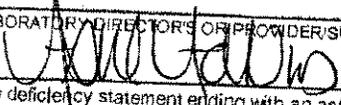


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/31/2014
FORM APPROVED
OMB NO. 0938-0391

RECEIVED
FEB 24 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2014
NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS A Recertification Survey was initiated on 01/14/14 and concluded on 01/16/14. Deficiencies were cited with the highest scope and severity of a "E".	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Bridge Point Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." <u>F280</u> Resident #11's care plan and the Nursing Assistant Kardex was updated by a licensed nurse on 1/16/14 including the 10/27/13 Fall intervention of having therapy evaluate the resident and the amount of assistance required for transfers, ambulation and toileting. The Director of Nursing, and the Unit Managers will audit current resident care plans and Nursing Assistant Kardex by 2-21-14 to determine that the resident care plans and Kardex reflect the residents current needs including but not limited to fall	2/22/14	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy it was determined the facility failed to revise the Comprehensive Care Plan for one (1) of twenty-four (24) sampled residents (Resident #11).	F 280			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  2/24/14 NHA					

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 280	Continued From page 1 Although the Quarterly Minimum Data Set (MDS) assessment completed on 10/24/13 for Resident #11 revealed the facility assessed the resident as requiring one (1) person physical assist for transfers and toileting and supervision and set up help for ambulation, the Comprehensive Plan of Care was not specific as to how much assistance the resident required in these areas. In addition, Resident #11's care plan was not revised after sustaining a fall on 10/27/13. Although Nursing had made a referral to Physical Therapy (PT) and the PT communication to nursing on 11/12/13 revealed Resident #11 required staff assistance with transfers and ambulation, the care plan was not revised to reflect this. The findings include: Review of the facility's policy titled, Nursing Care Plans, revised 01/02/14, revealed the care plan was to include measurable objectives to meet resident needs and goals as identified by the assessment process. Further review revealed the Comprehensive Care Plan was reviewed and revised a minimum of quarterly and as needed to reflect response to care and changing needs and goals. Observation of Resident #11 on 01/14/14 at 11:30 AM revealed the resident was standing unattended at the bedside, opening a dresser drawer. Resident #11 was observed again at 2:30 PM on 01/14/14 self-propelling to the toilet in the Hall Shower Room. Resident #11 commented he/she liked to use the shower room bathroom because there was more room for his/her wheelchair; and, therefore did not need assistance with toileting. Interview with Resident	F 280	interventions and the amount of assistance required for transfers, ambulation, and toileting. Any issues identified will be addressed at that time. Licensed nurses will be re-educated by the Director of Nursing and Unit Managers on the care plan policy by 2/21/14. Education will include updating care plans and the nursing assistant Kardex after a fall or change in the plan of care including the amount of assistance needed with activities of daily living. The Director of Nursing and/or Unit Managers will audit 6 resident care plans and nursing assistant Kardex's weekly for 8 weeks, and then monthly for 4 months to determine that the resident care plans and Kardex reflect the residents current needs including but not limited to fall interventions and the amount of assistance required for transfers, ambulation, and toileting. Any concerns identified will be addressed at that time. The results of the audits will be presented by the Director of Nursing to the Performance Improvement committee monthly x6 months for further review and recommendations.	

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F 280 Continued From page 2
#11 at the time of this observation revealed the resident remarked, "i take myself to the toilet so i do not have to wait for help". Observation of Resident #11 on 01/15/14 at 9:25 AM, revealed him/her standing independently at the bedside straightening the sheets and blankets on his/her bed. Interview at the time of the observation with Resident #11 revealed he/she stated, " I know I am a little unsteady but I like to do things for myself".

Review of Resident #11's medical record revealed the facility admitted the resident on 03/13/13, with diagnoses which included a Personal History of Falls, Muscle Weakness, Difficulty Walking, and Dementia. Review of the Quarterly Minimum Data Set (MDS) assessment completed on 10/24/13 revealed the facility assessed Resident #11 as having a Brief Interview for Mental Status (BIMS) of a fourteen (14) out of fifteen (15), which indicated the resident was cognitively intact. Continued review of the MDS assessment revealed the facility assessed Resident #11 as requiring one (1) person physical assist for transfers and toileting and supervision and set up for ambulation.

Review of the Comprehensive Care Plan initiated 05/06/11, revealed Resident #11 had a history of falls and non-compliance with asking for assistance before transferring. The care plan included falls interventions; however there was no documented it contained specific interventions related to the MDS assessment which indicated Resident #11 required one (1) person physical assistance for transfers and toileting and supervision for ambulation. Review of the Certified Nursing Assistant (CNA) Kardex Report for January 2014 revealed Resident #11 was to

F 280

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F 280	<p>Continued From page 3</p> <p>transfer and toilet with the assist of two (2) and ambulation was marked as not applicable.</p> <p>Review of the Risk Management/Quality Assurance Form revealed on 10/27/13 at 9:45 AM, Resident #11 was found sitting on the floor on his/her buttocks. Continued review of the Form revealed Resident #11 had stated he/she was getting out of bed to transfer to his/her wheelchair to go to the rest room and slid down to the floor. Further review revealed the resident sustained no injury.</p> <p>Review of the Rehabilitation Referral (form used by nursing staff to communicate with Rehabilitation services) dated 10/28/13, revealed it indicated Resident #11 had fallen on 10/27/13 and was using the bedside table as a walker to aide in stability to transfer from the bed to the wheelchair. Further review of this form revealed nursing staff had documented, "Could resident benefit from the use of a walker or therapy services"?</p> <p>Review of the Physical Therapy (PT) Communication Form To Nursing dated 11/12/13 revealed Resident #11 was to transfer with supervision due to decreased safety with transfer technique and could ambulate with a rolling walker with care giver assistance.</p> <p>Interview with the Therapy Program Director (TPD) on 01/15/13 at 11:00 AM revealed Resident #11 was discharged from PT on 10/24/13 with contact guard assist (caregiver assistance with a gait belt). The TPD revealed there was a verbal conversation with the Unit Manager and a Physical Therapist Assistant (PTA) after the fall on 10/27/13, which was not</p>	F 280			

