

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

PRINTED: 02/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/26/2012
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NAME OF PROVIDER OR SUPPLIER BON HARBOR NSG & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2420 W. 3RD ST. OWENSBORO, KY 42301
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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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F 000	INITIAL COMMENTS The annual standard health survey, for recertification, was initiated on 01/24/12 and concluded on 01/26/12 and the Life Safety Code Survey was conducted on 01/25/12 with deficiencies cited at the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would be imposed. An abbreviated survey was initiated on 01/24/12 and concluded on 01/26/12 to investigate KY 17018, KY17321, KY17322 and KY17572. The Division of Health Care substantiated the allegation for KY17321 as verified by the evidence. Federal and State deficiencies were cited. The Division of Health Care unsubstantiated the allegation for KY17018 due to lack of sufficient evidence; however, unrelated deficiencies were cited. The Division of Health Care unsubstantiated the allegations for KY17322 and KY17572 due to lack of sufficient evidence. Therefore, no regulatory violations were identified.	F 000	Submission of this plan of correction is not a legal admission that a deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	
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F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the Housekeeping quality control inspection	F 253		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christina Malvern TITLE: X 1244 (X6) DATE: 02-24-2012

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

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F 253	Continued From page 1 sheet, it was determined the facility failed to provide effective housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior for residents. There were thirteen (13) resident wheelchairs of the ninety-three (93) resident wheelchairs in use that were in disrepair. One (1) of the two (2) shower rooms was missing the corner tiles on the divider wall. The handwashing sink in a residents room was slow to drain affecting two (2) residents. A resident room was missing tile by the sink affecting two (2) residents. A hole was found behind a residents room door. Curtains were found in a residents room that were not hung appropriately leaving large sections hanging free affecting two (2) residents. A hole was found in a residents closet door. Three (3) residents were noted to not have an overbed light cord. The wall under an air conditioning unit was peeling and had brown colored stains and smudges. A resident bathroom had a noticeable musty odor, gnats were noted flying around the room, and the wall to the left of the commode was uneven with yellow colored stains. The findings include: The facility did not provide a policy and procedure for general maintenance and housekeeping. Review of the Building Service Work Order requests revealed the request log was being used, however, none of the identified areas of concern had been reported on the maintenance logs. Observations during the environmental tour of the	F 253	F253 An inventory of wheelchairs will be completed, parts ordered and repairs will be made by 02-29-2012. The North shower room missing tiles will be replaced by 02-29-2012. The kick panel to the door leading into the shower will be replaced by 02-29-2012. The hand washing sink in Room 343 was unclogged on 02-02-2012. The tile in Room 463 was replaced on 02-02-2012. The window curtain in Room 450 was rehung on 02-14-2012. The hole behind the entrance door in Room 342 was repaired on 02-02-2012. The hole in the closet door of Room 467 was repaired on 02-03-2012. The overbed light cords for Rooms 339-1, 339-2 and 333-1 were replaced on 01-27-2012. The wall under the air conditioning unit in Room 332 was repaired and the air conditioning vent re-hung on 02-15-2012. The shared bathroom for Rooms 110 and 112 has been deep cleaned and Pest Control has treated the space the bathroom for rooms 110 and 112 were noted to be clean, odor free and free of nest as observed by the Administrator on 02-16-2012. The wall near the baseboard in the bathroom for rooms 110 and 112 was noted to be clean, smooth and even in texture as observed by the Administrator on 02-16-2012. An audit of all facility rooms and corridors will be conducted by the Maintenance Director by 2-29-2012 to identify any concerns with repairs. Any identified concerns will be corrected immediately. The Administrator observed on 02-14-2012 that there were no pests identified in the facility.	
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F 253	Continued From page 2 facility, 01/24/12 at 9:35 AM , and subsequent observations during the standard survey 01/24/12-01/28/12 revealed the following items were in need of repair: 1. There were thirteen (13) wheelchairs identified with arm rests that were cracked and peeling with rough edges: The wheelchairs identified belonged to resident's in rooms 101-2, 109-1, 217-1, 219-2, 222-1, 229-1, 452-1, 454-1, 455-1, 455-2, 456-1, 457-2, 458-1. Interview with Certified Nursing Assistant (CNA) #8, on 01/26/12 at 4:20 PM, revealed the night shift was responsible to inspect all wheelchairs and turn in a work order for any concerns. Interview with CNA #7, on 01/26/12 at 4:50 PM, revealed everyone was responsible to make sure the wheelchairs were clean and report any problems to maintenance to be repaired due to risk for abrasions on the residents arms.	F 253	All Facility staff will be re-educated regarding reporting of maintenance and housekeeping issues by the District Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager. The Maintenance Director will be re-educated by the Administrator regarding completing a monthly wheel chair check to assure any needing repairs. This re-education will be completed by 02-29-2012. Pest Control will complete monthly inspections to identify any concerns with pest. All re-education will be completed by 02-29-2012 with no staff working past 02-29-2012 without having received this re-education. The Maintenance Director or Maintenance Assistant and the Housekeeping supervisor will complete facility rounds weekly for twelve (12) weeks assure all concerns with repair and cleanliness have been identified, reported and corrected. The Administrator will complete weekly rounds for twelve (12) weeks to assure the facility remains pest free.	
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	Interview with Licensed Practical Nurse #5, on 01/26/12 at 5:00 PM, revealed ripped wheelchair arms could cut the resident's arms. Therapy does the monitoring of the wheelchairs but we report it when we notice a problem. Interview with the South Unit Manager, on 01/26/12 at 5:20 PM, revealed everyone was responsible for monitoring the wheelchairs. The Unit Manager revealed the night shift cleans the wheelchairs and should be inspecting them at that time. The Unit Manager revealed there was a potential for skin tears. The Unit Manager revealed she was surprised there were problems with the wheelchairs as she had just completed		The results of these audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months and quarterly for three (3) quarters in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. Compliance Date: 03-07-2012	03-07-2012
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F 253	<p>Continued From page 3 and audit of the wheelchairs for her unit. However, she revealed she had been monitoring for cleanliness and not the condition or maintenance of the wheelchairs.</p> <p>Interview with the Maintenance Director, on 01/26/12 at 4:30 PM, revealed once a month he goes through the facility and checks the wheelchairs. The Maintenance Director revealed this task was part of their monitoring system called TELS. He further revealed he did not remember when this was last done. A copy of the last audit was not provided, as requested, by the facility.</p> <p>2. The North shower room commode divider wall had missing tile on each corner approximately twelve (12) inches from the floor. The door leading into the shower room had a kick panel with the corner peeled away, exposing wood with black and brown colored stains.</p>	F 253		
	<p>3. The handwashing sink in room 343 was slow to drain.</p> <p>4. The tile under the sink next to the baseboard was missing, approximately 12 inch in length, in room 463.</p> <p>5. The widow curtain in room 450 was not hung appropriately leaving large sections of the curtain hanging free.</p> <p>Interview with the two residents in room 450, on 01/26/12 at 3:00 PM, revealed they felt the curtains looked terrible and it was not homelike. The residents stated the curtains had been left that way for several months after the facility</p>			



