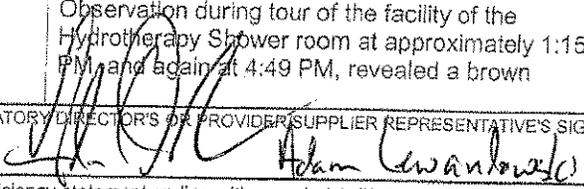


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185447	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/17/2015
NAME OF PROVIDER OR SUPPLIER VILLASPRING OF ERLANGER			STREET ADDRESS, CITY, STATE, ZIP CODE 630 VIOX DRIVE ERLANGER, KY 41018	
(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 04/14/15 and concluded on 04/17/15. Deficiencies were cited with the highest Scope and Severity of a "E".	F 000	<i>Without admitting or denying the validity or existence of the alleged deficiencies, including but not limited to any determinations of scope or severity, Villaspring provides the following plan of correction. This plan of correction is submitted as required by the state and federal guidelines and is not an admission or agreement with any of the cited information. This plan of correction is not meant to establish any standard of care, contract, obligation or position and Villaspring reserves all right to raise all possible contention and defenses in any civil or criminal claim action or proceeding. THIS PLAN OF CORRECTION SERVES AS Villaspring of Erlanger CREDIBLE ALLEGATION OF SUBSTANTIAL COMPLIANCE AS OF 5/20/15.</i>	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure the bathroom floor of the Hydrotherapy Shower room was sanitized to promote a sanitary, orderly, and comfortable environment as evidenced by a brown substance observed on the bathroom floor. The findings include: Review of the facility's policy titled, "Guidelines to Good Housekeeping", dated 02/08/03, revealed it was the policy of the facility's environmental services, for the nursing department, to provide guidelines specific for cleaning duties to provide an optimum environment for the staff, residents, and visitors. Further review of the policy revealed the floor of the resident's shower would be cleansed with a sanitizing solution. Observation during tour of the facility of the Hydrotherapy Shower room at approximately 1:15 PM and again at 4:49 PM, revealed a brown	F 253	1. Substance was cleaned from the floor of the shower room on 4/14/15 by nursing staff followed by disinfection of the floor by the housekeeping staff 4/14/15. 2. An audit of each resident room/shower room will be completed by RN unit managers and/or Housekeeping Supervisor by 5/13/15 to ensure each room is clean, sanitary, orderly, and a comfortable environment. Any concerns will be addressed at the time of the audit. Each housekeeper has a checklist for every room that they complete on a daily basis to ensure that all rooms, including shower rooms are clean and sanitary. Daily rounds are performed by the housekeeping staff; rounds are performed by nursing staff each shift to assure a	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Adam Lewandowski Administrator			DATE 5/11/15	

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

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F 253	<p>Continued From page 1</p> <p>substance on the floor of the shower to the right of the shower room door.</p> <p>Interview with Certified Nursing Assistant (CNA) #11, on 04/14/15 at 4:50 PM, revealed the brown substance on the floor of the shower room looked like it was "poop". She reported the "poop" should have been cleaned up off the floor after the resident's shower. Per interview, she would have normally cleaned it up, as it was the responsibility of the aides to clean stool off the floor after a resident's shower.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 04/15/15 at 10:54 AM, revealed the CNA should have cleaned the stool off the shower room floor and then called housekeeping to disinfect the floor. She reported this was important for infection control and to maintain a sanitary environment.</p> <p>Interview with Housekeeper #1, on 04/15/15 at 9:38 AM, revealed staff should not have left the stool on the floor. She stated staff should have cleaned the stool off the floor, then called housekeeping to sanitize the area. Housekeeper #1 reported no one called her to sanitize the floor of the shower room.</p> <p>Interview with Housekeeper # 2, on 04/15/15 at 9:55 AM, revealed she was scheduled to clean the shower room in the mornings; however, the nursing staff was responsible for keeping the showers clean. She stated if stool was left on the floor of the shower, then nursing staff should have cleaned it up and called housekeeping to come and disinfect the area. Continued interview with Housekeeper #2 revealed no one called her yesterday to disinfect the shower room floor.</p>	F 253	<p>environment for the residents including but not limited to ensure the bathroom floor of the Hydrotherapy Shower room is sanitized to promote a sanitary, orderly, and comfortable environment.</p> <p>In addition, weekly rounds are performed by the administrator, DON, Maintenance Supervisor, and Housekeeping Supervisor on each unit to assure a sanitary, orderly and comfortable environment for the residents.</p> <p>3. Additional education will be taught to each staff member by the Administrator, DON, ADON, RN Unit Managers, and/or Housekeeping Supervisor by 5/20/15 on the survey findings including but not limited to the importance of and proper procedure for cleaning visibly soiled areas, disinfecting and notification of housekeeping for sanitizing areas to promote a sanitary, orderly, and comfortable environment. Evidence of learning will be demonstrated by verbalization and Q&A.</p> <p>4. A Performance Improvement (PI) audit for Environmental Control will be utilized to review resident</p>		

