no corrective action could be accomplished. 2) All residents have the potential to be affected by the deficient practice. 3) Licensed nurses have been educated to always contact the resident's interested family member or legal representative and to advise the cognitive resident of any new orders received. They shall document the notification directly on the physician's telephone order in the appropriate place. The education was provided by the Director of Nursing (DON) on 3/21/2011. 4) The RN Unit Supervisors will do a daily visual check of new physician's orders to ensure the interested family member or legal representative has been contacted, followed by the LPN QI Coordinator performing 10 random bi-weekly		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: ADMINISTRATOR (X6) DATE: 3/23/11

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

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F 157	<p>Continued From page 1</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to ensure notification of a change in treatment was provided the interested family member for one resident (#10), in the selected sample of 18. The resident had a Urinary Tract Infection (UTI) and an antibiotic was ordered. Findings include:</p> <p>Review of the policy, "Notification of Physician" (undated), revealed the facility would notify the attending physician of any changes in the resident's condition. The charge nurse on duty was responsible for ensuring the family was notified of these changes and of new orders.</p> <p>1. Resident #10 was readmitted to the facility on 01/04/11, with diagnoses to include UTI and Chronic Kidney Disease. A review of the quarterly Minimum Data Set (MDS), dated 11/29/10, revealed the facility identified Resident #10 as frequently incontinent of the bladder.</p> <p>A review of "Telephone Orders", dated 01/12/11 and 02/05/11, revealed a order was received for an antibiotic to treat a Urinary Tract Infection (UTI). There was no documented evidence the facility notified the resident's family.</p> <p>An interview with Licensed Practical Nurse #2, on 02/18/11 at 11:15 AM, revealed if she received a</p>	F 157	<p>visual checks of the new physician's telephone orders to monitor for compliance with family/cognitive resident notification. The ongoing visual checks completed by the RN Unit Supervisors and LPN QI Coordinator will be logged as performed to track facility compliance. Any noncompliance is to be reported to the DON. 5) Completion Date: March 25, 2011</p>	03/25/11

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F 157	Continued From page 2 new order for a resident, she notified the family and made a notation on the actual order, as opposed to documenting the notification in the nurse's notes. If she was unable to contact a family member, she informed the resident of the new order. An interview with Registered Nurse #2, on 02/18/11 at 3:30 PM, revealed a resident's family should be notified of any new order. If a resident was cognitively intact, family might not be notified. She stated Resident #10 had recently experienced a decline cognitively. A interview with the Director of Nursing, on 02/18/11 at 4:00 PM, revealed she expected staff to notify the resident's family of any new orders. If the nurse was unable to contact a family member, they should "keep trying".	F 157		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed ensure services provided or arranged by the facility, met professional standards of quality for one resident, (#10), in the selected sample of 18 and one resident (#25), not in the selected sample. The facility failed to ensure a repeat urinalysis (UA) was obtained in accordance with physician's orders for Resident #10.	F 281	1) Resident #10 is no longer a resident in the facility therefore no corrective action could be accomplished. The physician was contacted regarding resident # 25 and advised of the resident refusing to accept the ordered method of medication administration of her Niferex, Miralax, and Questran. The Niferex has been discontinued and orders were received to administer the Miralax and Questran mixed in strawberry mighty shake. CMA # 1 was verbally instructed by the DON on 3/7/2011 to always give medications exactly as ordered, never alter the ordered method of administration, and to report any	

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F 281	<p>Continued From page 3</p> <p>The facility failed to administer medications in accordance with the physician's orders for Resident #25. Findings include:</p> <p>1. A record review revealed Resident #10 was readmitted to the facility on 01/04/11, with diagnoses to include Urinary Tract Infection (UTI) and Chronic Kidney Disease. A review of the quarterly Minimum Data Set (MDS), dated 11/29/10, revealed the facility identified Resident #10 as cognitively intact and frequently incontinent of the bladder.</p> <p>A review of "Telephone Orders" dated 01/12/11, revealed an order for an antibiotic for ten days to treat a UTI, with a repeat UA, to be obtained in ten days, which was due on 01/22/11. However, there was no documented evidence in the clinical record the repeat UA was obtained, until 02/03/11.</p> <p>An interview with Licensed Practical Nurse (LPN) #2, on 02/16/11 at 3:20 PM and 02/18/11 at 11:15 AM, revealed the repeat UA was not obtained as per physician's order. LPN #2 stated she attempted to collect the urine specimen on 01/23/11, however, the specimen was contaminated. No action was taken to collect the urine specimen and the resident's primary physician made rounds on 02/02/11. At that time, the physician was informed the UA had not been collected. The physician requested the UA be obtained, however, an order was not written. LPN #2 stated she considered the physician's request to be, "an extension of the original order". She stated normally the interaction would have been documented in the nurse's note, however, she did not document the physician's statement.</p>	F 281	<p>refusals immediately to the nurse so she can notify the physician for further orders.</p> <p>2) All residents have the potential to be affected by the same deficient practice.</p> <p>3) Licensed Nurses were in-serviced on 3/21/2011 by the DON on proper procedure & protocol related to obtaining a urinalysis. In-service content included: The physician must be notified immediately if an order hasn't been completed so they can obtain any further orders. There are no standing orders for catheterization. It is unacceptable to catheterize a resident without a physician's order. They must have a physician's order for a follow up UA. All interaction with the physician should be documented in the nurses notes and an order be written on the physicians telephone orders. If a follow up UA is ordered the nurse receiving the order is responsible for placing it on the calendar at the nurse's desk on the appropriate date. The nurses were instructed to review the daily calendar at the beginning of their shift for any labs/tasks that have been ordered. Once the task is complete they will mark it off the calendar as done with their initials beside that task. Nurses also need to look back a few</p>		