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F 253	Continued From page 4 removed them for cleaning. One resident stated he/she just deals with it, as they rolled their eyes and sighed. 6. The Wall behind the entrance door in room 342 had a hole approximately 8 inches in circumference. Interview with the resident in room 342-1, on 01/26/12 at 3:10 PM, revealed the hole had been in the wall for almost a year. 7. The closet door in room 467 had a hole approximately 6-8 inches in length. 8. Rooms 339-1, 339-2, and 333-1 had no overbed light cord. 9. The wall under the air conditioning unit in room 332 was peeled away and had brown colored stains and smudges. Subsequent observations revealed the air conditioning vent was no longer hanging on the wall and found to be sitting on the floor. 10. The shared bathroom for room 110 and 112, affecting 4 residents, had a musty odor. Gnats were seen flying around the room and resting on walls. The wall near the baseboard to the left of the commode was uneven and rough in texture with yellow colored stains. Interview with the residents of room 110, on 01/26/12 at 3:15 PM, revealed the facility had been working on the commode due to frequent clogs and overflowing. The residents stated the room now has an odor and have they both have seen fly's in the room which had been reported to	F 253			



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F 253	<p>Continued From page 5 the nursing staff.</p> <p>Interview with the West Unit Manager, on 01/26/12 at 5:05 PM, revealed there was a cleaning schedule for each wheelchair and she was dependent on staff to report if an issue was found on nights. The Unit Manager also reported light cords are used frequently and the staff should be reporting them to be repaired. The Unit Manager revealed she did make rounds frequently but had not noticed the light cords were missing for three residents. The Unit Manager revealed residents not having access to the overbed light could impede independence.</p> <p>Interview with the Maintenance Director, on 01/26/12 at 3:35 PM, revealed he did water temp checks and resident door checks monthly. The Maintenance Director revealed every 2 weeks he looked at the resident's walls, light cords, and paint. The Maintenance director revealed he did not use an auditing tool, move trash cans around or move resident equipment to inspect for areas of concern. When asked if he felt the system was working, the Maintenance Director revealed there were flaws in everything.</p> <p>Concurrent interview with the Housekeeping Supervisor, on 01/26/12 at 3:35 PM, revealed areas of missing tile should have been reported to maintenance by housekeeping. The Housekeeping Supervisor revealed housekeepers are expected to report any areas of concern to maintenance for repair. The Housekeeping Supervisor revealed audits are done daily with a minimum of 2 resident rooms, 1 common area, and 2 bathrooms.</p>	F 253		



