

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

PRINTED: 03/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/27/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER THE GRANDVIEW A NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 640 WATER TOWER BYPASS CAMPBELLSVILLE, KY 42719
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS	F 000		
F 280 SS=D	<p>AMENDED 03/13/14 A Standard Health Survey for recertification was completed on 02/25 - 02/27/14. The facility was found not meeting the minimum requirements for recertification with deficiencies cited at the highest S/S of a D. A Life Safety Code Survey was conducted on 02/26/14 with no deficiencies.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <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 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 interviews, and record reviews, it was determined the facility failed to revise the plan of care for one (1) of sixteen (16) sampled residents</p>	F 280	<p><i>The Grandview Nursing and Rehabilitation Facility do not believe nor does the facility admit that any deficiencies exist. The Grandview Nursing and Rehabilitation reserves all rights to contest the survey findings through informal dispute resolutions administrative or legal proceedings. This plan of corrections does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is it meant to establish any standard care, contract, obligation or position. The Grandview Nursing and Rehabilitation reserves all rights to raise all possible contentions and criminal claim, action or proceeding. Nothing contained in the plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self-critical examination privileges which The Grandview Nursing and Rehabilitation does not waive, reserves the right to assert in any administrative, civil or criminal claim action or proceeding. The Grandview Nursing and Rehabilitation offers its responses, credible allegations of compliance and plan of correction as part of its ongoing effort to provide quality care to residents.</i></p>	

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

x [Signature]

TITLE

x Administrator

(X6) DATE

x 4/9/14

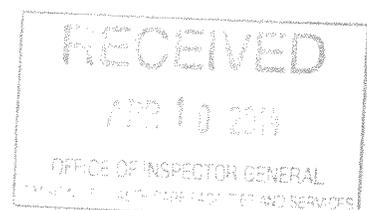
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

APR 10 2014

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

PRINTED: 03/13/2014
FORM APPROVED
OMB NO. 0938-0391

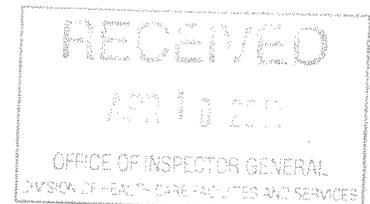
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/27/2014
NAME OF PROVIDER OR SUPPLIER THE GRANDVIEW A NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 640 WATER TOWER BYPASS CAMPBELLSVILLE, KY 42719		
(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 280	Continued From page 1 (Resident #12). The facility failed to reflect new physician orders for the Multiple Drug Resistant Organism (MDRO) Antibiotic Vancomycin being received at the dialysis center for a shunt infection and subsequent culture and sensitivity results in the plan of care. The findings include: The facility did not provide a policy specific to revision of care plans. Review of the clinical record for Resident #12 revealed the facility admitted the resident on 05/09/12, with diagnoses of End Stage Renal Disease, Renal Dialysis, Chronic Kidney Disease, Diabetes Type II, Alzheimer's disease, Paralysis Agitans, Difficulty Walking and Generalized Anxiety Disorder. A nursing note, dated 01/20/14 at 3:00 PM, revealed the Dialysis Nurse called with new orders from the physician to start Cipro 500 mg twice a day for 10 days and at dialysis she will be receiving Vancomycin for infection at shunt cath site. The family was updated. The record revealed LPN #4 wrote and transcribed the order for the Cipro medication. The nursing care plan for Resident #12 was updated, on 01/20/14, regarding the administration of the Cipro medication for 10 days for a shunt site infection. No mention was made in the resident's chart or the care plan regarding the resident receiving Vancomycin or an update on the culture and sensitivity of the shunt site infection. LPN # 4 was not available for an interview. An interview with the Interim Director of Nursing, MDS Coordinator, and the Administrator on, 02/27/14 at 10:30 AM, revealed they were not	F 280	<u>F 280 483.20(d)(3), 483.10(k)(2)</u> <u>RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</u> It is and was on the day of survey the policy and practice of The Grandview Nursing and Rehab to honor Resident Rights to participate in planning care and treatment. <u>1.</u> Resident #12 care plan was updated on 2/27/14 addressing the antibiotic that resident #12 received at the dialysis center. Resident #12 has received the antibiotics as ordered at the dialysis center and the facility. The shunt is working properly and contact isolation is no longer required. <u>2.</u> All dialysis residents have been reviewed by the Director of Nursing and care collaboration established with the dialysis center. All labs of all dialysis residents were reviewed for any infectious process and none were identified. All other residents presently receiving antibiotics were reviewed for infectious process that would require isolation. No other residents were identified.		