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F 281	<p>Continued From page 4</p> <p>A review of the physician's progress notes, dated 02/02/11 at 3:10 PM, revealed no information related to request for the UA. A review of "Telephone Orders", dated 02/02/11 at 3:10 PM, revealed no new order for a UA.</p> <p>An interview with LPN #3, on 02/18/11 at 10:30 AM, revealed he was the "night shift" charge nurse, on 02/02/11. A note was left at the nurse's desk requesting the urine specimen. He did not know the reason for the request and he stated, "I just figured the resident had completed an antibiotic." He stated if a UA was not obtained as ordered, the physician should be notified and new orders written. LPN #3 stated he collected the urine specimen by catheterization, because the resident was unable to urinate. He did not have a written order for catheterization and did not call the physician. He stated, "I did not know I had to."</p> <p>An interview with LPN #2, on 02/18/11 at 11:15 AM, revealed the "night shift" charge nurse collected the catheterized urine specimen on 02/03/11, because the resident's physician had "standing orders" to catheterize a resident, if unable to be obtain by voiding.</p> <p>A review of, "Physician's Standing Orders Pertaining to Suspected UTI's" (undated), revealed a urine specimen should be obtained and sent to the lab. The results would be sent to the physician's office for further orders. The "standing orders" did not include catheterization in the event the resident was unable to void and were not signed by the physician.</p> <p>An interview with the resident's primary physician, on 02/17/11 at 3:45 PM, revealed when a repeat</p>	F 281	<p>days on the calendar as a second check to ensure all tasks are completed on the prior shifts. CMA's were in-serviced by the DON on 3/21/2011 related to proper medication administration. Education included: Medications must always be administered exactly as ordered by the physician. Medications must be mixed exactly as ordered. If a resident refuses to take medication you must immediately report it to the charge nurse so the physician can be notified for further orders.</p> <p>4) SDC (Staff Development Coordinator) will do 5 random weekly visual observations of medication passes x two months followed by the LPN QI Coordinator performing 10 random monthly visual observations of medication passes to monitor for compliance with medication administration. Visual observations by SDC and LPN QI Coordinator will be documented for compliance to maintain competency and efficiency of the medication pass. Any noncompliance noted will be reported to the DON.</p> <p>The RN Unit Supervisors will do a daily visual check of the calendar to ensure that follow up labs/tasks have been marked off and initialed by the nurse that completed the</p>		

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F 281	<p>Continued From page 5</p> <p>urinalysis was ordered in ten days; a few days late would be ok, but, "two weeks was a bit much." She stated that if staff were unable to obtain a urine specimen by voiding, she would expect staff to notify her for orders to catheterize the resident.</p> <p>An interview with the Director of Nursing, on 02/18/11 at 4:00 PM, revealed nursing staff should not catheterize a resident without an order from the physician. She expected staff to follow physician's orders.</p> <p>2. Resident #25 was admitted to the facility on 12/18/09, with diagnoses to include Cerebrovascular Disease and Delusional Disorder.</p> <p>A review of the physician's orders, dated February 2011, revealed the laxative, Miralax, was to be given as one heaping tablespoon in eight ounces of water. An iron medication, Niferex 150 milligrams (mg), was to be given with orange juice and a medication for lowering cholesterol, Questran Lyle, was to be given as one packet in water, twice a day.</p> <p>An observation during the medication pass on 02/17/11 at 8:50 AM, revealed Certified Medication Aide (CMA) #1 opened the contents of the iron capsule and mixed it with other crushed medications in a small plastic cup and stirred the medications into vanilla pudding. Additionally, the CMA mixed the Miralax with a five ounce cup of strawberry milkshake and mixed the Questran in a cup with the Miralax, prior to administration.</p> <p>An interview with CMA #1 on 02/17/11 at 9:30 AM, revealed the resident refused to accept the iron</p>	F 281	<p>labs/tasks. The LPN QI Coordinator will do 10 random bi-weekly visual checks of the calendar to monitor for continued compliance with follow up labs/tasks being completed. The visual checks will be documented to track facility compliance with any noncompliance reported to the DON.</p> <p>5) Completion Date: March 25, 2011</p>	03/25/11

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F 281	Continued From page 6 medication in orange juice and the laxative in water and the resident would spit the medication out, because it tasted bad. Therefore, she had mixed the medications in alternate substances for "quite some time." An interview with the pharmacist on 02/17/11 at 10:05 AM, revealed the medications should given as ordered by the physician, although, she saw no harm in mixing the medications as given by CMT #1. The pharmacist stated the CMA did not follow the physician orders for administration of these medications and the physician should have been made aware of need to alter the mixing of the medications for administration. An interview, on 02/17/11 at 10:25 AM, with Licensed Practical Nurse (LPN) #1 and CMA #1, revealed the LPN #1 was not aware the medications were given differently than ordered and the physician should have been notified regarding the fact the resident would not accept the medications in water, prior to altering substances used to mix with the medications.	F 281		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure care was provided in accordance with the care plan interventions for six residents, (#2, #3,	F 282	1) Care plans related to incontinence care and falls were reviewed and updated, if indicated, by the RN Unit Supervisors to reflect the resident's current status and interventions on the affected residents #2, #3, #4, #8, and #13. Care plan reviews related to incontinence care on resident #2, #4, and #13 were reviewed and updated by the East Wing RN Unit Supervisor on 2/28/2011. Resident # 8's care plan related to falls was reviewed and updated on	

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F 282	<p>Continued From page 7</p> <p>#4, #8, #10 and #13), in the selected sample of 18 and one resident (#21), not in the selected sample.</p> <p>The facility failed to ensure care plan interventions were implemented for Residents #2, #3, #4, #10 and #13. The facility failed to ensure fall prevention interventions were implemented for Resident #8 and #21. Findings include:</p> <p>A review of the policy, "Care Plans" (undated), revealed the purpose of the care plans were to assure all disciplines coordinated the care of each resident to maximize, maintain, or achieve the highest practicable level of well-being. The policy revealed State Registered Nurse Aide (SRNA) assignment sheets/care plans were derived from the computed resident care plan and were updated with any new pertinent information and interventions.</p> <p>1. Resident #2 was admitted to the facility on 11/17/10, with diagnoses to include Chronic Renal Failure, Senile Dementia and Urinary Tract Infections. A review of the admission assessment dated 12/14/10, revealed the facility identified Resident #2 as frequently incontinent of bowel and bladder. A review of the care plan for incontinence dated 12/10/10, revealed interventions included briefs and the extensive assistance of two staff members for incontinent care. A review of the SRNA care plan revealed interventions included the application of Vaseline as a protective barrier, after each incontinent episode.</p> <p>An observation during the provision of incontinent care, on 02/16/11 at 10:00 AM, revealed SRNA #1</p>	F 282	<p>3/11/2011 by the West Wing RN Unit Supervisor. Resident #10 and # 21 no longer reside in the facility, therefore, no corrective action can be accomplished for them related to the deficient practice. Licensed nurses were educated by the DON on 3/21/2011 and SRNA's were in-serviced by SDC on 3/7/2011, 3/8/2011, 3/10/2011, and 3/14/2011 regarding proper protocol for reading, implementing, and performing interventions on the residents care plan and the nurse aide assignment sheets/care plan.</p> <p>2) All residents have the potential to be affected by the deficient practice.</p> <p>3) All Licensed nurses and SRNA's have been in-serviced on proper protocol for reading, implementing, and performing interventions on the residents care plan and the nurse aide assignment sheets/care plan. The nurses in-service was completed by the DON on 3/21/2011. Nurse in-service content: Nurses are responsible for updating information as it changes on the residents care plan and the nurse aide assignment sheet/care plan. All care plans will be reviewed and updated, if indicated, to reflect the correct treatment to be used on incontinent residents post each incontinent episode and to reflect</p>		