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F 280	<p>Continued From page 4</p> <p>documented, during which it was determined Resident #11 did not need a rolling walker because there had not been a decline after the fall on 10/27/13. She stated, Resident #11 was evaluated on 11/12/13 by PT to need supervision with transfers. The TPD stated Resident #11 was to transfer with supervision and the use of a gait belt.</p> <p>Interview, on 01/15/14 at 2:30 PM, with Registered Nurse (RN) #3, who was assigned to the resident, revealed she was uncertain if Resident #11 was care planned for assistance for toileting and transfers. RN #3 stated she was uncertain who determined if residents were safe to transfer and toilet independently; and revealed Resident #11 did transfer and toilet independently.</p> <p>Interview with the Unit Manager, RN #4 on 1/15/14 at 3:00 PM revealed she was uncertain if Resident #11 required supervision with transfers and toileting. Unit Manager/RN #4 stated she had referred Resident #11 to PT for evaluation after the fall on 10/27/13 but was uncertain of PT's findings and recommendations.</p> <p>Interview with the Restorative Nursing Director, Licensed Practical Nurse (LPN) #1 on 01/15/14 at 2:00 PM, revealed Resident #11 was discharged from PT at his/her maximum potential in December 2013 with assist of one for transfers and toileting and the use of a gait belt when ambulating. LPN #1 was uncertain if Resident #11 was to be toileting and transferring independently at this time. Continued interview with LPN#1 on 1/16/14 at 11:30 AM, revealed a resident's care plan should be revised or changed if there are any declines or improvements in the</p>	F 280			

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F 280	Continued From page 5 resident's condition. She indicated Resident #11's care plan should have been revised. Interview, on 01/16/14 at 11:20 AM, with Certified Nursing Assistant (CNA) #4, who was assigned to the resident, revealed she determined a resident's needs from looking at the CNA Kardex; the verbal report given to her from the CNA on the shift prior to her shift; and her personal knowledge of a resident's needs to determine whether residents should transfer and toilet independently. CNA #4 stated Resident # 11 transferred and toileted independently. After reviewing the CNA Kardex for Resident #11, CNA #4 stated according to it the resident required the assistance of two (2) staff for transfers, and toilet use. Further interview with the Unit Manager/RN #4 on 01/16/14 at 11:50 AM revealed the Comprehensive Plan of Care was not revised after the fall on 10/27/13; however should have been updated by the nurse who assessed the resident after the fall to indicate whether a new intervention should have been placed then. She further stated the Care Plan should have been revised with the interventions recommended by PT for January 2014 Resident #11 to transfer with supervision. She stated it was her responsibility to see that the care plans were updated and that the interventions were carried out. The Unit Manager commented she needed to review all of Resident #11's care plans.	F 280		
F 282 SS=D	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	F 282		

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F 282	<p>Continued From page 6 accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policies, it was determined the facility failed to ensure services provided were in accordance with each resident's individualized written Plan of Care for one (1) of twenty-four (24) sampled residents (Resident #1).</p> <p>Resident #1's Comprehensive Plan of Care revealed the resident was care planned for the potential for falls related to attempts to transfer unassisted and included interventions of a pressure alarm to his/her wheelchair and an intervention for padded bed side rails for positioning, which was also listed as an intervention under the self care deficit care plan. However, observations on 01/14/14 and 01/15/14 revealed Resident #1 had no pressure alarm to his/her wheelchair and no padded bed side rails.</p> <p>The findings include:</p> <p>Review of the facility policy titled, "Care Plans", revised date 01/02/14, revealed a comprehensive, individualized care plan was to be developed by the interdisciplinary team for each patient. The purpose of the care plan was to provide necessary care and services to attain or maintain the patient's highest practicable physical, mental, and psychosocial well being. Further policy review revealed the care plan was based on assessments/evaluations of the resident and was to be communicated to appropriate staff.</p>	F 282	<p><u>F 282</u></p> <p>The physician for Resident #1 was notified by a licensed nurse on 1-16-14 and new orders obtained to discontinue the pressure alarm and to use a tab alarm to the wheelchair and the padded side rails were discontinued. The care plan and nursing assistant Kardex for resident #1 was updated by a licensed nurse on 1-16-14 with the new orders related to the wheelchair alarm and padded side rails.</p> <p>The Director of Nursing and the Unit Managers will audit current resident care plans and the residents by 2-21-14 to determine that care and services are provided in accordance with the care plan. Any concerns identified will be addressed at that time.</p> <p>Licensed nurses and nursing assistants will be re-educated by the Director of Nursing and Unit Managers on providing services in accordance with the residents care plan policy by 2/21/14.</p>		

2/21/14

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F 282

Continued From page 7

Review of Resident #1's medical record revealed the facility re-admitted the resident on 09/18/13, with diagnoses which included Non-Alzheimer's Dementia, Parkinson's Disease, Anxiety and Psychosis. Review of the Quarterly Minimum Data Set (MDS) assessment dated 12/31/13, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of twelve (12) which indicated the resident was moderately impaired cognitively. Further review revealed the facility assessed Resident #1 to require extensive assist of two (2) staff for transfers.

Review of Resident #1's Comprehensive Care Plans revealed a care plan for the potential for falls related to the resident's attempts to transfer unassisted and use of psychoactive medications, with a revised date of 10/08/13. Continued review of this care plan revealed interventions which included a pressure alarm to Resident #1's wheelchair and bilateral padded bed side rails to assist with positioning in bed. In addition, Resident #1 had a self care deficit care plan, revised date of 10/08/13, which also listed bilateral padded side rails for bed mobility.