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F 253	Continued From page 2 Interview with the Director of Nursing (DON), on 04/17/15 at 10:00 AM, revealed it would have been her expectation for staff to have cleaned the stool off the floor of the shower room. She reported staff had access to disinfectant wipes and should have cleaned the stool off the floor with those. Per interview, staff should have then called housekeeping to come and sanitize the area. The DON revealed this was important because it was an infection control issue. Interview with the Administrator, on 04/17/15 at 10:32 AM, revealed it was his expectation someone would have cleaned the stool up after the resident's shower, or as soon as care was provided for the resident. Continued interview with the Administrator revealed it was important to do this for infection control purposes.	F 253	rooms and shower room. This PI Worksheet is being completed by the Housekeeping Supervisor and/or RN unit managers weekly for 4 weeks, then monthly. If issues are noted, the Housekeeping Supervisor or RN Unit Manager will takes appropriate action at the time the concern is noted. A copy of the worksheets is attached as EXHIBIT C. The PI Worksheet results will be reported to the Quality Assurance Committee for additional comments/interventions and for a determination of the need of continued formal ongoing monitoring.	
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	F 280	The QA Committee meets at least quarterly and consists of the Medical Director, DON, Administrator and at least three (3) Departments Heads (ADON, RN Unit Managers, Business Office Coordinator, Dietician, Chef, Social Service Director and Assistant, Activities Director, Housekeeping Supervisor, Maintenance Director, Admissions Liaison, Director of Rehabilitation, and/or Medical Record Coordinator).	

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F 280	Continued From page 3 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 ensure the Comprehensive Care Plan was revised related to Isolation Precautions for Escherichia Coli (E-coli) Extended-Spectrum Beta-Lactamases (ESBL) of the urine for one (1) of twenty-four (24) sampled residents (Resident #14). Observation revealed an Isolation Precaution sign outside the doorway of Resident #14. However, continued observation revealed no Personal Protective Equipment (PPE) was stored near or at the doorway of the resident's room. Additionally, staff were not observed using PPE prior to entering Resident #14's room to provide care or treatment. The findings include: Review of the facility's policy titled, "Care Plan Completion" dated July 2010, revealed the care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. Review of the facility's policy titled, "MRSA and ESBL Management", dated February 2015, revealed the facility in efforts to practice Infection	F 280	5. Environmental Supervisor will monitor compliance by observation, interview and review of audits. Date of Compliance:	5/20/15	

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F 280	<p>Continued From page 4</p> <p>control guidelines to prevent acquisition and spread of Methicillin Resistant Staph Aureus (MRSA) and Extended Spectrum Beta Lactamase (ESBL) producers, was to immediately implement appropriate infection control measures (Contact Precautions) to prevent person-to-person transmission of MRSA/ESBL. Per the Policy, the facility should update the resident's care plan and Kardex (nurse aide care plan) for the specific precautions and to place PPE, gloves, gowns, and masks outside the resident's room for staff to utilize.</p> <p>Review of Resident #14's clinical record revealed the facility re-admitted the resident on 12/17/13, with diagnoses which included Multi-drug Resistant Organism (MDRO) and Urinary Tract Infection. Review of the Annual Minimum Data Set (MDS) Assessment dated 03/12/15, revealed the facility assessed Resident #14 as being severely cognitively impaired, to require extensive assist of one (10 person for toileting. Continued review of Resident #14's MDS Assessment revealed the facility assessed the resident as frequently incontinent of urine and occasionally incontinent of bowel.</p> <p>Review of a laboratory (lab) test report for urinalysis with culture and sensitivity (U/A with C&S) obtained on 04/07/15, revealed on 04/10/15, the facility received Resident #14's urine culture results which confirmed the resident had E-coli ESBL organisms in his/her urine. However, review of Resident #14's Comprehensive Care Plan initiated on 03/26/15, revealed no documented evidence it was revised to include the ESBL or with interventions for isolation precautions related to the ESBL.</p>	F 280	<p>F280</p> <ol style="list-style-type: none"> 1. Resident #14 Comprehensive Care Plan and Kardex (nurse aide care plan) was reviewed by RN RAI Coordinator and revised on 4/14/15 to include isolation precautions. Her care plan is up-to-date and current with her assessment. PPE (Personal Protective Equipment) was placed outside Resident #14 door on 4/17/15. Resident #14 infection resolved on 4/19/15 and she is no longer in isolation; care plan updated 4/19/15. 2. Each resident with isolation precautions Comprehensive Care Plan was reviewed by the DON on 4/30/15 to ensure completion. An expanded sample of Comprehensive Care Plan will be reviewed before 5/20/15 by DON, MDS nurses, and/or -RN Unit Managers to ensure that they are developed within 7 days of the comprehensive assessment and revised with subsequent assessments/changes including but not limited to infections, isolation precautions, and maintaining regular bowel monitoring. <p>The facility periodically reviews and revises each resident's individualized Comprehensive Care</p>		