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F 282	<p>Continued From page 8</p> <p>and SRNA #2 removed a thick white cream from the resident's buttocks, cleansed the resident's perineal area and applied a clean brief, without applying a protective barrier. Interviews with SRNA #1 and SRNA #2, at the time of the observation, revealed they were unaware the physician had ordered a barrier cream or that care plan interventions required application of Vaseline. SRNA #1 stated that if there was no ointment in the resident's drawer, they did not apply any ointment.</p> <p>An interview with Registered Nurse (RN) #1 on 02/16/11 at 10:30 AM, revealed the SRNAs should be aware of the resident's need for a protective skin ointment, which was documented on the SRNA care plan and the SRNAs were supposed to read and sign the SRNA care plan, prior to their shift.</p> <p>2. Resident #13 was admitted to the facility on 01/17/11, with diagnoses to include Advanced Huntington's Disease, Severe Malnutrition and Sacral Decubitus. A review of the admission assessment dated 02/04/11, revealed the facility identified Resident #13 as requiring extensive assistance of two staff/members for transfer and bed mobility and was frequently incontinent of bowel and bladder. The resident was identified with two Stage II pressure sores to the lumbar and coccyx areas, on admission. A review of the care plan for incontinence dated 01/18/11, revealed interventions included the resident wore briefs when out of bed and was totally dependent on two staff members for care. A review of the SRNA care plan dated February 2011, revealed interventions included the application of Vaseline, to be applied as a protective ointment, after each incontinent episode.</p>	F 282	<p>the current fall interventions. SRNA's were in-serviced by the SDC 3/7/2011, 3/8/2011, 3/10/2011, and 3/14/2011. SRNA in-service content: SRNA's must always read the residents nurse aide assignment sheet/care plan at the beginning of their shift to ensure they have the most current information available to provide the correct care for their resident. The interventions on the nurse aide care plan must be followed exactly as written. They must use the correct incontinent care product post each incontinent episode. Interventions on the care plan can't be omitted. Implemented fall interventions must be completed as written on the care plan. You must read the care plan to know exactly what you should be checking, applying, or removing related to falls. If a resident has a chair pad alarm and you are transferring that resident to another chair you must place the alarm in the chair you are sitting them in.</p> <p>4) SDC will perform 10 random weekly visual checks of incontinence care and fall interventions in place. She will also randomly quiz 10 SRNA's weekly on their knowledge of the nurse aide assignment/care plan for their assigned residents to ensure they are reading their care plans and providing proper care.</p>	

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F 282	<p>Continued From page 9</p> <p>An observation during the provision of incontinent care, on 2/18/11 at 3:40 PM, revealed SRNA #3 and SRNA #4 did not apply the protective ointment, following incontinent care. Interviews with SRNA #3 and SRNA #4, at the time of the observation revealed they were not required to apply a protective ointment, just "keep the resident clean and dry."</p> <p>An interview with RN #1, on 02/13/11 at 3:55 PM, revealed the RN expected the SRNAs to apply a protective ointment after provision of incontinent care for Resident #13 and the intervention was documented on the SRNA care plan.</p> <p>An interview, on 02/18/11 at 4:10 PM, with the Director of Nurses (DON) revealed the SRNAs were required to review and sign the SRNA care plans for their assigned residents, prior to their shift, and note any changes which might have occurred, since they last worked with the resident.</p> <p>3. Resident #3 was admitted to the facility on 02/02/11, with diagnoses to include Muscle Weakness and Benign Prostatic Hypertrophy. A review of the "Resident Care Plan" dated 02/02/11 and the "Nurses Assistant Assignments" dated 02/04/11, revealed the facility identified Resident #3 at risk for alteration in skin integrity, due to incontinence. Care plan interventions included application of Vaseline as a protective barrier, after incontinent episodes.</p> <p>Observation during the provision of incontinent care on 02/16/11 at 9:30 AM, revealed SRNA #5 did not apply the protective ointment, after the incontinent care.</p>	F 282	<p>SDC will perform the checks for two months followed by the LPN QI Coordinator or a designated LPN QI Committee member performing 5 random monthly visual checks. The ongoing visual checks will be logged as they are performed to monitor for facility compliance with any noncompliance reported to the DON.</p> <p>5) Completion Date: March 25, 2011</p>	03/25/11	

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F 282	<p>Continued From page 10</p> <p>4. Resident #10 was admitted to the facility on 01/04/11, with diagnoses to include Urinary Tract Infection (UTI) and Chronic Kidney Disease. A review of the quarterly assessment, dated 11/29/10, revealed the facility identified Resident #10 as cognitively intact with frequent incontinence of bowel and bladder. A review of the "Resident Care Plan" dated 01/04/11 and revised 02/17/11 and the "Nurses Assistant Assignments" dated 02/01/11, revealed interventions included the application of Vaseline, after every incontinent episode.</p> <p>An observation during the provision of incontinent care on 02/16/11 1:00 PM, revealed SRNA #5 did not apply the protective skin barrier, after the provision of incontinent care.</p> <p>An interview with SRNA #5 on 02/17/11 at 2:30 PM, revealed she never applied Vaseline after providing incontinent care for Resident #3 or Resident #10. She stated the ointment was stored in the supply room and was not used often.</p> <p>5. Resident #4 was admitted to the facility with diagnoses to include Dementia, Diabetes Mellitus-Type II, Hypertension, and Depressive Disorder.</p> <p>A review of the comprehensive care plan for "Alteration in bowel and bladder status" dated 02/03/11, revealed interventions included special skin care to the perineal and groin area post incontinence which included the use of adult incontinent briefs every two hours, per the assistance of two staff. After the incontinent care, Vaseline was to be applied to the resident's perineal area.</p>	F 282			