Observations of Resident #1's wheelchair and bed side rails on 01/14/14 at 9:47 AM, at 1:28 PM, and at 3:21 PM; and on 01/15/14 at 8:22 AM and at 9:04 AM revealed no evidence of a pressure alarm on the resident's wheelchair and no evidence of padded side rails. Additional observations of Resident #1 on 11/15/14 at 10:27 AM, at 11:24 AM, and at 2:36 PM revealed a pull tab alarm device had been placed on the wheelchair.

F 282

The Director of Nursing and/or Unit Managers will audit 6 resident care plans and the resident weekly for 8 weeks, then 6 resident care plans monthly 4 months to determine that the resident care plans and Kardex reflect the residents current needs including but not limited to fall interventions and the amount of assistance required for transfers, ambulation, and toileting.. Any concerns identified will be addressed at that time. Results of the audits will be presented to the Performance Improvement Committee monthly 6 months for further review and recommendation.

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F 282	<p>Continued From page 8</p> <p>Interview with State Registered Nurse Assistant (SRNA) #6 caring for Resident #1, on 01/15/14 at 9:54 AM, revealed she did not see any alarm on Resident #1's wheelchair or padded bed side rails. The SRNA stated she thought the pressure alarm intervention was on the aide care plan; however was not certain.</p> <p>Interview, on 01/16/14 at 4:24 PM, with Licensed Practical Nurse (LPN) #2, who cared for Resident #1, revealed the resident had a pressure alarm to his/her wheelchair as a fall precaution. After observing Resident #1's wheelchair at the time of the interview, LPN #2 stated the resident had a pull tab alarm device in place, not a pressure alarm as indicated in the care plan. She further stated Resident #1 should have had the pressure alarm; and if the alarm was changed to a different one then the care plan should have been revised. Continued interview with LPN #2 revealed Resident #1's bed rails were not padded which was usually done for seizures; however should have been as per the care plan. She indicated if the padded side rails were discontinued the care plan should have been revised.</p> <p>Interview, on 01/16/14 at 5:06 PM, with the Unit Manager/Registered Nurse (RN) #6 revealed Resident #1 was supposed to have a pressure alarm on his/her wheelchair; but currently there was not one (1) in the building so a pull tab alarm had been placed on the resident's wheelchair. The RN stated staff were supposed to monitor to ensure the pressure alarm was in place to the wheelchair. Continued interview with RN # 6 revealed Resident #1 had a history of seizures and his/her side rails should have been padded for resident safety. She stated she thought when the resident's bed had been changed out, the bed</p>	F 282			

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F 282 Continued From page 9
rails were not padded as indicated in the care plan.

Interview, on 01/16/14 at 4:44 PM, with the Assistant Director of Nursing (ADON) revealed the purpose of the care plan was to guide care of a resident. The ADON stated if Resident #1's care plan interventions included a pressure alarm device to the wheelchair the alarm should have been on the wheelchair. She further stated if the resident now had a tab alarm device it was the nurse's responsibility to check and clarify what alarm the resident had. Continued interview with the ADON, revealed nurses should have ensured the side rails of the bed were padded as indicated in the care plan. The ADON stated she thought the resident had a history of seizures and needed the padded side rails.

F 282

F 323
SS=D 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

F 323

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 by:
Based on observations, interviews, record review, and review of facility policy, it was determined the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for one (1) of twenty-four (24) sampled residents (Resident

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F 323	Continued From page 10 #1). Record review revealed Resident #1 had a history of a fall when attempting to self transfer to the toilet. Resident #1 was care planned for the potential for falls related to attempts to transfer unassisted and included an intervention of a pressure alarm to his/her wheelchair. In addition, interviews revealed the resident had a history of seizures and had an intervention for padded bed side rails. However, observations on 01/14/14 and 01/15/14 revealed Resident #1 had no pressure alarm to his/her wheelchair or padded bed side rails. The findings include: Review of the facility's policy: "Accidents, Incidents, and Adverse Events", revised date 09/01/13, revealed the purpose was to provide a safe and healthful environment for residents, visitors, and staff. Review of the facility's policy: "Care Plans", revised date 01/02/14, revealed the purpose of the care plan was to provide necessary care and services to attain or maintain the patient's highest practicable physical, mental, and psychosocial well being. Further policy review revealed the care plan was based on assessments/evaluations of the resident and was to be communicated to appropriate staff. Review of Resident #1's medical record revealed the facility re-admitted the resident on 09/18/13, with diagnoses which included Psychosis, Non-Alzheimer's Dementia, History of Falls, and Anxiety. Interview, on 01/16/14 at 5:06 PM, with the Unit Manager/Registered Nurse (RN) #6	F 323	<u>F323</u> The physician for Resident #1 was notified by a licensed nurse on 1-16-14 and new orders obtained to discontinue the pressure alarm and to use a tab alarm to the wheelchair and the padded side rails were discontinued. The care plan and nursing assistant Kardex for resident #1 was updated by a licensed nurse on 1-16-14 with the new orders related to the wheelchair alarm and padded side rails. The Director of Nursing and Unit managers will complete an audit of current resident care plans and safety devices to ensure each resident receives adequate supervision and assistive devices to prevent accidents by 2-21-14. Any concerns identified will be addressed at that time. The Director of Nursing and the Unit Managers will re-educate licensed nurses and nursing assistants to the facility accident, incidents and adverse effects policy by 2/21/14 to include validating that devices are in	2/22/14	

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

PRINTED: 01/31/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/16/2014
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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042
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F 323

Continued From page 11 revealed Resident #1 had a history of Seizures.