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F 253	<p>Continued From page 6</p> <p>Review of the Housekeeping Quality Control Inspection auditing tool revealed doors, floors, blinds/windows, vents/ac units, odor, baseboards, and sinks are included in the auditing tool.</p> <p>Interview with the Director of Nursing (DON), on 01/26/12 at 5:45 PM, revealed the system for monitoring the wheelchairs was if something was noticed the staff were to notify maintenance or the therapy department. The DON revealed the night shift was washing the wheelchairs and they need more education as to monitoring and reporting of problems. The DON revealed arm rests in disrepair were a potential cause of skin tears. The Don further revealed that having a cord on the overbed light would make it more convenient for the residents to access their lighting. The DON revealed Unit Managers, ADON, DON, and Administration are all responsible to ensure there was a safe comfortable interior.</p>	F 253		
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F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280	F 280	
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SS=D	<p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's</p>		<p>The careplan for resident #3 was updated on 01-27-2012 to monitor for signs and symptoms of aspiration including the family preference to feed the resident who is ordered to have nothing by mouth.</p> <p>The Interdisciplinary Team consisting of the Director of Nursing, Assistant Director of Nursing, Unit Managers, Director of Education and Training, Social Services Director, Social Services Assistant, Life Enrichment Director, and Nutrition Services Manager will review all current resident's careplans by 2-29-2012 to assure careplans have been revised and meet the needs of the resident. Any identified as not meeting the needs of the resident will be revised immediately.</p>	
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F 280	<p>Continued From page 7</p> <p>legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to revise the comprehensive care plan for one (1) of twenty-six (26) sampled residents, Resident #3. The facility assessed Resident #3 as aspirating food and fluids and was to have nothing by mouth. On 01/04/12, the family decided to feed the resident and signed a statement that they understood feeding the resident was against medical advise. The facility failed to address this on the care plan.</p>	F 280	<p>The Interdisciplinary Team consisting of the Assistant Director of Nursing, Unit Managers, Director of Education and Training, Social Services Director, Social Services Assistant, Life Enrichment Director, and Nutrition Services Manager will be re-educated by the Director of Nursing on revising careplans to meet the needs of the resident. This education will occur by 2-29-2012.</p> <p>The Director of Nursing or the Assistant Director of Nursing will audit five (5) resident careplans per week for twelve (12) weeks to assure the careplans have been revised to meet the needs of the resident. The results of these audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months and quarterly for three (3) quarters in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The</p>	
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	<p>The findings include:</p> <p>Review of the facility policy for care plans, dated January 2012, revealed care plans addressed residents' needs to attain or maintain the residents' highest well-being. The care plan must be reviewed and revised according to the Resident Assessment Instrument Instructions.</p> <p>Review of the clinical record for Resident #3, revealed the facility admitted the resident with diagnoses of Diabetes, Hypertension and Oropharyngeal Dysphagia. The facility completed a significant change Minimum Data Set (MDS)</p>		<p>The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.</p> <p>Compliance date: 03-07-2012</p>	03-07-2012
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F 280	Continued From page 8 assessment which revealed the resident was slowly losing weight. On 12/13/11, a gastric tube was surgically implanted and the facility began tube feeding Resident #3. On 01/01/12, the speech therapist initiated aspiration precautions and instructed staff that she was the one person allowed to provide the resident with any oral feedings. The facility had the family sign an Against Medical Advice form, on 01/04/12, when the family determined they would provide the resident with oral feedings even though the resident aspirated easily.	F 280		
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	Observation of Resident #3, on 01/24/12 at 12:30 PM, 2:30 PM and 3:55 PM, and on 01/25/12 at 11:00 AM and 3:00 PM, revealed the resident receiving tube feedings with no members of the immediate family present. The head of the bed was elevated just at forty-five (45) degrees.			
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	Review of the facility's comprehensive care plan for Resident #3, revealed the resident was to have nothing by mouth and received tube feeding for nutrition. There was no documentation located on the care plan to address the resident's aspiration precautions or to address the family's decision to feed the resident orally. Interview with the MDS Coordinator, on 01/26/12 at 5:00 PM, revealed the care plan did not include interventions to address the family feeding the resident orally or to address the aspiration precautions for Resident #3. She stated interventions should have included elevating the head of the bed to forty-five (45) degrees to sixty			
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F 280	Continued From page 9 (60) degrees, monitoring for signs and symptoms of aspiration and monitoring the family when they fed the resident orally. She stated Resident #3's care plan should have been revised to reflect the resident's actual care when the changes occurred. Interview with the Director of Nursing, on 01/26/12 at 3:00 PM, revealed resident care plans were to be revised as needed and to reflect that staff were to monitor residents for signs and symptoms of aspiration when tube feedings were in use.	F 280		
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.	F 281	F281 An observation by the Director of Nursing on 01-27-2012 noted that medications were being signed out after administration. LPN #2 received corrective discipline 01-27-12. The Director of Nursing observed LPN #2 on 01/28/2012 and noted that LPN #2 was administering medications per policy including signing out medications after administration.	
	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 follow facility procedures for medication administration on the 400 Hall. Licensed Practical Nurse (LPN) #2 was observed to document that medications were administered to residents prior to the medications actually being administered for two (2) of four (4) residents on the medication pass. The findings include: Review of the facility policy for Medication		All licensed staff will be re-educated by the District Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager on the facility policy for documenting medication administration to include documentation of administration after medications have been administered. This re-education will be completed by 2/29/2012. The Education and Training Director, Director of Nursing, Assistant Director of Nursing or Unit Managers will observe a medication pass five (5) times per week for two weeks, then three (3) times per week for one (1) week, then two (2) times per week for two (2) weeks, then weekly for eight (7) weeks to assure that documentation of medication administration occurs after administration of the medications.	