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

PRINTED: 03/13/2014
FORM APPROVED
OMB NO. 0938-0391

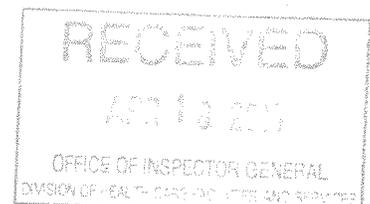
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/27/2014
NAME OF PROVIDER OR SUPPLIER THE GRANDVIEW A NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 640 WATER TOWER BYPASS CAMPBELLSVILLE, KY 42719		
(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 280	Continued From page 2 aware Resident #12 had been receiving the antibiotic Vancomycin at the dialysis center for a shunt infection. The procedure for updating the nursing care plans of the residents was the responsibility of the staff nurse, the Unit Coordinator and the MDS Coordinator.	F 280	3. The pre/post dialysis form was revised on March 1, 2014. The Administrator and The Director of Nursing met with Dialysis Center on 3/17/14, to discuss the revisions made to the pre/post dialysis sheet to establish clear channels of communication and care coordination. The Director of Nursing conducted an in-service on 3/17/14 . All nursing staff(LPN/RN's) were educated of the revisions made to the pre/post dialysis form. The Director of Nursing also re-educated all nursing staff (LPN/RN's) of the care plan process to ensure all aspects of residents needs are care planned so the needs of the resident are met.		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, it was determined the facility failed to ensure a medication administration rate of less than 5% for one (1) of sixteen (16) sampled residents and one (1) of five (5) unsampled residents. (Resident #6, and Unsampled Resident B). LPN #3 used improper administration of two medications per G/Tube for Resident #6 and crushed two medications together and administered them together with no flush between the medications. In addition, LPN #3 administered two nasal inhalers directly in succession together with no interval of time between the medications. LPN #1 utilized a nonrecommended anatomical site for a subcutaneous insulin injection. This resulted in three medication errors out of an opportunity of 25 which resulted in an medication error rate of 12%. The findings include:	F 332	4. As part of the facilities ongoing Quality Assurance Program all pre and post dialysis forms will be reviewed by the Unit Coordinator or Charge Nurse daily upon resident's return to the facility to ensure coordination of care. As an additional measure the Quality of Care committee which includes the Administrator and Director of Nursing will review all pre and post dialysis forms and dialysis care plans weekly to ensure the plan of care reflects the care the resident is receiving. This will be an ongoing practice.	3/21/14	



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

PRINTED: 03/13/2014
FORM APPROVED
OMB NO. 0938-0391

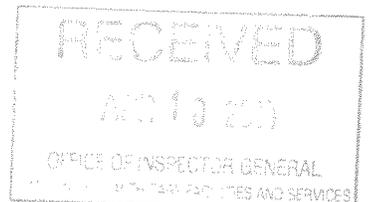
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/27/2014
NAME OF PROVIDER OR SUPPLIER THE GRANDVIEW A NURSING & REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 640 WATER TOWER BYPASS CAMPBELLSVILLE, KY 42719		
(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 332	<p>Continued From page 3</p> <p>1. Review of the facility's policy and procedure titled HA9: Enteral Tube Medication Administration, (rev 12/07/12), revealed medications should be crushed to a powder to avoid clogging the tube. Medications may be crushed and must be given separately and flushed with at least 5 milli-liters (ml) of warm water between each medication. The soufflé cup is rinsed with water to get all of the medication.</p> <p>Observation of an enteral tube medication pass, on 02/26/14 at 09:35 AM, for Resident #6, revealed LPN #3 was observed to crush two medications together, Lopressor 25 mg one tablet and Isordil 30 mg two tablets, the nurse dissolved the medications together in water, and administered both of the medications together with no flush observed between the two medications.</p> <p>Interview, on 02/27/14 at 2:30 PM, with LPN #3 revealed it was her usual practice during the administration of medication through an enteral tube to crush the medication separately and to administer the medication separately with a flush of water in-between each medication. She did not know why she crushed the two medications for Resident #6.</p> <p>Interview with the MDS Coordinator and Interim Director of Nursing, on 02/27/14 at 3:25 PM, revealed it was their expectation that all of the staff nurses follow the policy and procedure for the administration of medication through an enteral tube and administer each medication separately and flush with water between each medication.</p> <p>2. Review of the facility's policy and procedure</p>	F 332	<p>F 332 489.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>It is and was on the day of survey for the facility to have a medication error rate of 5% or less</p> <p><u>1.</u> The sampled and unsampled residents have not had any adverse effects related to the practice of medication administration. All residents have been physically assessed by the Charge Nurse.</p> <p><u>2.</u> All nurses have been re-educated by the pharmacy related to proper medication administration specifically proper G-tube administration, insulin site selection and nasal spray administration. All residents have been and are assessed weekly. No adverse reactions have been noted related to medication administration.</p> <p><u>3.</u> An inservice was conducted by pharmacy on 3-17-14 for all licensed staff (LPN's and RN's) reviewing proper administration of medications by various routes and selection sites for insulin administration. The pharmacy will pass medications with all nurses at least annually to establish compliance. They will pass with all new nursing staff before the end of orientation to establish competence.</p>	