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F 280	<p>Continued From page 5</p> <p>Observation of Resident #14 while on tour on 04/14/15 at 1:19 PM, revealed a magnetic sign located at the right side of the room door which stated to report to the nurse before entering. Continued observation revealed no PPE was present for staff or visitor to use before entering the resident's room. Further observation revealed Certified Nursing Assistant(CNA) #7 entering Resident #14's room with a lunch tray without donning PPE.</p> <p>Interview with CNA #7 on 04/14/15 at 1:32 PM, revealed Resident #14's diagnosis for Isolation Precautions was ESBL in the urine. She stated she should have worn PPE when she entered the resident's room to prevent the potential to spread the illness to other residents.</p> <p>Interview with CNA #4 on 04/14/15 at 6:42 PM, revealed Resident #14 required physical assist of one (1) person, and she assisted the resident to the bathroom with a gait belt. She revealed she was not aware of Resident #14's diagnosis for the Isolation Precaution posted outside the room. However, stated the Isolation Precautions were for Pneumonia she thought. Per interview, she wore gloves when she toileted Resident #14, but never wore a gown. Continued interview revealed anything that urine came in contact with, she wrapped in a bag, except for adult briefs which were put in the trash can in the resident's room. Further interview revealed she should not have entered Resident #14's room and provided incontinent care without wearing PPE to include wearing a gown, as there was the potential to spread the illness to other residents.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 04/17/15 at 11:46 AM, revealed the</p>	F 280	<p>Plan after each assessment. User Defined Assessments are implemented to document acute issues and revised with change, in MD orders including but not limited to isolation precautions.</p> <p>3. Licensed nursing staff will receive addition education and reinforcement by 5/20/15 regarding the survey results including but not limited to the completion and revision of resident Comprehensive Care Plans with assessment changes including MD orders and isolation precautions. This education will be taught by the DON, ADON, and/or the RN Unit Managers. Evidence of learning will be demonstrated by verbalization and Q&A.</p> <p>4. A PI worksheet is being completed to ensure care plans are in place and revised as needed. A copy of the worksheet is attached as EXHIBIT D. This PI worksheet is being completed by the DON, ADON, RN Unit Managers and/or RN MDS staff weekly X 4 then monthly thereafter. If issues are noted the DON, ADON, RN Unit Managers and/or RN MDS staff will take appropriate action at the time the concern is noted to assure the care plan is accurate. Results of the PI</p>		