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F 281	Continued From page 10 Administration, undated, revealed medications were documented as administered after the resident swallowed the medication. Observation of medication pass, on 01/25/12 at 8:10 AM, revealed LPN #2 pulled the morning medications out for Resident A, then initialed the Medication Administration Record (MAR) for each of the medications due. LPN #2 then went to the resident's room and gave the medications to the resident.	F 281	The results of these audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months and quarterly for three (3) quarters in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly. Compliance date: 03-07-2012	03-07-2012	
	Observation of the medication pass, on 01/25/12 at 8:30 AM, revealed LPN #2 pulled the medications due for the morning and initialed the MAR for each of the medications pulled for Resident B. She then went to the resident's room and administered the medications.				
F 309	Interview with LPN #2, on 01/25/12 at 9:00 AM, revealed it was acceptable for nurses to document medications as given prior to the actual administration of the medications. She then pulled out a facility policy and stated the medication was not to be documented until the resident swallowed the medications. She stated she did document the medications as given prior to actually administering the medications. Interview with the Director of Nursing, on 01/28/12 at 3:00 PM, revealed medications were not documented as administered until the resident swallowed the medications. 483.26 PROVIDE CARE/SERVICES FOR	F 309			



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F 309 SS=D	Continued From page 11 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy for Pain Management, revision date July, 2011, it was determined the facility failed to ensure one (1) of twenty-six (26) sampled residents received pain medications as ordered by the physician. The facility failed to administer Resident #21's transdermal (medication patch applied to the skin) pain patch as ordered by the physician on 10/16/11 and was not administered until 10/20/11 when received from the pharmacy. The findings are: Review of the facility's policy for Pain Management revealed a resident's pain level should be assessed any time it was suspected a resident was in pain, and the facility recognized resident self-reporting of pain as the most reliable indicator of pain. The Pain Management Policy included:... Item 10...the administration of scheduled and/or as needed pain medication to be administered as ordered by the physician as an intervention to manage pain.	F 309	F309 Resident #21's Duragesic 100 microgram per hour (mcg/hr) was noted by the Director of Nursing on 01-27-2012 to be in the medication cart and applied on the resident as ordered. An audit of all current resident's medications available compared to the resident's medication administration record will be completed by the Director of Nursing, Assistant Director of Nursing and Unit Managers by 2-29-2012 to assure all are available. Any identified concerns will be immediately corrected. All Licensed staff will be re-educated by the District Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager on obtaining a written prescription timely to ensure the medication is delivered and available to resident when due, as well as notification to the Director of Nursing when there is a delay in supplying a medication. This re-education will be completed by 2-29-2012 with no licensed staff working past 2-29-2012 without having received this re-education. The Director of Nursing, Assistant Director of Nursing or Unit Managers will audit Medication Administration Records and medications available for fifteen (15) residents weekly for twelve (12) weeks.	