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

PRINTED: 03/13/2014
FORM APPROVED
OMB NO. 0938-0391

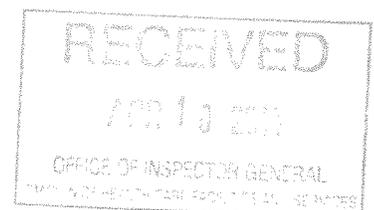
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/27/2014
NAME OF PROVIDER OR SUPPLIER THE GRANDVIEW A NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 640 WATER TOWER BYPASS CAMPBELLSVILLE, KY 42719		
(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 332	Continued From page 4 titled Nasal Inhaler, Spray, and Pump Administration, not dated, revealed after removing the spray bottle from the nostril, have the resident tilt their head back for several seconds to aid penetration of the drug. Repeat for the other nostril, if indicated. Review of the Medication Pass Review for other administration procedures revealed the staff was to be aware of timing/spacing requirements with eye drops and inhaled medications. Review of the Tips for Administering Inhaled Medications revealed if a second puff of the same medication is prescribed, the nurse should wait at least one minute between puffs. Some medications require longer spacing, such as two minutes between puffs. Observation of the administration of two nasal inhalers, on 02/26/14 at 09:30 AM, for Resident #6, revealed LPN #3 was observed to administer two nasal inhalers Nasonex nasal spray two sprays to each nostril, and Flonase nasal spray two sprays to each nostril to the resident in direct sequence with no interval between the two different nasal inhalant medications. Interview, on 02/27/14 at 2:30 PM, with LPN #3 revealed it was her usual practice to provide an interval of one minute between the administrations of more than one nasal inhaler. She did not know why she administered both of the nasal inhalers in direct sequence. Interview with the MDS Coordinator and Interim Director of Nursing, on 02/27/14 at 3:25 PM, revealed it was their expectation that all of the staff nurses provide an interval of 3-5 minutes between the administrations of different nasal inhalers.	F 332	4. As part of the facility's ongoing quality assurance program the Director of Nursing will do at least one medication administration competency check of licensed staff (LPN/RN's) weekly to ensure competence of the nursing staff. This practice will continue for the next three months. If no additional problems are identified then the audits will be continued by pharmacy as described above. All medication administration competency check offs will be maintained by the Director of Nursing in a file in her office.	3/21/14	



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

PRINTED: 03/13/2014
FORM APPROVED
OMB NO. 0938-0391

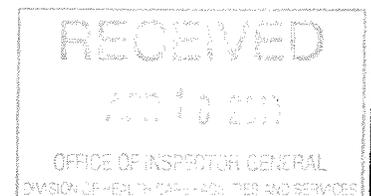
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/27/2014
NAME OF PROVIDER OR SUPPLIER THE GRANDVIEW A NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 640 WATER TOWER BYPASS CAMPBELLSVILLE, KY 42719		
(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 332	Continued From page 5 3. Review of the facility's policy and procedure titled Subcutaneous Medication Administration, not dated, revealed the nurse was to select an appropriate site for injection. The sites listed for use were: left buttock; right buttock; left arm; right arm; left thigh; right thigh; left abdomen; and right abdomen. Review of the facility's Insulin Injection Tips provided as an inservice training to the nurses revealed possible insulin injection sites were identified as described above. Review of the Joslin Diabetes Center, Harvard University, Tips for Insulin Injection, revealed insulin is not to be injected around the umbilicus (belly button) as the area is tough and absorption is inconsistent. Observation of the administration of a subcutaneous (SQ) insulin injection, on 02/26/14 at 8:45 AM, for Unsampled Resident B, revealed LPN #1 administered Levemir Insulin 30 units SQ directly to the right of resident's umbilicus. Interview, on 02/27/14 at 2:45 PM, with LPN #1 revealed that she had not been taught in nursing school to avoid the direct area surrounding the umbilicus when administering an injection. Interview with the MDS Coordinator and Interim Director of Nursing, on 02/27/14 at 3:25 PM, revealed it was their expectation that all of the staff nurses follow the facility's policy and procedure with the administration of all IM and SQ injections, including the recommended sites of administration.	F 332			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	<u>F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</u> It is and was on the day of survey the policy and practice of the facility to 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.		