Review of the Quarterly Minimum Data Set (MDS) assessment dated 12/31/13, revealed the facility assessed Resident #1 to require extensive assist of two (2) staff for transfers. Further review of the MDS assessment revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of twelve (12) indicating the resident had moderate cognitive impairment.

Continued review of Resident #1's medical record revealed an Interdisciplinary Progress Note on 09/04/13 time 11:30 AM, which noted the resident was lying on the floor in the room next to the bathroom door. The Note stated the resident had attempted to self transfer to the toilet, lost his/her footing and fell to the floor. Further review of the Note revealed no injury was noted.

Review of the Comprehensive Care Plans for Resident #1, revised 10/08/13, revealed the resident was care planned for the potential for fall and self care deficit. Review of these care plans revealed interventions which included the use of a pressure alarm to Resident #1's wheelchair and for padded half side rails on the bed to assist with bed mobility.

Review of the January Monthly Physician Orders revealed an order for a pressure alarm to Resident #1's wheelchair which staff were to check placement and function of every shift. Further review of the January Monthly Physician Orders revealed an order for bilateral padded half side rails.

Review of the January 2014 Treatment

F 323 place, checked for placement and function and documented accordingly.

The Director of Nursing and/or Nursing Supervisors will conduct daily rounds randomly across all three shifts to observe for resident safety. Any concerns identified will be addressed at that time.

The Director of Nursing and/or the Unit Managers will audit 6 residents, care plans and safety devices weekly x8 weeks and then monthly x4 months to determine that residents receive adequate supervision and assistive devices to prevent accidents. Any concerns identified will be addressed at that time. Results of the audits will be presented by the Director of Nursing to the Performance Improvement Committee monthly x6 months for further review and recommendation.

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

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OMB NO. 0938-0391

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F 323	<p>Continued From page 12</p> <p>Administration Record (TAR) revealed Resident #1's wheelchair pressure alarm intervention was to be checked to ensure it was in place and functional every shift. Continued review revealed staff initials indicating the alarm was in place everyday, including 01/14/14 day shift.</p> <p>Observations, on 01/14/14 of Resident #1's wheelchair and bed side rails at 9:47 AM, at 1:28 PM, and at 3:21 PM; and, on 01/15/14 at 8:22 AM and at 9:04 AM revealed no evidence of a pressure alarm on Resident #1's wheelchair and no evidence of padded side rails on the bed as per Physician Orders. Additional observations of the resident on 11/15/14 at 10:27 AM, at 11:24 AM, and at 2:36 PM revealed a pull tab alarm had been placed on Resident #1's wheelchair.</p> <p>Interview with State Registered Nurse Assistant (SRNA) #6 caring for Resident #1, on 01/15/14 at 9:54 AM, revealed there was no alarm on Resident #1's wheelchair or padded side rails on the bed.</p> <p>Interview, on 01/16/14 at 4:24 PM, with Licensed Practical Nurse (LPN) #2, who cared for Resident #1, revealed a pressure alarm was to be in place to his/her wheelchair as a fall precaution. LPN #2 also stated padded side rails were usually put in place as a seizure precaution. She indicated Resident #1's bedside rails were not padded; however should have been.</p> <p>Interview, on 01/16/14 at 5:06 PM, with the Unit Manager/Registered Nurse (RN) #6 revealed Resident #1 should have had a pressure alarm on his/her wheelchair; however there was not one available currently so a pull tab alarm was placed on his/her wheelchair. According to RN #6, staff</p>	F 323		

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

PRINTED: 01/31/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2014
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F 323	Continued From page 13 were supposed to monitor the wheelchair pressure alarm was in place. She indicated she did not know why nursing staff had noted the device as being in place on the TAR, when it was not in place. Continued interview with RN # 6 revealed Resident #1's side rails should have been padded as ordered. She indicated when Resident #1's bed had been switched out apparently the side rails had not been padded. Interview, on 01/16/14 at 4:44 PM, with the Assistant Director of Nursing (ADON) revealed Resident #1 had previously had a pressure alarm; but she thought it had been removed because it made the resident mad. According to the ADON, if Resident #1's orders and care plans included a pressure alarm device to the wheelchair it should have been in place. She stated if Resident #1 had a pull tab alarm now, it was nursing's responsibility to clarify what was in place and what was ordered. Continued interview with the ADON revealed nursing staff should have ensured the bed rails were padded as ordered and care planned. The ADON indicated she thought the resident had a history of seizures; therefore needed the padded side rails.	F 323			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431			

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

PRINTED: 01/31/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2014
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F 431	<p>Continued From page 14</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of facility policy, it was determined the facility failed to ensure all biologicals (Normal Saline) and drugs (two vials of Insulin and one vial of tuberculin serum) were stored to ensure they were not available for use after the expiration date.</p> <p>Findings include: Review of the facility's policy titled "Storage and Expiration Dating of Drugs, Biological, Syringes,</p>	F 431	<p><u>F431</u></p> <p>The normal saline with an expiration of August 2013 identified on the 100 hall nursing station crash cart and the vial of tuberculin serum and bottle of Levemir Insulin identified in the 100 hallway medication was discarded by the licensed nurse on 1/16/14. The vial of Novolog Insulin in the 300 hall medication refrigerator was discarded by the licensed nurse on 1/16/14.</p> <p>The Director of Nursing and Unit Managers completed an audit on <u>1/20/14</u> of medication carts, medication refrigerators, and crash carts on each unit to determine that there are no expired medications or open and undated medications present. No other concerns were identified.</p> <p>The Director of Nursing and Unit Managers will re-educate licensed nurses on the Storage and expiration dating of drugs, biological, syringes, and needles by 2/21/14. Any concerns identified will be addressed at that time.</p> <p>The Director of Nursing and/or Unit managers will complete an audit of medication carts, medication</p>	2/22/14	

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

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F 431

Continued From page 15
and Needles", effective 08/01/02 and revised 05/16/11, revealed drugs and biologicals were stored under proper conditions with regard to sanitation, temperature, light, moisture, ventilation, segregation, safety, security, and expiration date. Continued review revealed the purpose of proper storage was to ensure the stability and quality of drugs and biologicals were maintained.