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F 309	Continued From page 12 Review of the clinical record for Resident #21 revealed the facility admitted the resident on 03/15/02 with diagnoses of: Bilateral Knee Replacements; Osteoarthritis; and Ventroperitoneal Shunt (Implanted device in the brain to drain excess cerebrospinal fluid into the abdominal cavity). Review of the Pain Data Collection and Assessment form, dated 09/26/11 and performed quarterly, revealed the resident reported a pain level of nine (9) on a ten-point scale, with ten (10) being the highest level of pain. The resident reported the pain level interfered with daily activities and reported difficulty with sleep, and the resident described the pain as hurting all over the body. The Pain Data Collection and Assessment, dated 12/22/11, revealed Resident #21 reported a pain level of eight (8) on the ten-point scale, and reported the pain interfered with daily activities and sleep.	F 309	The results of these audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months and quarterly for three (3) quarters in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.	03-07-2012
			Compliance date: 03-07-2012	

	Review of the Medication Record for Resident #21, revealed a physician order dated 10/15/11 for a transdermal Duragesic 100 microgram per hour (mcg/hr) patch and a Duragesic 25 mcg/hr every seventy-two (72) hours. The Duragesic 100 mcg/hr patch was documented as administered on 10/12/11, was not documented as administered on 10/15/11 or 10/18/11, and was documented as administered on 10/20/11 at 2:00 PM. Review of the Physician's Note for Resident #21, dated 10/20/11, revealed Resident #21 rated the pain level as severe and all over the body. The Physician Note documented that Nursing notified the Nurse Practitioner on 10/20/11 that the Pharmacy required a written prescription for Duragesic 100 mcg/hr patch, and stated that			
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F 309	<p>Continued From page 13</p> <p>Resident #21 did not have Duragesic 100 mcg/hr patches available at the facility.</p> <p>Review of the Nursing Progress Notes for Resident #21, dated 12/20/11 at 1:30 AM, revealed Resident #21 was calling out and awake all night because she was sick and said, "I can't take it," and became angry and shouted at the nurse. [An indication of pain per the facility's pain policy].</p> <p>Interview, on 01/26/12 at 9:00 AM, with Resident #21 revealed the source of the pain was in both knees and the back, and rated the current pain level as nine (9). Resident #21 said the pain was constant and rated the pain as an eight (8) or nine (9) and said the pain was never completely relieved.</p> <p>Interview, on 01/26/12 at 10:30 AM, with LPN #1</p>	F 309		
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	<p>revealed that Resident #21 was assessed on 01/26/12 at 8:00 AM when Resident #21 was given one (1) Lortab 10 (pain medication). LPN #1 stated Resident #21 complained of back pain as a result of arthritis. LPN #1 reported Resident #21 preferred the pain medication to be administered as soon as possible because the pain was never completely relieved.</p> <p>Interview, on 01/26/12 at 1:30 PM, with the Director of Nursing (DON) revealed she did not believe Resident #21 understood the pain scale used at the facility because the resident always reported a pain level of eight (8) or nine (9). The DON said when Resident #21 rated the pain by a representative number on the ten (10) point pain scale, it was the resident's perception of pain, and was not an accurate description of the pain level</p>			
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F 309	Continued From page 14 experienced by the resident. The DON did not know the reason for the delay in reorder of the Duragesic patches for Resident #21 on 10/15/11, and said if Resident #21 was having pain when the Duragesic 100 mcg/hr patch was not available in the facility, the resident could have requested a Lortab 10 more frequently to treat the pain. Interview with the Unit Manger, on 01/26/12 at 11:00 AM, revealed she was aware the resident received Lortab on a scheduled basis and the resident wanted the medication as soon as it could be provided and usually got the medication one hour before it was scheduled to be given. Often times, the resident would come to the nurse's desk to ask for the pain medication. The Unit Manager further explained the Pharmacy required a hard copy of the prescription for Duragesic Patches because they could not be refilled without a new prescription. The patches come with a label on them which should be removed when the last patch was used. The label is attached to a form and faxed or sent to the pharmacy to alert and begin the process of obtaining a new prescription from the physician. Interview, on 01/26/12 at 1:55 PM, with the Pharmacist revealed the Pharmacy was required to obtain a hard (written) prescription for narcotics each time a narcotic was dispensed to the facility and said that was the accepted practice. The Pharmacist said it would have been prudent for the facility to notify the Pharmacy on 10/12/11 when the last Duragesic 100 mcg/hr patch was administered, which would have provided ample time to obtain a prescription for the medication prior to the next date of administration on	F 309		