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

PRINTED: 03/13/2014
FORM APPROVED
OMB NO. 0938-0391

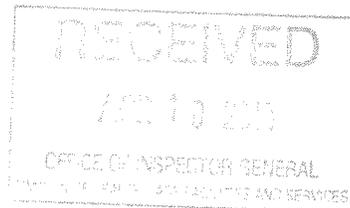
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/27/2014
NAME OF PROVIDER OR SUPPLIER THE GRANDVIEW A NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 640 WATER TOWER BYPASS CAMPBELLSVILLE, KY 42719		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 6</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 -</p> <ol style="list-style-type: none"> (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>(b) Preventing Spread of Infection</p> <ol style="list-style-type: none"> (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. <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:</p>	F 441	<ol style="list-style-type: none"> 1. Resident #12 completed the antibiotic therapy as ordered by the physician and no further isolation is required. 2. All residents are assessed at least weekly or as their condition warrants. All dialysis residents have been assessed by the Charge Nurse and collaboration of care established to ensure any potential infection is communicated to this facility. 3. The pre/post dialysis form has been revised to include any infectious process that the dialysis center is following. These forms will be reviewed by the Unit Coordinator or Charge Nurse upon residents to the facility. If the dialysis fails to completely fill out the form the form will be sent back via fax for completion. This will ensure any potential infection will be quickly communicated and identified by both care providers and precautions put in place. The Director of Nursing in-serviced all licensed nursing staff (LPN and RN's) on 3/17/14 of the revisions made to the pre/post dialysis form. All licensed nursing staff (LPN and RN's) were educated of the revisions made for the process of these forms as well. As part of the facility's ongoing quality assurance program the residents antibiotic log is reviewed weekly during Quality Care meeting. 		



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

PRINTED: 03/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/27/2014
NAME OF PROVIDER OR SUPPLIER THE GRANDVIEW A NURSING & REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 640 WATER TOWER BYPASS CAMPBELLSVILLE, KY 42719	
(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)
F 441	<p>Continued From page 7</p> <p>Based on interviews, and record reviews, it was determined the facility failed to ensure infection control procedures were followed for an antibiotic resistant contagious infection for one (1) of sixteen (16) sampled residents (Resident #12). The facility staff was aware the resident was receiving Vancomycin for a multi drug resistant organism (MDRO) antibiotic at dialysis; however, failed to inform administration for surveillance and the initiation of contact precautions.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure for Multi-Drug Resistant Organisms (MDROs) from the Infection Prevention manual for Long Term Care, revealed the purpose was to prevent transmission of multi-drug resistant organism (MDROs). When implementation of routine control measures was not effective, control measure should be intensified. The policy was prevention, containment and eradication measures including use of contact precautions were indicated to prevent the spread of resistant microorganisms that have been identified within a facility. Prevention and control of MDRO's within the facility was considered a resident safety measure. Statistics would be kept for the facility related to MDRO's. One isolate per resident was used when tabulating statistics related to MDRO's.</p> <p>Review of the clinical record for Resident #12 revealed the facility admitted the resident on 05/09/12, with diagnoses of End Stage Renal Disease, Renal Dialysis, Chronic Kidney Disease, Diabetes Type II, Alzheimer's disease, Paralysis Agitans, Difficulty Walking and Generalized Anxiety Disorder. The record revealed a nursing</p>	F 441	<p>4.</p> <p>As part as the facility's ongoing quality assurance program, all pre/post dialysis forms will be reviewed weekly in Quality Care meeting to assure all communication between the facility and the dialysis center has been addressed.</p> <p style="text-align: right;">3/21/14</p>



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

PRINTED: 03/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/27/2014
NAME OF PROVIDER OR SUPPLIER THE GRANDVIEW A NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 640 WATER TOWER BYPASS CAMPBELLSVILLE, KY 42719		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 8</p> <p>note entry, dated 01/20/14 at 3:00 PM, that stated a Dialysis Nurse called with new orders from the physician to start Cipro 500 mg twice a day for 10 days and at dialysis the resident would be receiving Vancomycin for infection at the shunt cath site. The family was updated. The record revealed LPN #4 wrote and transcribed the order for the Cipro medication. The nursing care plan for Resident #12 was updated, on 01/20/14, regarding the administration of the Cipro medication for 10 days for a shunt site infection. No mention was made in the resident's chart or care plan regarding the Resident receiving Vancomycin or an update on the culture and sensitivity of the shunt site infection. Review of the infection control surveillance sheets for the month of December 2013 and January 2014, revealed no documented evidence of a shunt infection for Resident #12.</p> <p>LPN # 4 was not available for an interview.</p> <p>Interview with the Interim Director of Nursing, MDS Coordinator, and the Administrator, on 02/27/14 at 10:30 AM, revealed they were not aware Resident #12 had been receiving the antibiotic Vancomycin at the dialysis center for a shunt infection. The Interim Director of Nursing and MDS Coordinator revealed they and the Medical Records Coordinator had been tracking the surveillance of the infections in the facility based on the written MD orders which were recorded in the resident's record. The Interim Director of Nursing, MDS Coordinator, and the Administrator stated they should have been aware of Resident #12's shunt infections and her receiving Vancomycin at the dialysis center.</p>	F 441			