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F 282	<p>Continued From page 11</p> <p>An observation during the provision of incontinent care on 02/16/11 at 10:50 AM, revealed SRNA #7 and two additional staff assisted Resident #4 to toilet and removed a wet incontinent brief. SRNA #1 did not apply Vaseline to the resident's perineal area, after toileting the resident.</p> <p>An interview with SRNA #7 on 02/17/11 at 4:45 PM, revealed the resident's care plan was located in a book, kept at the nursing station. She signed the resident's care plan, and reviewed the care plans for any changes to the resident's care. SRNA #7 stated she signed the care plan books at the end of her shift, prior to leaving work. She stated, "I completely forgot about the Vaseline and it was right there, because we store the skin protectant in the cabinet above the toilet and Resident #4 gets it after toileting or incontinent care".</p> <p>An interview with RN #1 on 02/18/11 at 2:30 PM, revealed the Vaseline treatment was an intervention included on all care plans at the facility. The aides actually use a protective cream rather than Vaseline. RN #1 stated she informed the DON regarding the issue and they planned to discuss it in the care plan meeting. The aides signed off care plans each shift, which indicated care had been provided, according to care plans. The SRNAs were responsible for providing the care in accordance with care plans. If the aides had a question about the resident's care, they were expected to review the care plan. She stated the aides were expected to review the care plan through out the day and provide the care according to the individual plans</p> <p>6. Resident #21 was admitted to the facility on 02/08/11, with diagnoses to include Malaise and</p>	F 282		

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F 282	<p>Continued From page 12</p> <p>Fatigue. An admission nursing assessment, dated 02/08/11, revealed the facility identified the resident as non-ambulatory and totally dependent on staff for activities of daily living. A review of the Nursing Assistant Care Plan, dated February 2011, revealed interventions to provide care with the assistance of two staff members with mobility. Safety devices included floor pad alarms with black non-skid mats placed beside the bed, a bed pad alarm to the bed, a wedge cushion to the wheel chair and a chair pad alarm with Dycem (non skid material) to the wheel chair. The SRNA care plan was signed each shift, during the period of 02/08-10/11, to indicate all care on the care plan, "in addition to any special instruction given during report, have been completed."</p> <p>An interview on 02/18/11 at 2:50 PM with SRNA #3, revealed Resident #21 had sustained a fall and had been assisted to transfer to a recliner from a wheelchair, by an unknown individual, prior to the fall. The SRNA stated she saw the resident on the floor, when exiting a resident room and overheard someone state, the resident "crawled out" of the recliner.</p> <p>An interview with RN #1, on 02/18/11 at 10:38 AM, revealed Resident #21 had been admitted to the facility two days prior to the fall. The resident had history of falls at the facility where the resident had previously resided. The fall on 02/10/11 at 2:45 PM, occurred after the resident was transferred from the alarmed wheel chair to the recliner. The transfer of the resident was made due to the need for maintenance to adjust the height of the wheel chair. The staff member responsible for the transfer of the resident to the manual recliner, did not transfer the seat pad sensor alarm to the seat of the recliner. The</p>	F 282		
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F 282	<p>Continued From page 13</p> <p>Identity of the staff member responsible for the transfer of Resident #21 was not determined.</p> <p>An interview with Maintenance Worker #1 on 02/18/11 at 3:20 PM, revealed he did not participate in the resident's transfer to the recliner and he did not know who transferred the resident. He went to retrieve tools from the nursing desk at approximately 2:30 PM, and when he turned around, the resident was on the floor, lying on his/her left side. He stated, "The whole thing could not have lasted 12-24 minutes."</p> <p>7. Resident #8 was admitted to the facility on 03/22/10, with diagnoses to include Alzheimer's Disease, History of Falls with Hip Fracture, Glaucoma, Depressive Disorder, Delusional Disorder and Urinary Retention. A review of the quarterly MDS, dated 11/29/10, revealed the facility identified Resident #8 as moderately cognitively impaired and required extensive assistance with bed mobility, transfers, and ambulation.</p> <p>A review of the "Resident Care Plan", dated 12/02/10 and the "Nurses Assistant Assignments" dated 02/01/11, revealed interventions included hourly "alarm checks" to ensure placement and function, "grippy socks" to be worn while in bed and the wheelchair was to be located outside the resident room, when Resident #8 was in bed.</p> <p>Observations, on 02/15/11 from 3:25 PM to 4:35 PM and 02/16/11 from 9:30 AM to 10:35 AM, revealed Resident #8 was seated in a wheelchair across from the nurse's station. Staff did not check the resident's "clip" alarm or "chair pad" alarm, during the period of observations.</p>	F 282		

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F 282	Continued From page 14 Observations, on 02/17/11 at 8:50 AM and 9:05 AM, revealed Resident #8 was lying in bed and was not wearing "grippy socks" and the resident's wheelchair was located in the room, at the foot of the bed. An interview with SRNA #5, on 02/17/11 at 2:30 PM, revealed she was responsible for checking the alarms every two hours, unless specified to check them hourly. She stated the hourly alarms were not always checked every hour. She was not aware Resident #8 could not have his/her wheelchair in the room, while in bed and was not aware the resident was to wear "grippy socks", while in bed. An interview with SRNA #6, on 02/18/11 at 11:35 AM, revealed she did not look at the SRNA care plan book, until the end of her shift. She skimmed over the care plan before signing the book and depended on her co-workers to let her know of any changes made to a resident's care.	F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by:	F 315	1) SRNA's involved in the deficient care during survey were re-educated by the SDC on 2/16, 2/17, and 2/18/2011 on proper procedure/protocol for perineal/incontinent care so they can provide appropriate treatment/care to prevent urinary tract infections on resident #2, #3, #5, and # 13. Resident #10 is no longer a resident in the facility therefore no corrective action could be accomplished. 2) All residents have the potential to be affected by the deficient practice.	