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F 309 F 371 SS=F	Continued From page 15 10/15/11. 483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 309 F 371	F371 A new prep table was ordered on 2-17-2012. The rusty drawers have been covered/ lined until the new prep table arrives. An observation by the Nutritional Services Manager on 02-17-2012 noted staff to be using gloves to scrape dirty dishes and washing hands appropriately. An audit of the kitchen area was completed by the Nutritional Services Manager on 02-16-2012 to identify any concerns with sanitation, any identified concerns will be immediately corrected. An observation by the Administrator on 01-27-2012 noted staff to be using appropriate hand sanitation between serving residents as well as appropriate storage of the ice scoop in a plastic bag. An observation by the Nutritional Services manager noted staff to be using gloves to scrape dirty dishes and washing hands appropriately. An audit of the kitchen area was completed by the Nutritional Services Manager on 02-16-2012 to identify any concerns with sanitation, any identified concerns will be immediately corrected. An observation by the Administrator on 01-27-2012 noted staff to be using appropriate hand sanitation between serving residents as well as appropriate storage of the ice scoop in a plastic bag.	
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy for Personal Hygiene and Dishware Storage, it was determined the facility failed to store utensils in a clean drawer. In addition, the facility failed to wash hands when going from a dirty to a clean task, failed to store the ice scoop in a separate container from the ice and failed to wash hands between touching residents and serving food/beverages. The findings include: Review of the facility's policy for Storage of Dishware did not address storage of food service utensils. 1. Observation, on 01/24/12 at 9:35 AM, during the initial tour of the kitchen with the Acting Nutrition Service Manager revealed two (2)			



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F 371	<p>Continued From page 16</p> <p>drawers in the food preparation area, used by the Cook, had rusted interiors used to store food service utensils. Both drawers contained rust-colored dust and food particles among the serving utensils.</p> <p>Interview, on 01/24/12 at 9:40 AM, with the Acting Nutrition Service Manager revealed the rusted drawers were going to be replaced soon because they had become rusted. The Acting Nutrition Service Manager said staff do not use the food service utensils in the drawers because of the condition of the drawers, but was not sure why the food service utensils were stored in the rusted drawers, in the food preparation area.</p>	F 371	<p>The Nutritional Services Manager will re-educate the dietary service personal related to following the cleaning schedule and hand washing in the kitchen area. This education will be completed by 2-29-2012. No dietary staff will work past 2-29-2012 without having received this re-education. All Direct care staff and Department heads will be re-educated by the Director of Education and Training, The Director of Nursing, Assistant Director of Nursing or Unit Managers related to hand sanitation during meal service and storage of ice scoops. No direct care staff or Department Head staff will work past 2-29-2012 without having received this re-education.</p>	
	<p>2. Review of the facility's policy for Personal Hygiene revealed hands should be washed after touching anything that may contaminate the hands such as dirty dishes, unsanitized equipment, or washcloths, and before and after wearing gloves.</p>		<p>The Nutritional Services Manager or Assistant Nutritional Services Manager will perform weekly kitchen sanitation rounds for twelve (12) weeks. The Nutritional Service Manager or the Assistant Nutritional Service Manager will complete observations of the dietary staff during tray line and clean up to assure that staff are using appropriate hand washing and wearing gloves when appropriate three (3) times per week for twelve (12) weeks. The Administrator will complete weekly observations of meal service to assure staff are using appropriate hand sanitation and the ice scoop is stored appropriately three (3) times per week for two (2) weeks followed by weekly for ten (10) weeks.</p>	
	<p>Observation, on 01/26/12 at 2:20 PM, during the kitchen sanitation tour with the Acting Nutrition Director and the Nutrition Director in Training, revealed Dietary Staff #1 scraped and rinsed dirty dishes without the use of gloves and used hand sanitizer gel rather than handwashing before performing tasks with clean dishes removed from the dishwasher. Further observation revealed three (3) dispensers in the dishwashing room and one (1) in the main kitchen area used by kitchen staff for disinfection of the hands.</p> <p>Interview, on 01/26/12 at 2:30 PM, with Dietary Staff #1 revealed he was responsible for cleaning and sanitizing the dishes after lunch. Dietary</p>			