Observation of the Nursing Station Crash Cart on the 100 Hallway, on 01/16/14 at 1:10 PM, revealed a container of normal saline with an expiration date of August of 2013.

Interview with Licensed Practical Nurse (LPN) #1, conducted on 01/16/14 at 1:20 PM, revealed the normal saline was expired and should be thrown away and replaced. She stated nightly cart checks by the nurse included monitoring for expired items. She could not say why the expired Normal Saline remained on the cart.

Observation of the medication refrigerator on the 100 Hallway, on 01/16/14 at 1:15 PM, revealed a vial of tuberculin serum had been opened, but there was no time or date on the bottle when the medication had been opened.

Interview with LPN #4, on 01/16/14 at 1:25 PM, revealed she did not know why the tuberculin medication vial had not been dated and timed when it was opened. She stated the vial would have to be discarded and a new one ordered to replace it.

Observation of the medication refrigerator for the 100 Hallway, on 01/16/14 at 1:30 PM, revealed a bottle of Levemir Insulin 100 units/milliliter (ml)

F 431

refrigerators, and crash carts weekly for 8 weeks and then monthly x4 months to determine that there are not expired medications or open and undated medications present. Any concerns identified will be addressed at that time. Results of these audits will be presented by the Director of Nursing to the Performance Improvement Committee monthly x6 months for further review and recommendation.

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

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OMB NO. 0938-0391

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F 431	Continued From page 18 was dated as having been opened on December 12, 2013 (over thirty days open). An interview conducted on 01/16/14 at 1:35 PM with a 200 Hallway staff nurse, LPN #2, revealed she did not know how it happened the Insulin was expired and remained available for use. She stated the medication vial should have been discarded when it had been open for over 30 days. Observation of the 300 Hallway medication refrigerator, on 01/16/14 at 12:50 PM, revealed a vial of Novolog Insulin 100 units/ml which had been opened, but was not timed or dated when the medication had been opened. An interview conducted on 01/16/14 at 1:00 PM with LPN #3, revealed she could not explain why the open vial of Insulin was not dated. She stated all medication vials were to be dated and time when opened by the nurse. She acknowledged there was no way to know when thirty (30) days had passed; therefore, there was no way to know if, or when, the Insulin expired. Continued interview revealed the Insulin would have to be discarded and replaced. An interview with the Assistant Director of Nursing, on 01/16/14 at 4:30 PM, revealed it was her expectation that all biologicals were properly stored and discarded when they were expired. She further explained she expected all medications to be dated and timed when upon opening, and discarded when they were over thirty (30) days old.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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

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F 441	Continued From page 17 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F441 Residents #1, #14 and unsampled resident's A, F, and G were assessed by a licensed nurse on 1/17/14 to determine any signs of symptoms of infection related improper hand washing and/or gloving technique during perineal or urinary catheter care. No concerns were identified. The uncovered and unlabeled bedpans in room 119 were removed by the STNA on 1/14/14 and replaced with properly labeled and covered bedpans. Center Infection Control rounds were completed on 1/15/14 and 1/16/14 by the administrator to identify any other infection control issues. Any identified concerns were addressed. The Director of Nursing and Unit Managers completed a center Infection Control Round on 1/15/14 and 1/16/14 to determine any concerns with Infection Control practices including but not limited to handwashing during perineal/urinary catheter care and properly labeled and stored bed pans. Any concerns identified were addressed at that time.	

2/2/14

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

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F 441	<p>Continued From page 18</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and review of facility policies, it was determined the facility failed to 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 for two (2) of twenty-four (24) sampled residents (Resident #1 and #14) and three (3) Unsampled Residents (Unsampled Residents: A, F, and G). The nursing staff used improper hand washing and/or gloving technique during the provision of perineal care, and urinary catheter care for Residents' #1, and #14 and Unsampled Residents' A, F, and G.</p> <p>In addition, two (2) bedpans were observed to be uncovered and unlabeled in the bathroom of Room 119.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Infectious Disease Management", effective date 10/01/13, revealed the facility would use appropriate infection control, environmental decontamination, and prevention measures for the prevention and management of infectious diseases.</p> <p>Review of the facility's policy titled, "Hand Hygiene", revised date 10/01/13, revealed personnel were to adhere to hand hygiene practices which included the use of soap and water when hands were visibly soiled and alcohol based hand rubs for routine decontamination in clinical situations. Continued review revealed the purpose of the policy was to improve hand hygiene practices and reduce the transmission of</p>	F 441	<p>The Director of Nursing and Unit Managers re-educated licensed nurses and nursing assistants to the Infection control policy by 2-21-14. Education will include the facility's infection control program, guidelines to prevent the development and transmission of infections, pericare/foley catheter care, dating, labeling and proper storage of resident care supplies, hand washing, and glove usage. A post test was completed following the education. Nursing assistants were observed by the Director of Nursing Services, Unit Managers and Nursing Supervisors and completed skill competency return demonstrations related to Perineal and Urinary Catheter Care as of 2-21-14. Any concerns identified with these care practices were addressed at that time.</p> <p>Infection Control Surveillance rounds which includes but not limited to proper labeling and storage of bed pans and handwashing/gloving technique will be completed weekly by the Director of Nursing Services, Unit Managers, and/or Nursing Supervisors for 8 weeks, then monthly for 10 months. The Director of Nursing Services, Unit Managers, and/or Nursing Supervisors will complete skills competency return demonstrations of 3 nursing assistants providing pericare and/or foley catheter care to determine that proper handwashing and gloving technique are implemented weekly x8 weeks and</p>	