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F 315	<p>Continued From page 15</p> <p>Based on observation, interview and record review, it was determined the facility failed to provide appropriate treatment and services related to incontinent care for five residents (#2, #3, #5, #10 and #13), in the selected sample of 18.</p> <p>Findings include:</p> <p>A review of the policy/procedure, "Perineal Care" (undated), revealed to gently wash, rinse, and dry perineal area, wiping from "clean" urethral area toward "dirty" rectal area to avoid contaminating urethral area with germs from the rectal area.</p> <p>1. Resident #2 was admitted to the facility on 11/17/10, with diagnoses to include Urinary Tract Infections. A review of the admission assessment, dated 12/14/10, revealed the facility identified Resident #2 as frequently incontinent of bowel and bladder. A review of the care plan for incontinence, dated 12/10/10, revealed interventions included briefs and the extensive assistance of two staff members for incontinent care. A review of the State Registered Nurse Aide (SRNA) care plan revealed the resident was provided perineal cleansing with the assistance of two staff members.</p> <p>An observation during the provision of incontinent care for Resident #2, on 02/16/11 at 10:00 AM, revealed State Registered Nurse Aide (SRNA) #1 used the same area of the washcloth, using a wiping motion, to cleanse the perineal area, which contaminated the clean area. Interview with SRNA #1, at the time of the observation, revealed she was trained to provide incontinent care and to fold the wash cloth avoiding using a contaminated surface, but had "forgotten this."</p>	F 315	<p>3) All SRNA's are being re-educated by the SDC on proper procedure/ protocol for perineal/incontinent care. Education began on 3/11/2011 and will be completed on 3/25/2011 Education to include: A computer based in-service through Silverchair learning systems with a post test that required 100% to pass was completed on 3/17/2011. They are being instructed on the correct method for cleansing the perineal area which is wiping from the clean urethral area to dirty rectal area. To never use a scrubbing, or back and forth wiping motion to cleanse the perineal area as this may cause contamination and lead to a UTI. Never use the same area of a washcloth more than once while providing perineal care. Always use a clean washcloth to rinse the perineal area. Never rinse out a washcloth and reuse it when providing perineal care, you must use a clean washcloth. All soiled linens should be placed in a plastic bag immediately after use. Once the education is completed SRNA's will be required to do a return demonstration of providing proper perineal care.</p> <p>4) Post re-education SDC & LPN QI Coordinator will complete a competency check off on each SRNA followed by an annual competency</p>		

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F 315	<p>Continued From page 16</p> <p>An interview with Registered Nurse (RN) #1, on 02/16/11 at 10:30 AM, revealed the SRNAs remain aware of appropriate incontinent care technique and to fold the wash cloth with each wipe.</p> <p>2. Resident #13 was admitted to the facility on 01/17/11, with diagnoses to include Sacral Decubitus (pressure sore). A review of the admission assessment, dated 02/04/11, revealed the facility identified Resident #13 as frequently incontinent and requiring extensive assistance of two staff members for transfer and bed mobility. Resident #13 had two Stage II pressure sores to the lumbar and coccyx areas, on admission.</p> <p>A review of the care plan for incontinence, dated 01/18/11, revealed interventions included the use of briefs when out of bed and total dependence on two staff members for care. A review of the SRNA care plan, dated February 2011, revealed interventions to assist the resident with perineal cleansing.</p> <p>An observation during the provision of incontinent care, on 2/18/11 at 3:40 PM, revealed SRNA #3 and SRNA #4 provided the care and SRNA #4 cleansed the resident's perineal area with a washcloth and a back and forth wiping motion. Interview with SRNA #4, at the time of the observation, revealed she had been trained not to do this, but was "nervous."</p> <p>An interview with RN #1, on 02/13/11 at 3:55 PM, revealed the RN expected the CNAs to fold the wash cloth, between wipes.</p> <p>An interview with the Director of Nurses, on 02/18/11 at 4:10 PM, revealed the SRNAs were</p>	F 315	<p>check off. The competency checks offs will be completed by 3/25/2011. SDC will perform 10 random weekly visual observations of provision of perineal/incontinence care. SDC will perform the checks for two months followed by the LPN QI Coordinator or designated LPN QI Committee member performing 5 random monthly visual observations. The visual observations of perineal/incontinence care will be logged to monitor for continued compliance. The competency checks will be documented and maintained for evaluation of competency.</p> <p>5) Completion Date: March 25, 26, 2011</p>	<p>03/25/11 03/26/11 LJ-Administrator Cm-DIG per phone on 03/24/11 1 o 4pm</p>

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F 315	<p>Continued From page 17</p> <p>trained to provide proper perineal care.</p> <p>3. Resident #5 was admitted to the facility, on 09/07/07, with diagnoses to include Depression, Dementia, Hypertension, and History of Fracture of Left Hip.</p> <p>An observation, on 02/16/11 at 9:40 AM, revealed SRNA #1 with the assistance of a second SRNA provided incontinent care for Resident #5. Observation revealed SRNA #1 saturated a wash cloth with peri wash and used a back and forth wiping motion to cleanse the resident's left groin area. She obtained a second washcloth and saturated it with peri wash and repeated the same back and forth wiping motion in the resident's right groin area. SRNA #1 obtained a third wash cloth and saturated it with peri and cleansed the vagina using the back and forth wiping motion. The two SRNA's rolled the resident to the left and observed Resident #5 was incontinent of bowel. SRNA #1 obtained an incontinent brief, saturated it with peri wash, and wiped the feces off the resident's buttocks twice, using the same area of the incontinent brief. SRNA #1 used another area of the same incontinent brief to wipe Resident #5's buttocks with a back and forth motion, using the same area of the brief. She obtained a second incontinent brief, squirted peri wash on the brief and proceeded to wipe the resident's buttocks using a back and forth motion using the same area of the brief.</p> <p>An interview with SRNA #1, on 02/16/11 at 9:50 AM, revealed when incontinent care was provided the SRNA should clean an area with one wipe of the wash cloth and then get another clean cloth. SRNA #1 stated she did not realize she was wiping back and forth with the same area of the</p>	F 315			

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F 315	<p>Continued From page 18</p> <p>wash cloth. She stated, "I should know better because the back and forth wiping with the same cloth could cause them to get an infection".</p> <p>4. Resident #3 was admitted to the facility, on 02/02/11, with diagnoses to include Benign Prostatic Hypertrophy (BPH).</p> <p>An observation during the provision of incontinent care, on 02/16/11 at 1:00 PM, revealed Resident #3 was positioned in bed positioned on his/her left side. State Registered Nurse Aide (SRNA) #10 was observed to cleanse the resident's buttocks with a washcloth using a front to back "swiping" motion. She handed the soiled washcloth to SRNA #5 and SRNA #5 placed the soiled washcloth on the resident's dresser. The resident was repositioned on his/her back and SRNA #5 handed the soiled washcloth from the dresser to SRNA #10. SRNA #10 used the soiled washcloth to cleanse the resident's peri area using a "swiping" motion.</p> <p>An interview with SRNA #10, on 02/16/11 at 1:35 PM, revealed she should have used a clean washcloth after cleansing the resident's rectal area. She stated she was in a hurry because the nurse was waiting to conduct the resident's skin assessment. She stated, "The care was a total flop, nothing went right."</p> <p>An interview with SRNA #5, on 02/16/11 at 1:50 PM, revealed she should have placed the soiled washcloth in a bag, instead of placing it on the dresser and a new washcloth should have been used. She stated she realized what she had done and stated, "I knew you would get me on that one."</p>	F 315		