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F 371	<p>Continued From page 17</p> <p>Staff #1 reported he last washed his hands at 1:30 PM upon arrival to work for his scheduled shift. Dietary Staff #1 said he was trained to use hand sanitizer gel when moving from dirty dishes to clean dishes and said it was not necessary to wash the hands with soap and water or wear gloves if the hands were sanitized with gel.</p> <p>Interview, on 01/26/12 at 2:45 PM, with the Nutrition Director in Training revealed she did not know if Dietary Staff #1 should have washed his hands with soap and water, rather than sanitize with hand gel. Further interview, on 01/26/12 at 2:45 PM, with the Acting Nutrition Director revealed that staff were trained to use gloves to scrape and rinse dirty dishes, and then use hand sanitizer gel no more than three (3) consecutive times, then wash hands with soap and water.</p> <p>Interview, on 01/26/12 at 3:10 PM, with Dietary Staff #2 revealed she was trained not to use hand sanitizer gel as a substitute for handwashing with soap and water.</p>	F 371	<p>The results of these audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months and quarterly for three (3) quarters in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.</p> <p>Compliance date: 03/07/2012</p>	03-07-2012
	<p>Observation of the lunch meal in the dining room, on 01/25/12 at 11:20 AM, revealed the Activity Director going from resident to resident touching their arms, shoulders and wheelchair handles then scooping ice into glasses and serving residents drinks without washing her hands.</p>			



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F 371	Continued From page 18 Interview with the Activity Director, on 01/25/12 at 12:30 PM, revealed she did not realize she was touching residents and preparing drinks and serving residents without washing her hands. She stated this was not a good infection control practice.	F 371			
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.	F 441	F441 The ice scoop is stored in a clean, plastic bag as observed by the Administrator on 01-27-2012. The Director of Nursing observed on 01-27-2012 that staff were using appropriate hand hygiene with medication administration, catheter care and skin assessments.		
	(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.		The ice scoop is stored in a clean, plastic bag as observed by the Administrator on 01-27-2012. The Director of Nursing observed on 01-27-2012 that staff were using appropriate hand hygiene with medication administration, catheter care and skin assessments.		
	(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.		All direct care staff will be re-educated by the District Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager on the facility's policy for hand hygiene including hand hygiene during catheter care, skin assessments, and medication administration as well as appropriate storage of the ice scoop. This re-education will be completed by 2-29-2012, with no staff working after 2-29-2012 without having received this re-education.		



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F 441	Continued From page 19 (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 Handwashing techniques, CDC (Center for Disease Control) Guideline for Hand Hygiene in Health-Care Settings, the facility's policy and procedure for hand hygiene, and the Lippincott's textbook for nursing assistants, it was determined the facility failed to have an effective infection control program regarding hand hygiene. During one (1) of the two (2) meal observations the ice scoop was observed being repeatedly	F 441	The Director of Nursing, Assistant Director of Nursing or Unit Managers will observe meal service, catheter care, and medication administration and skin assessments five (5) times per week for two (2) weeks followed by three (3) times per week for two (2) weeks and then weekly for eight (8) weeks to assure that staff are using appropriate hand sanitation and that the ice scoop is stored appropriately. The results of these audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months and quarterly for three (3) quarters in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly	03-07-2012
	stored in the ice container by multiple staff members. During medication pass a nurse was observed to pick up a pill packet off the floor and proceed to give a resident medication without proper hand hygiene. During medication pass a nurse was observed to turn off the water faucet with her bare hands after performing hand washing. During catheter care a Certified Nursing Assistant (CNA) was observed assisting a resident with clean clothing, without changing gloves or performing hand hygiene on one (1) of the twenty-six (26) sampled residents. During the skin assessment for one (1) of twenty-six (26) sampled residents (Resident #6), hand hygiene was not practiced between glove change. The findings include:		Compliance date: 03-07-2012	



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F 441	Continued From page 20 Review of the CDC Guidelines for Hand Hygiene In Health-Care Settings, dated 10/25/02, revealed the following indications for handwashing and hand antiseptics: decontaminate hands before having direct contact with patients; decontaminate hands after contact with body fluids or excretions, mucous membranes, nonintact 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.	F 441		
	The facility did not provide a policy for proper storage of the ice scoop.			
	Review of the Lippincott's textbook for nursing assistants, 2005, revealed after cath care procedure is completed, remove your gloves and dispose of them in a facility-approved container. Assist the person into the supine position and help the person into clean clothing. 1. Observation of catheter care for Resident #7, on 01/24/12 at 4:00 PM, revealed CNA #4 completed catheter/perineal care on the resident, without changing gloves and washing hands, the CNA removed the resident's top and applied a clean nightgown. Interview with CNA #7, on 01/26/11 at 5:45 PM,			