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

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F 441	<p>Continued From page 19</p> <p>pathogenic microorganisms. Further review revealed hands were to be decontaminated or washed when moving from a contaminated body site to a clean body site during patient care, before putting on gloves, and after removing gloves.</p> <p>1. Review of Resident #1's medical record revealed the resident was re-admitted by the facility on 09/18/13 with diagnoses which included Non-Alzheimer's Dementia, Parkinson's Disease, Chronic Heart Failure, Peripheral Vascular Disease, Hypertension, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Late Effect Cerebral Vascular Disease, Anxiety, Psychosis, Generalized Pain, Arthritis, and Obesity.</p> <p>Observation of Resident #1's bed bath by State Registered Nursing Assistant (SRNA) #6, on 01/15/14 at 9:04 AM, revealed the SRNA washed, rinsed and dried the resident's vaginal area, changed gloves, applied Hydraguard cream to the groin area, changed gloves, cleansed and dried the buttock area, removed her gloves, and applied an adult brief. The SRNA then put on gloves and applied lotion to the resident's arms, then changed gloves and washed the resident's legs.</p> <p>Interview with SRNA #6, on 01/15/14 at 9:54 AM, revealed when performing Resident #1's bed bath she changed her gloves multiple times, but did not wash her hands between glove changes. She stated she was supposed to wash her hands when she changed gloves for infection control and to prevent cross contamination.</p> <p>2. Review of Unsampled Resident G's medical</p>	F 441	<p>then monthly x10 months. Any concerns identified will be addressed at that time. The Director of Nursing will submit a summary of audit and skills competency results to the monthly Performance Improvement Committee meeting monthly x12 months for review and further recommendations.</p>		

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

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F 441	<p>Continued From page 20</p> <p>record revealed the resident was re-admitted by the facility on 09/17/09 with diagnoses which included Dementia, Hypertension, Hypertrophy of the Prostate, Disorder of the Kidney and Ureter, Retention of Urine, and Chronic Heart Failure.</p> <p>Observation of urinary catheter care and perineal care provided for Unsampled Resident G, on 01/14/14 at 6:25 AM, revealed SRNA #5 the following washed her hands and gloved prior to providing care. She removed the resident's brief, cleansed the area where the urinary catheter entered the resident, repositioned the resident and cleansed the buttock area. The SRNA then applied a new brief, changed gloves, removed the resident's gown and dressed the resident in a shirt and socks.</p> <p>Interview with SRNA #5, on 01/14/14 at 6:40 AM, revealed she should have washed her hands between glove changes for infection control reasons.</p> <p>Interview with the Assistant Director of Nursing (ADON)/Acting Director of Nursing(DON)/Infection Control Nurse, on 01/16/14 at 4:44 PM, revealed during the provision of perineal care and urinary catheter care, staff should have washed their hands when they changed their gloves.</p> <p>3. Observation, on 01/14/14 at 5:30 AM, of perineal care for Unsampled Resident A revealed SRNA # 7 cleansed the resident's perineal area, then cleansed the resident's rectum and buttocks with a wet washcloth. With the same soiled gloves, SRNA #7 was observed to pull the resident up in the bed with a draw sheet and</p>	F 441			

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

PRINTED: 01/31/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2014
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F 441	<p>Continued From page 21</p> <p>attached the call bell to the bed.</p> <p>4. Observation, on 01/14/14 at 6:40 AM, of perineal care for Unsampled Resident F revealed SRNA #7 performed perineal care and cleansed the resident's rectum with a wet washcloth, applied a brief, and with the same soiled gloves used the bed control device to lower the bed and attach the call bell to the bed. The SRNA then removed the soiled gloves, and without washing her hands, pulled the bed linens up over the resident.</p> <p>Interview with SRNA #7, on 01/14/13 at 6:45 AM, revealed she should have removed the soiled gloves and washed her hands after performing perineal care care and prior to touching objects such as the bed control, call bell and bed linens. She acknowledged she had contaminated items in the rooms of Unsampled Resident A and Unsampled Resident F by not removing her gloves when they became soiled, and by not washing her hands when she changed her gloves.</p> <p>5. Observation, on 01/14/14 at 2:00 PM, of perineal care for Resident #14 revealed SRNA #8 performed perineal care, cleansed the resident's buttocks, and with the same soiled gloves applied Remedy Nutrashield to the residents buttocks and applied a brief. Without removing the soiled gloves, SRNA #8 opened the dresser drawer by the bed, and lowered the bed with the bed control.</p> <p>Interview with SRNA #8, on 01/14/14 at 2:20 PM, revealed she should have removed her soiled gloves and washed her hands after performing perineal care, and prior to touching objects such</p>	F 441			

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

PRINTED: 01/31/2014
FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 22</p> <p>as the drawer and the bed control. She also acknowledged she had contaminated the tube of Remedy Nutrashield by handling it with soiled gloves.</p> <p>Interview, on 01/16/14 at 4:00 PM, with the ADON/Acting DON/Infection Control Nurse, revealed staff should remove gloves and wash hands after perineal care and anytime gloves were removed. She stated the Unit Managers and Wound Nurse randomly watched staff perform perineal care; however, they did not document those audits.</p> <p>6. Observation, on 01/14/14 at 5:40 AM, revealed two (2) bedpans inserted into the handicap rail on the wall of the bathroom in Room #119 which were unlabeled and uncovered.</p> <p>Interview with SRNA #1, on 01/14/14 at 5:40 AM, revealed the bedpans should not be stored in this manner. She stated this had happened before. The SRNA stated the bedpans should have been labeled and covered to prevent another resident from using them. Continued interview revealed the practice could lead to the spread of infection.</p> <p>Interview, with Registered Nurse (RN) #1, on 01/15/14 at 10:10 AM, revealed the bedpans should have been labeled and covered with a bag at all times while stored. RN #1 stated this was an infection control concern.</p> <p>Interview with ADON/Acting DON/Infection Control Nurse, on 01/16/14 at 2:55 PM, revealed the bedpans should have been labeled and covered. She stated uncovered and unlabeled bedpans were an infection control issue.</p>	F 441		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/31/2014
FORM APPROVED
OMB NO. 0938-0391