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F 315	Continued From page 19 5. Resident #10 was readmitted to the facility on 01/04/11, with diagnoses to include Urinary Tract Infection and Chronic Kidney Disease. A review of the quarterly MDS assessment, dated 11/29/10, revealed the facility identified the resident as cognitively intact and required limited assistance with hygiene and extensive assistance with bathing. The MDS revealed the resident was frequently incontinent of bowel and bladder. An observation during the provision of incontinent care, on 02/16/11 at 9:30 AM, revealed the resident was transferred to bed and rolled on to his/her left side. Observation revealed SRNA #5 cleansed the resident's peri area and rectal area all in one back and forth "swiping motion", using the same washcloth. She changed the washcloth and rinsed the peri area and rectum using the same manner back and forth motion. An interview with SRNA #5, on 02/16/11 at 1:50 PM, revealed normally she would cleanse the peri area and then roll the resident to the side cleansing the rectal area. She stated she was aware the "swiping" from front to back repeatedly with the same washcloth caused contamination.	F 315			
F 323 SS=D	483.25(h) FREE OF ACCIDENT / HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323	1) Resident # 21 no longer resides in the facility therefore no corrective action could be accomplished. Resident # 8's fall interventions have been reviewed and updated to reflect the resident's current status. Care plans were reviewed and updated by the West Wing RN Unit Supervisor on 3/11/2011. Licensed nurses and SRNA's were educated on proper protocol for reading, implementing, and performing fall		

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F 323	<p>Continued From page 20</p> <p>by: Based on observations, interviews and record review, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for two residents (#8 and #21), in the selected sample of 18. The facility failed to ensure implementation of care plan interventions directed at prevention of falls. Findings include:</p> <p>1. Resident #21 was admitted to the facility, on 02/08/11, with diagnoses to include Muscle Weakness, Malaise and Fatigue. An admission nursing assessment, dated 02/08/11, revealed the resident was identified as non-ambulatory and totally dependent on staff for activities of daily living. A review of the Falls Assessment, dated 02/08-10/11, revealed the resident was assessed as a high risk for falls on admission, due to a history of falls prior to admission. Floor pad alarms and a bed pad alarm was initiated as preventative measures related to the risk for falls. On 02/09/11, a wedge-edged mattress was added to the bed. A wedge cushion, Dycem (non skid material) and a chair pad alarm was added to the wheel chair. A plan to adjust the height of the front of the wheelchair was added, on 02/10/11.</p> <p>A review of the Nursing Assistant Care Plan, dated February 2011, revealed the resident required the assistance of two staff members with mobility. Safety devices included floor pad alarms with black non-skid mats beside the bed, bed pad alarm to the bed, wedge cushion to the wheel chair and chair pad alarm with Dycem to the wheel chair. The SRNA care plan was signed for each shift 02/08-10/11, which indicated all</p>	F 323	<p>Interventions that are placed on the residents care plan and nurse aide assignment sheets/care plan to promote resident safety. Nurses were educated by the DON on 3/21/2011. SRNA's were educated by SDC on 3/7, 3/8, 3/10, & 3/14/2011.</p> <p>2) All residents have the potential to be affected by the deficient practice.</p> <p>3) Licensed nurses and SRNA's were educated on proper protocol for reading, implementing, and performing care planned fall interventions. Nurse's education included: Nurses are responsible for updating information as it changes on the residents care plan and the nurse aide assignment sheet/care plan. All care plans will be reviewed and updated, if indicated, to reflect current fall interventions. SRNA's education included: To always read the residents nurse aide assignment sheet/care plan at the beginning of their shift to ensure they have the most current information available to provide the correct care for their resident. The fall interventions on the nurse aide care plan must be followed exactly as written. Interventions on the care plan can't be omitted. You must read the care plan to know exactly</p>		

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F 323	<p>Continued From page 21</p> <p>care on the care plan, in addition to any special instruction given during report, had been completed.</p> <p>A review of the facility's fall investigation and nurse's notes, dated 02/10/11, revealed on 02/10/11 at 2:45 PM, Resident #21 was found lying in the floor in front of a recliner, near the nursing station. The recliner had the foot elevated and the resident sustained a hematoma to the left forehead and a light purple bruise to the left shoulder. The resident denied pain, but was observed guarding the left shoulder. Labs and mobile x-rays were obtained, per physician order, which revealed no fracture. A possible reoccurrence of pneumonia was noted and the resident was transferred to the local hospital for evaluation, at 5:05 PM.</p> <p>An interview with State Registered Nurse Aide (SRNA) #5, on 02/18/11 at 2:50 PM, revealed she was assigned to care for the resident at the time of the fall, but she was unaware who had transferred the resident to the recliner. The SRNA stated she observed Resident #21 lying on the floor as she exited another resident room. She overheard someone say the resident had "crawled out of " the recliner.</p> <p>An interview with Registered Nurse (RN) #1, on 02/18/11 at 10:38 AM, revealed the resident had been admitted to the facility two days prior to the fall and had a history of falls, prior to admission. The facility's investigation revealed the resident had been transferred to the recliner from the alarmed wheel chair, in order for maintenance to adjust the height of the wheel chair. The seat pad sensor alarm was not transferred to the recliner. The staff responsible for transferring the resident</p>	F 323	<p>what you should be checking, applying, or removing related to falls. If a resident has a chair pad alarm and you are transferring that resident to another chair you must place the alarm in the chair you are sitting them in. Alarm checks do not mean to just look at them. To perform an alarm check you need to check the alarm to make sure it is in place and functioning properly at the specified time intervals on the care plan. Remember, the fall interventions are put in place to protect the resident and if you don't complete them as care planned you are increasing the risk of the resident's safety. Nurses were educated by the DON on 3/21/2011. SRNA's were educated by SDC on 3/7, 3/8, 3/10, & 3/14/2011.</p> <p>4) SDC will complete 10 random weekly visual checks to monitor performance of SRNA's implementing care planned fall interventions. She will also randomly quiz 10 SRNA's weekly on their knowledge of the nurse aide assignment/care plan for their assigned residents to ensure they are reading their care plans and implementing the fall interventions per the resident's plan of care. SDC will perform the checks for two months followed by the LPN QI Coordinator or a designated LPN QI</p>		