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F 441	Continued From page 21 revealed she realized she used the same contaminated gloves to assist the resident into a clean gown after she had completed the task. The CNA revealed she had received training and was inserviced at the facility regarding the proper use of gloves. The CNA revealed the use of gloves from dirty to a clean task was a potential for contamination and infection control. Interview with the District Education and Training Director, on 01/26/12 at 6:55 PM revealed she does monitor for handwashing by walking around and watching care. The Education and Training Director revealed education had been provided, on handwashing and glove changes, routinely and upon hire. She revealed improper technique can have a potential infection control issue. The Education and Training Director revealed she did not use a tool when rounding. She revealed she wrote things down on a note pad when she noticed an issue.	F 441			
	The facility did not provide the recent audits performed by the District Education and Training Director. Review of the facility's in-service records revealed guidelines for perineal care, completed on 06/22/11, revealed after performing care the staff were to remove their gloves and wash their hands before touching clean clothing, linens, or the resident. Review of the facility's in-service on infection control, completed 12/21/11, revealed the section on hand hygiene stated to complete handwashing with soap and water when hands are visibly soiled, before eating, after using the restroom,				



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F 441	Continued From page 22 and when providing care for someone with c-diff. Interview with the Director of Nursing (DON), on 01/26/12 at 5:45 PM, revealed the observation was an infection control problem and revealed in-servicing was provided to the nursing staff. The DON revealed she monitors for handwashing by doing spot checks daily. The DON revealed if she notices a problem she trains the staff immediately, but had not noticed any issues during rounds. However, the DON revealed she had not observed a procedure that required gloves changes and stated she relied on the unit managers to watch and report any problems. 2. Observation during meal service, on 01/24/12 at 5:10 PM, revealed the staff were placing the ice scoop directly in the ice container on the beverage cart. Multiple staff members were observed serving ice and placing the scoop back down in the container.	F 441		
	Interview with the District Education and Training Director, on 01/26/12 at 6:55 PM, revealed staff were trained on the storage of the ice scoop and staff are aware they were to use a bag to store the ice scoop in, which is changed nightly. Review of in-service records revealed storage of the ice scoop was completed on 08/26/11. The outline of the in-service revealed the scoop must be placed in the baggie on the cart. The bag must be changed each night and be sure to date and time the bag. Interview with the DON, on 01/26/12 at 7:12 PM, revealed storage of the ice scoop during meal service was just brought to her attention on			



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F 441	Continued From page 23 01/25/12. The DON revealed she had monitored a meal service, and had noticed the scoop being stored in the ice container. However, the DON revealed she did not see this as an issue if the handle was sticking up. 3. Observations of the dinner meal in the dining room, on 01/24/12 at 5:20 PM, revealed the staff members were scooping ice into glasses and pouring up drinks for residents. After the staff members scooped up the ice, they placed the ice scoop back into the bin of ice. Six (6) different staff members were noted to be preparing drinks and passing them out to residents.	F 441			
	Interview with Certified Nurse Aide (CNA) #11, on 01/25/12 at 5:40 PM, revealed staff should not be placing the ice scoop back in the bin of ice after touching the handle. The scoop should be placed in a separate bin so as not to contaminate the ice as the scoop handle could have germs. She indicated she had received training on infection control. Interview with Licensed Practical Nurse (LPN) #4, on 01/24/12 at 5:45 PM, revealed staff forgot to make sure the ice scoop handled by staff was not placed back on top of the ice being used for residents' drinks. She stated the ice scoop handle was contaminated and should not have been placed back in the bin of ice between uses.				



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F 441	Continued From page 24 4. Observation of the medication pass on 01/25/12 at 8:10 AM, revealed LPN #2 picking up a medication packet from the floor then picking up a cup of medication and administering the medication to a resident without washing her hands. Interview with LPN #2, on 01/25/12 at 9:00 AM, revealed she should have washed her hands after picking something up off the floor and before administering the resident's medication. She stated this was an infection control problem. 5. Review of the facility hand washing policy, dated April 2010, revealed staff were to turn off water faucets with a paper towel and they were finished washing their hands.	F 441			
	Review of the staff member training records revealed staff were trained to turn the water faucets off using a paper towel after hand washing was completed. Observation of the medication pass, on 01/25/12 at 8:10 AM, revealed LPN #2 washing her hands twice between medication administrations for five (5) seconds and six (6) seconds respectively. In addition, she turned the water faucet off with the back of her bare wrist. Interview with LPN #2, on 01/25/12 at 9:00 AM, revealed it was facility policy to turn the water				