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F 520 F 520 SS=E	Continued From page 23 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of facility's policy, and review of the Plan of Correction, it was determined the facility failed to maintain a Quality Assessment and Assurance Program that developed and implemented appropriate plans of action to correct quality deficiencies. This was evidenced by repeated deficiencies related to the facility's failure to	F 520 F 520	F520 Residents #1, #14 and unsampled resident's A, F, and G were assessed by a licensed nurse on 1/17/14 to determine any signs of symptoms of infection related improper hand washing and/or gloving technique during perineal or urinary catheter care. No concerns were identified. The uncovered and unlabeled bedpans in room 119 were removed by the STNA on 1/14/14 and replaced with properly labeled and covered bedpans. Center Infection Control rounds were completed on 1/17/14 by the Administrator to identify any other infection control issues. Any identified concerns were addressed at that time. The Director of Nursing and Unit Managers completed a center Infection Control Round on 1/17/14 to determine any concerns with Infection Control practices		

2/22/14

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

PRINTED: 01/31/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/16/2014
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--------------------	--	---------------	---	----------------------

F 520	<p>Continued From page 24</p> <p>ensure there was an effective infection control program.</p> <p>The findings include:</p> <p>Review of the facility policy entitled "Center Quality Improvement (QI) Process", revised 04/01/03, revealed the purpose of the policy was to standardize the way Centers approach QI processes, to provide a framework for structuring and implementing data driven quality improvement, to establish and maintain a quality improvement process that will satisfy Genesis internal standards of excellence and regulatory requirements, and to ensure the appropriateness, efficiency, and effectiveness of the Quality Improvement Plan by evaluating the plan on an annual basis.</p> <p>Based on observation, interview and record review, it was determined the facility failed to maintain an effective infection control program in order to prevent the development and transmission of disease and infection within the facility. This was a repeat deficiency for the facility which was cited 03/01/13 for deficiencies related to staff failing to use proper infection control technique for Foley catheter/incontinence care and failing to ensure bed pans were labeled with the resident's name and bagged/covered.</p> <p>Review of the facility's Plan of Correction, with a compliance date of 04/08/13, revealed re-education of nursing staff would be completed by 04/07/13 by the Director of Nurses (DON), Assistant Director of Nursing (DON), and or Unit Managers to include the facility's infection control program guidelines to prevent the development and transmission of infections, perineal</p>	F 520	<p>including but not limited to handwashing during perineal/urinary catheter care and properly labeled and stored bed pans. Any concerns identified were addressed at that time. A Performance Improvement Committee meeting was held on 1/29/14 and a summary of findings from the Infection Control rounds were submitted by the Director of Nursing and reviewed for further recommendation.</p> <p>The Manager of Clinical Operations reeducated the Administrator and Director of Nursing on 2-10-14 to the Performance Improvement policy and procedure to include developing and implementing plans of action to correct quality deficiencies including the area of monitoring Infection Control practices. The Director of Nursing and Unit Managers re-educated licensed nurses and nursing assistants to the Infection control policy by 2-21-14. Education will include the facility's infection control program, guidelines to prevent the development and transmission of infections, pericare/foley catheter care, dating, labeling and proper storage of resident care supplies, hand washing, and glove usage. A post test</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 520

Continued From page 25
care/Foley catheter care, dating, labeling and proper storage of resident care supplies, hand washing, and glove usage. Further review revealed infection control surveillance rounds would be completed weekly by the Administrator, DON, or ADON for four (4) weeks. The surveillance would include proper storage of resident care items including bedpans. The DON, ADON, Unit Managers and /or Nursing Supervisors would complete random observations of perineal care and/or Foley catheter care skills for nursing staff weekly for four (4) weeks, then three (3) times monthly for one (1) month, then monthly.

Observations during this survey revealed the nursing staff used improper hand washing and/or gloving technique during observations of perineal care, and Urinary Catheter care for Residents #1 and #14 and Unsampled Residents A, F, and G. Also initial tour observations on 01/14/14 revealed two (2) fracture bed pans were observed to be uncovered and unlabeled on the bathroom floor of Room 119. (Refer to F-441)

Interview, on 01/16/14 at 4:00 PM, with the Assistant Director of Nursing (ADON)/Acting DON/Infection Control Nurse, revealed the facility recently conducted inservices in 11/13 and 12/13 related to hand washing, glove usage, and perineal care. She stated staff was inserviced on hire and yearly related to infection control and the unit managers and wound nurse randomly watched staff perform perineal care; however, they did not document their audits.

Interview with the Administrator, on 01/16/14 at 5:00 PM, revealed after the last standard survey, staff was inserviced related to perineal care/Foley

F 520

was completed following the education. Nursing assistants were observed by the Director of Nursing Services, Unit Managers and Nursing Supervisors and completed skill competency return demonstrations related to Perineal and Urinary Catheter Care as of 2-21-14. Any concerns identified with these care practices were addressed at that time.