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F 323	<p>Continued From page 22 was not identified.</p> <p>An interview with Maintenance Worker #1, on 02/18/11 at 3:20 PM, revealed he did not participate in the resident's transfer and did not know the identity of the responsible individual. At approximately 2:30 PM, he observed the resident lying on the floor on his/her left side. He stated he had retrieved tools and returned to adjust the resident's wheelchair and "the whole thing could not have lasted more than 12-24 minutes."</p> <p>2. Resident #8 was admitted to the facility, on 03/22/10, with diagnoses to include Alzheimer's Disease, Delusional Disorder, and History of Falls with Hip Fracture. A review of the quarterly Minimum Data Set, dated 11/29/10, revealed the facility identified the resident as moderately cognitively impaired and required extensive assistance with bed mobility, transfer and ambulation.</p> <p>A review of the "Falls Investigation", dated 08/27/10, revealed Resident #8 sustained a fall, on 08/26/10, after the resident attempted to get out of bed unassisted. A new intervention for alarm checks every hour was added to the plan of care.</p> <p>Observations, on 02/15/11 from 3:25 PM to 4:35 PM and 02/16/11 from 9:30 AM to 10:35 AM, revealed Resident #8 was seated in a wheelchair across from the nurse's station. Staff did not check the resident's "clip" alarm or "chair pad" alarm, during the observations.</p> <p>An interview with SRNA #5, on 02/17/11 at 2:30 PM, revealed some residents have hourly "alarm checks", but staff do not always check the alarms</p>	F 323	<p>Committee member performing 5 random visual monthly checks of SRNA's implementing care planned fall interventions and quizzing of the SRNA's on their knowledge of the nurse aide assignment/care plan for their assigned residents. The ongoing visual checks and quizzing of the SRNA's care plan knowledge will be logged to monitor for continued compliance of implemented fall interventions and care plan knowledge. Noncompliance is to be reported to the DON.</p> <p>5) Completion Date: March 25, 2011</p>	03/25/11	

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F 323	<p>Continued From page 23 every hour.</p> <p>An interview with RN #2, on 02/18/11 at 3:30 PM, revealed the functioning of the alarms for Resident #8 should be completed every hour.</p> <p>A review of the "Falls Investigation", dated 06/14/10 and 11/24/10, revealed the resident sustained a fall, on 06/12/10, during a self transfer from the bed to the wheelchair. On 11/24/10, a fall occurred after the resident attempted to get out of bed unassisted. New interventions were implemented to ensure the wheelchair was removed from the room when the resident was in bed and the resident should wear "grippy socks" at night.</p> <p>Observations, on 02/17/11 at 8:50 AM and 9:05 AM, revealed Resident #8 was in bed and was not wearing "grippy socks". The resident's wheelchair was located at the foot of the bed.</p> <p>An interview with SRNA #11, on 02/18/11 at 1:35 PM, revealed she worked the "night shift", on 02/16/11. Resident #8 was assigned to her for care. She was aware the resident's wheelchair was supposed to be in the hallway, but stated, "I miss things a lot and I am not sure what happened that night."</p> <p>An interview with SRNA #5, on 02/17/11 at 2:30 PM, revealed she knew the resident's wheelchair should not be left beside the bed, but did not know it was supposed to remain in the room. She was also unaware the resident was supposed to wear "grippy socks" while in bed. She stated she should have known what interventions were included in the resident's care plan, but she did not read the interventions on the care plan daily.</p>	F 323		

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F 323	Continued From page 24	F 323		
F 441 SS=D	<p>An interview with the Director of Nursing, on 02/18/11 at 4:00 PM, revealed the nurse on the unit should have made rounds to ensure the resident's were provided care, in accordance with the care plan. She expected the SRNAs to read the care plans at the beginning of their shift, but "they obviously were not reading the care plans."</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted</p>	F 441	<p>1) Resident # 10 is no longer a resident in the facility therefore no corrective action could be accomplished for her. SRNA #4 involved in resident #13's care during the survey has been re-educated on the hand washing policy & procedure which includes directions for when gloves should be changed. The education was provided and documented by the SDC on 2/16/2011.</p> <p>2) All residents have the potential to be affected by the deficient practice.</p> <p>3) All SRNA's have been in-serviced by the SDC on infection control, proper procedure for hand washing, and glove removal/changing. The in-services were completed between the dates of 2/21/2011 and 3/21/2011. SRNA's were required to do a return demonstration of proper hand washing including glove removal/changing. SRNA's were also be tested on their knowledge of when to change their gloves.</p> <p>4) SDC performed a competency</p>	