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F 280	Continued From page 6 Comprehensive Care Plan and Kardex (CNA Care Plan) should have been updated and revised to include the ESBL, the Isolation Precautions and interventions related to the ESBL and precautions. Per interview, if the Comprehensive Care Plan and Kardex were not updated and revised, staff would not know what interventions to perform for the resident. She stated the potential harm for the resident would be re-infection of the same organism and spread to other residents within the facility. A post survey interview with the DON on 04/21/15 at 9:15 AM, revealed the Charge Nurses, Unit Managers, ADON and DON all reviewed residents' care plans quarterly and on an as needed basis. She stated concerns were entered on the care plan within twenty-four (24) hours. Per interview, the facility failed to carry out the process for care planning with regard to Resident #14's ESBL and the care needed for the resident who was in Isolation Precaution. She stated the potential harm for Resident #14 was possible cross-contamination and spread of the illness to the other residents. Interview with the Administrator on 04/17/15 at 12:28 PM, revealed his expectations were for staff to follow the facility's Isolation Precaution policy. He stated he expected staff to revise resident's care plans and Kardex to ensure the proper care was provided for residents. Per interview, the potential harm for failure to revise the care plan was a re-infection or failure to resolve the infection as there were no interventions put into place.	F 280	worksheet will be reported to the QA committee for a determination of the need for further ongoing formal monitoring. The QA Committee meets at least quarterly and consists of the Medical Director, DON, Administrator and at least three (3) Departments Heads. 5. Director of Nursing will monitor compliance by observation, interview and review of audits. Date of Compliance:	5/20/15	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281			

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F 281

Continued From page 7

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to meet professional standards of quality for one (1) of twenty four (24) sampled residents (Resident #13).

Resident #13 had a Physician's Order for NovoLOG FlexPen insulin 5 units subcutaneously (SQ) before meals; however, observation on 04/14/15, revealed the resident's NovoLOG FlexPen was administered after the supper meal.

The findings include:

Review of Facility's policy on Medication times clearly states it the policy of this organization to maintain medication time guidelines for consistency and proper administration. Medication times may be individualized based on resident request or physician order.

Review of Resident #13's medical record revealed the facility admitted the resident on 01/05/15, with diagnoses which included Diabetes Type II, Lumbago, Closed Fracture of Upper End of Tibia and Chronic Kidney Disease. Review of the Admission Minimum Data Set (MDS) Assessment dated 01/25/15, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of fourteen (14) which indicated the resident was cognitively intact. Review of Resident #13's Comprehensive

F 281

F281

1. Resident #13 no longer resides in the facility.
2. An audit was completed on 5/4/15 by DON and/or RN Unit Managers of the MARs of each resident receiving insulin to ensure proper administration times are being followed.

The facility nursing staff follows physician orders, administers medications as ordered and documents in the Electronic record including medication administration times. Physicians are notified of any concerns with medication administration.

The nursing supervisors and nursing management team perform periodic informal observational rounds, as a component of their daily duties, observing the direct care staff in rendering care for the residents including medication/Insulin administration. If concerns are noted, the nursing supervisor or manager takes appropriate interventions at that time, including additional one-on-one reeducation of the team member.

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F 281	<p>Continued From page 8</p> <p>Care Plan revealed the resident was care planned for the diagnosis of Diabetes Mellitus with interventions which included interventions to administer his/her Diabetes medications as ordered.</p> <p>Review of the Physician's Order dated 03/19/15, revealed an order for Resident #13 to receive NovoLOG FlexPen insulin 5 units before meals, and for the nurses to start teaching the resident to self-administer the insulin. Review of the April 2015 Medication Administration Record (MAR) revealed the NovoLOG FlexPen was to be administered at 7:30 AM, 11:00 AM and 4:00 PM.</p> <p>However, observation on 04/14/15 at 6:42 PM, revealed Registered Nurse (RN) #2 performed Resident #13's fingerstick blood sugar (FSBS), and then allowed the resident to administer his/her NovoLOG FlexPen at 6:42 PM after the supper meal was finished, not as ordered before the meal.</p> <p>Continued review of the April 2015 MAR revealed Resident #13 did not receive his/her NovoLOG FlexPen as ordered before meals and as scheduled on the MAR on the following dates and times: on 04/13/15 the 7:00 AM dose was administered at 10:36 AM, three (3) hours and thirty-six (36) minutes after it was due; the 11:00 AM dose was administered at 12:19 PM, one (1) hours and nineteen (19) minutes after it was due; the 4:00 PM was administered at 6:15 PM, two (2) hours and fifteen (15) minutes after it was due; on 04/14/15 the 7:00 AM dose was administered at 10:07 AM, three (3) hours and seven (7) minutes after it was due; the 11:00 AM was administered at 1:38 PM, two (2) hours and thirty-eight (38) minutes after it was due; and the</p>	F 281	<p>3. Additional education of licensed nurses will be completed on survey results including but not limited to medication times and providing medications as ordered including insulin taught by DON, ADON, and/or RN Unit Managers by 5/20/15. Evidence of learning will be demonstrated by verbalization and Q&A.</p> <p>4. A PI worksheet is being completed to monitor that MD orders for Insulin administration is correctly and timely administered. A copy of the worksheet is attached as EXHIBIT E. This PI worksheet is being completed by the DON, ADON, RN unit Managers and/or Team Lead Nurses weekly X 4 then monthly thereafter. If issues are noted the DON, ADON, RN unit Managers and/or Team Lead Nurses or designee takes appropriate action at the time the concern is noted. Results of the PI worksheet will be reported to the QA committee for a determination of the need for further ongoing formal monitoring. The QA Committee meets at least quarterly and consists of the Medical Director, DON, Administrator and at least three (3) Departments Heads.</p>	