Infection Control Surveillance rounds which includes but not limited to proper labeling and storage of bed pans and handwashing/gloving technique will be completed weekly by the Director of Nursing Services, Unit Managers, and/or Nursing Supervisors for 8 weeks, then monthly for 10 months. The Director of Nursing Services, Unit Managers, and/or Nursing Supervisors will complete skills competency return demonstrations of 3 nursing assistants providing pericare and/or foley catheter care to determine that proper handwashing and gloving technique are implemented weekly x8 weeks and then monthly x10 months. Any concerns identified will be addressed at that time. The Director of Nursing will submit a summary of audit and skills competency results to the monthly Performance Improvement Committee meeting monthly x12 months for review and further recommendations. The Administrator will complete an audit of the Performance Improvement minutes monthly x12 months to determine that appropriate plans of action to correct areas of concern, including but not limited to Infection Control practices, are developed and implemented. A

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

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F 520	Continued From page 26 catheter care, and the dating, labeling, and storage of resident care supplies as well as hand washing and glove usage. He stated the surveillance rounds were done as per the POC; however, the surveillance rounds were stopped in August or September 2013. He further stated these surveillance round should have been continued longer to ensure continued compliance.	F 520	summary of the Performance Improvement audits will be submitted to the Performance Improvement Committee by the Administrator monthly x12 months for further review and recommendation.		

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: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/14/2014
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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPOINT DRIVE FLORENCE, KY 41042
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: Construction Date 6/10/89</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) Story, Type III (000) Unprotected</p> <p>SMOKE COMPARTMENTS: Nine (9) smoke compartments.</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (Dry SYSTEM)</p> <p>EMERGENCY POWER: Type II Diesel Generator.</p> <p>A life safety code survey was conducted on 01/14/14. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for one hundred fifty-one (151) beds and the census was one hundred thirty-nine (139) the day of the survey.</p>	K 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Bridge Point Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>K052</p> <p>The fire alarm system was tested by the licensed contractor (Senco) on 1/22/14. No concerns were identified.</p> <p>The Maintenance Director has scheduled testing of the Fire Alarm system to occur in May 2014, August 2014, and November 2014 by the licensed contractor (Senco) to obtain and maintain compliance with NFPA 70 & 72.</p> <p>The Administrator reeducated the Maintenance Director to testing and maintaining the fire alarm system in accordance with the applicable</p>	2/22/14
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature] *[Signature]*

2/10/14

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.

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

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FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPOINT DRIVE FLORENCE, KY 41042		
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K 000	Continued From page 1	K 000			
K 052 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This STANDARD is not met as evidenced by: Based on interview and fire alarm inspection record review, it was determined the facility failed to test and maintain the fire alarm system per NFPA standards. The deficiency had the potential to affect all compartments, all residents, staff, and visitors. The facility is licensed for one hundred fifty-one(151) beds with a census of one hundred thirty-nine (139) on the day of the survey.</p> <p>The findings include:</p> <p>Fire alarm inspection record review, on 01/14/14 at 3:30 PM, with the Maintenance Director, revealed the facility failed to provide documentation to show the fire alarm system</p>	K 052	<p>requirements of the NFPA standards on 1/14/14.</p> <p>The Maintenance Director will submit a copy of the Fire Alarm system tests and maintenance quarterly to determine that tests are completed as scheduled and timely per NFPA standard. The Administrator or Maintenance Director will submit a summary of findings of the Fire Alarm system tests quarterly to the Performance Improvement Committee for 4 quarters for further review and recommendation.</p>		

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

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OMB NO. 0938-0391

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K 052	Continued From page 2 inspection had been completed the fourth quarter of 2013. Documentation of Fire Alarm quarterly inspections on 1/10/13, 4/17/13, and 8/26/13 revealed the system was in compliance and in working order. Interview, on 01/14/14 at 3:30 PM, with the Maintenance Director revealed he was advised by his Regional Maintenance Director after the third quarterly inspection that the fire alarm system was only to be inspected bi-annually, that was all that was required. Interview, on 01/14/14 at 4:00 PM, with the Administrator revealed that he and the Maintenance Director was informed by the Regional Director that the Fire Alarm System was to be inspected bi-annually only. After the State Surveyor showed him the code reference he stated that they would conduct quarterly inspections as required by NFPA. NFPA Standard: NFPA 101, 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.	K 052		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	<u>K062</u> The wiring, supported by the sprinkler piping on the 100 front hall, 100 back hall, 200 front hall, will be removed from the sprinkler piping and securely supported to alternative fixtures by 2/21/14 by the Maintenance Director. The Maintenance Director will complete an audit of the center sprinkler piping to determine that no sprinkler piping was being used to	2/22/14

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

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K 062	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, and interview, it was determined the facility failed to ensure the sprinkler system was inspected and maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) smoke compartments, seventy (70) residents, staff and residents. The facility is licensed for one hundred fifty-one (151) beds and the census the day of survey was one hundred thirty-nine (139). The findings include: Observation on 1/14/14 between 2:15 PM and 3:15 PM, revealed the sprinkler piping in 100 Front Hall, 200 Front Hall, 100 Back Hall, were being used to support various wiring. Sprinkler piping cannot be used to support building wiring. Interview on 1/14/14 at 2:25 PM, with the Maintenance Director, revealed he was unaware sprinkler piping was being used to support the various wires and unaware of this requirement. Interview on 1/14/14 at 4:00 PM, with the Administrator revealed he was unaware of this requirement. Reference: NFPA 25 (1998 edition) 2-2.2* Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage,	K 062	support other wiring on by 2/21/14. Any concerns identified will be addressed at that time. The Administrator and Maintenance Director were reeducated by the Regional Property Manager on 1/23/14 to the NFPA standard related to inspection and maintenance requirements to include the standard that sprinkler piping cannot be used to support wiring. The Maintenance Director or Maintenance assistant will inspect the facility sprinkler piping monthly for 6 months to determine that sprinkler piping is not supporting various wiring. Any concerns identified will be addressed at that time. The Administrator will submit results of the inspections to the Performance Improvement committee monthly x12 months for further review and recommendation.	

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: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/14/2014
NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042		
(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	
K 062	Continued From page 4 corrosion, and misalignment. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. Exception No. 1:* Pipe and fittings installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Pipe installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062			