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F 441	<p>Continued From page 25 professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure staff members washed their hands and changed gloves before and after resident care for two residents (#10 and #13), in the select sample of 18. Findings include:</p> <p>A review of the policy for "Handwashing" (undated), revealed staff were expected to wash their hands after changing a brief, after resident care, and after contact (and between contact) with different body fluids of the same resident.</p> <p>1. Resident #13 was admitted to the facility, on 01/17/11, with diagnoses to include Sacral Decubitus (pressure sore). A review of the admission assessment, dated 02/04/11, revealed the facility identified Resident #13 required extensive assistance of two staff members for transfer and bed mobility and was frequently incontinent of bowel and bladder. The resident was admitted with two Stage II pressure sores to the lumbar and coccyx areas.</p> <p>A review of the care plan for incontinence, dated 01/18/11, revealed the resident wore briefs when</p>	F 441	<p>check off on proper hand washing, glove removal with each SRNA to be followed by an annual competency check off. SDC completed the competency check offs on 3/21/2011. The hand washing/glove removal competency checks were documented as performed and will be maintained for evaluation of competency. The LPN Infection Control Nurse will perform 10 random weekly visual observations of provision of care for two months followed by 10 random monthly visual observations by a designated LPN QI Committee member for continued compliance with infection control related to hand washing and proper glove removal/changing. The ongoing visual observations will be logged as performed to monitor/track continued compliance with infection control related to hand washing and proper glove removal/changing.</p> <p>5) Completion Date: March 25, 2010 <i>2011</i></p> <p>03/25/11</p>	<p>03/25/11 LJ-Administrator cm-8IG per phone 03/24/11 @ 4pm</p>
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F 441	<p>Continued From page 26</p> <p>out of bed and was totally dependent on two staff members for care. A review of the State Registered Nurse Aide (SRNA) care plan, dated February 2011, revealed the SRNAs were to assist the resident with perineal cleansing.</p> <p>An observation during the provision of incontinent care, on 2/18/11 at 3:40 PM, revealed SRNA #4 did not change her gloves and wore the same gloves for disposing of the soiled brief, providing incontinent and assisting the resident with positioning.</p> <p>An interview with Registered Nurse (RN) #1, on 02/13/11 at 3:55 PM, revealed the RN expected the SRNAs to change gloves and wash their hands before and after perineal care and to change gloves, prior to repositioning the resident.</p> <p>An interview, with the Director of Nursing, on 02/18/11 at 4:10 PM, revealed the SRNAs had been trained to wash their hands and change gloves and she knew "they knew better".</p> <p>2. A record review revealed Resident #10 was readmitted to the facility, on 01/04/11, with diagnoses to include Urinary Tract Infection (UTI) and Chronic Kidney Disease. A review of the quarterly MDS, dated 11/29/10, revealed the facility identified the resident as cognitively intact and required limited assistance with hygiene and extensive assistance with bathing. The MDS revealed the resident was frequently incontinent of bowel and bladder.</p> <p>An observation during the provision of incontinent care, on 02/16/11 at 9:30 AM, revealed SRNA #10 assisted Resident #10 to bed. SRNA #10 was wearing gloves and removed the resident's brief</p>	F 441		

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F 441	Continued From page 27 and rolled the brief up. The SRNA dropped an ink pen onto the floor, picked up the pen with her soiled gloves and placed the pen in her pocket. After the provision of incontinent care, SRNA #5 applied the resident's clean brief wearing the soiled gloves, removed a soiled bedpan and rinsed it out in the bathroom. The SRNA assisted the resident into the wheelchair and removed the gait belt and placed the belt around her neck, while wearing the soiled gloves. An interview with SRNA #10, on 02/16/11 at 1:35 PM, revealed she thought if you remained in one resident's room and did not touch another resident, you did not need to change your gloves. She stated, "We had in-services all the time".	F 441		
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to ensure timeliness of laboratory services to meet the needs of its residents for one resident (#10), in the selected sample of 18. The facility failed to ensure a urinalysis (UA) was obtained per physician's order. Findings include: A review of the policy/procedure, "Lab Work/Results, Managing" (undated), revealed lab work should be scheduled per physician order.	F 502	1) Resident # 10 is no longer a resident in the facility therefore no corrective action could be accomplished for her. 2) All residents have the potential to be affected by the deficient practice. 3) RN Unit Supervisors were verbally in-serviced on 3/11/2011 by the DON regarding their daily duties related to checking follow up labs and to ensure they are completed. The daily checks must be done, they can't "get behind" on those tasks. Licensed Nurses were in-serviced 3/21/2011 by the DON on proper procedure & protocol related to obtaining a urinalysis. In-service content: The physician must be notified immediately if an order hasn't been completed so they can	

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F 502	<p>Continued From page 28</p> <p>Obtain the lab sample as ordered and document in the medical record.</p> <p>Resident #10 was readmitted to the facility, on 01/04/11, with diagnoses to include Urinary Tract Infection (UTI) and Chronic Kidney Disease.</p> <p>A review of "Telephone Orders", dated 01/12/11, revealed an order for antibiotic therapy for ten days to treat a UTI. A repeat Urinalysis (UA) was ordered to be obtained in ten days, due 01/22/11. Review of the medical record revealed no documented evidence the UA had been obtained as ordered.</p> <p>An interview with Licensed Practical Nurse #2, on 02/16/11 at 3:20 PM, revealed labs were documented on a calendar at the nurse's desk and were marked off after the specimens were obtained. She had attempted to obtain the specimen on 01/23/11, however, the specimen was contaminated. On 02/02/11, she noticed the specimen had not been collected and reported to the "night shift" charge nurse to obtain the UA. She revealed the urine specimen was sent to the lab 02/03/11.</p> <p>An interview with Registered Nurse #2, on 02/18/11 at 3:30 PM, revealed as the unit supervisor, she was responsible for making sure all lab work was completed. She reviewed the lab sheets daily, however, she had gotten behind on the reviews. She stated about ten days passed before she realized the UA had been missed.</p> <p>An interview with the Director of Nursing, on 02/18/11 at 4:00 PM, revealed the unit supervisor followed up on orders daily. She revealed the delay in obtaining the urine specimen should have</p>	F 502	<p>obtain any further orders. There are no standing orders for catheterization. It is unacceptable to catheterize a resident without a physicians order. They must have a physician's order for a follow up UA. All interaction with the physician should be documented in the nurses notes and an order be written on the physicians telephone orders. If a follow up UA is ordered the nurse receiving the order is responsible for placing it on the calendar at the nurse's desk on the appropriate date. The nurses were instructed to review the daily calendar at the beginning of their shift for any tasks that have been ordered. Once the task is complete they will mark it off the calendar as done with their initials beside that task. The charge nurse should check the calendar at the beginning of their shift for any tasks that need completing. Charge nurses also need to look back a few days on the calendar as a second check to ensure all tasks have been completed on the prior shifts.</p> <p>4) The RN Unit Supervisors will do a daily visual check of the calendar to ensure that follow up labs/tasks have been marked off and initialed by the nurse that completed the labs/tasks. The LPN QI Coordinator will do 10 random bi-weekly visual checks of the calendar to monitor</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/18/2011
NAME OF PROVIDER OR SUPPLIER CALVERT CITY CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029		
(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 502	Continued From page 29 been noticed at the "supervisor level".	F 502	for continued compliance with follow up labs/tasks being completed. The visual checks will be documented to track facility compliance with any noncompliance to be reported to the DON. 5) Completion Date: March 25, 2011	03/25/11	/

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

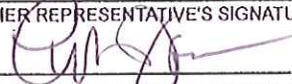
PRINTED: 02/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185234	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/17/2011
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NAME OF PROVIDER OR SUPPLIER CALVERT CITY CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029
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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)	(X6) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code survey was initiated and conducted on 02/17/11 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 3/14/11
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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.