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F 281	<p>Continued From page 9</p> <p>4:00 PM dose was administered at 6:48 PM, two (2) hours and forty-eight (48) minutes after it was due. Further review revealed RN #2 was the nurse administering the NovoLOG FlexPen on 04/13/15 and 04/14/15 at the above times, which were all after the scheduled times.</p> <p>Interview with RN #2 on 04/14/15 at approximately 6:45 PM revealed she was running behind with her medication pass due to sending another resident to the Emergency Room earlier in her shift. RN #2 stated resident's insulin should not be given after a meal was completed, unless the Physician had written the order to specifically give after a meal.</p> <p>Interview with the Pharmacy Consultant on 4/15/15 at 02:15 PM, revealed the leeway in giving insulin should be within thirty (30) minutes, but forty-five (45) minutes would be okay. The Pharmacy Consultant revealed insulin given after forty-five (45) minutes would be considered late.</p> <p>Interview, on 04/15/15 at 3:27 PM, with the First Floor Unit Manager, the unit Resident #13 resided on, revealed insulins should be given as the Physician ordered it. The Unit Manager reviewed the administration times for the NovoLOG FlexPen on 04/13/15 and 04/14/15 and stated the insulin had been administered late and the Physician should have been notified. Per interview, the Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Unit Managers reviewed residents' MARS at random times when time allowed. She stated her expectation for a nurse running behind would be to contact her Unit Manager and the Unit Manager would assist the nurse to ensure medications were administered timely. Further</p>	F 281	<p>5. The DON will monitor by observation, interview and review of audits. Date of Compliance:</p>	5/20/15
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F 281	Continued From page 10 interview revealed the Unit Manager was not aware RN #2 was running behind on medication pass. Interview with DON on 04/16/15 at 03:00 PM, revealed the nurses tried to do everything themselves instead of asking for help when they needed it. Per interview, revealed her expectation was for insulin to be given one (1) hour before or one (1) hour after the administration time. However, the Physician's ordered the insulin to be given before meals.	F 281		
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 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to follow the Comprehensive Care Plan for one (1) of twenty-four (24) sampled residents (Resident #4). Resident #4 had care plan interventions to monitor his/her bowel movements (BMs); however, there was no documented evidence the resident's BMs were being monitored. The findings include: Interview, on 04/17/15 at 10:34 AM, with the Administrator revealed the facility did not have a policy specific to following care plans. However,	F 282	F282 1. Resident #4's care plan was reviewed by the DON on 4/17/15; care plan is being followed by the nursing staff with interventions implemented including but not limited to monitoring of bowel movements. Resident #4 bowel monitoring program has remained effective and meeting care planned goals. 2. An audit was completed on 5/6/15 by the DON and/or RN Unit Managers to ensure that each resident has BM monitoring documented as listed on the Comprehensive Care Plan and that any resident who has not had a BM for 3 days has the care plan interventions/MD orders implemented. An additional audit of each Comprehensive Care Plan will be reviewed before 5/20/15 by DON, MDS nurses, and/or RN Unit Managers to ensure that they are developed within 7 days of the comprehensive assessment and revised with subsequent assessments/changes including but not limited to infections, isolation precautions, and maintaining regular bowel monitoring.	

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F 282	<p>Continued From page 11</p> <p>he stated he expected staff to follow the care plan interventions to ensure the resident received the proper care based on their assessed needs.</p> <p>Review of Resident #4's medical record revealed the facility admitted the resident on 03/14/14, with diagnoses which included Cerebral Vascular Accident (Stroke), Diabetes, Osteoporosis and Hypertension. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 03/17/15, revealed the facility assessed Resident #4 to have a Brief Interview for Mental Status score of fifteen (15), indicating no cognitive impairment.</p> <p>Review of Resident #4's Comprehensive Plan dated 02/12/15, revealed the resident was care planned for the potential for constipation, with a goal which included the resident having a BM every three (3) days. Continued review of the care plan revealed interventions which included to administer laxatives as ordered and monitor and record the frequency of the resident's stools (BMs).</p> <p>Review of the March 2015 "Documentation Survey Report" for Resident #4 revealed the report included the resident's bowel and bladder elimination. Continued review revealed Resident #4 was noted to have had a BM on 03/09/15; however, was not noted to have another BM until 03/18/15, with eight (8) days between BMs. Review of the electronic Progress Notes revealed no documented evidence nursing staff was monitoring Resident #4's BMs, as per the care plan.</p> <p>Interview, on 04/15/15 at 11:30 AM, with Resident #4 revealed he/she had gone longer than three (3) days before without having a BM. Per</p>	F 282	<p>Residents care plans are consistently implemented to meet the individualized care needs including the interventions related to bowel movements.</p> <p>The DON, ADON, RN Unit Managers, and/or Team Leads perform routine informal nursing rounds to observe the care that is being rendered to the residents, including but not limited to monitoring of regular bowel function per care plan. If issues are noted by the nursing management personnel, interventions will be taken at that time that may include additional one-on-one education with staff members.</p> <p>3. Additional education of nursing staff will be taught by 5/20/15 by the DON, ADON, and/or RN Unit Managers on survey results including but not limited to implementation of Comprehensive Care Plan interventions such as bowel movement monitoring, and communication of bowel movements. Evidence of learning will be demonstrated by verbalization and Q&A.</p> <p>4. A PI worksheet is being completed to monitor resident care plan</p>	

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F 282	Continued From page 12 interview, the resident had asked for a laxative, after becoming uncomfortable with stomach cramps from gas. Interview, on 04/16/15 at 3:01 PM, with Licensed Practical Nurse (LPN), #3 revealed she did not look at residents' Comprehensive Care Plans, as she followed the information on the computer and the Point Click Care dashboard. She stated she should have been aware what Resident #4 was care planned for to ensure residents received the proper care, as per the care plan. Interview, on 04/16/15 at 3:41 PM, with Registered Nurse (RN) #2 revealed all the nurses had access to residents' Comprehensive Care Plans, and she was not aware staff was not following the care plan interventions when providing residents' care. Interview, on 04/17/15 at 12:30 PM, with the Director of Nursing (DON), revealed it was her expectation for all staff members to follow residents' Comprehensive Care Plans. The DON revealed however, she was not aware staff were not following Resident #4's care plan. Continued interview revealed by not following the care plan for residents, the residents were not receiving the assessed care they required.	F 282	interventions implementation including bowel movement monitoring. A copy of the worksheet is attached as EXHIBIT D. This PI worksheet is being completed by the DON, ADON, RN unit Managers and/or Team Lead Nurses weekly X 4 then monthly thereafter. If issues are noted the DON, ADON, RN unit Managers and/or Team Lead Nurses or designee will take appropriate action at the time the concern is noted. Results of the PI worksheet will be reported to the QA committee for a determination of the need for further ongoing formal monitoring. The QA Committee meets at least quarterly and consists of the Medical Director, DON, Administrator and at least three (3) Departments Heads. 5. The DON will monitor by observation, interview and review of audits. Date of Compliance:	5/20/15	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309			

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F 309	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure its policy was followed related to bowel monitoring for one (1) of twenty-four (24) sampled residents. Resident #4 did not have a bowel movement (BM) for eight (8) days and staff did not follow the facility's established procedure for monitoring and initiating interventions to maintain regular bowel function. The findings include: Review of the facility's policy titled "Bowel Monitoring", revised January 2008, revealed each resident's bowel elimination was to be monitored and recorded every shift. Further review revealed the charge nurse was responsible to review the records to identify any resident who did not have a BM for three (3) consecutive days. In addition, the charge nurse would initiate necessary interventions to re-establish bowel pattern by listing the resident on the twenty four (24) report sheet, and/or communicating to the on-coming shift. Continued review revealed the night shift nurse would administer a laxative and/or suppository as ordered on the third day, and the following day shift nurse was to follow-up with the Physician if the resident had no BM. If a resident's BM status was uncertain, an abdominal assessment would be performed to include: vital signs, auscultation of bowel sounds, abdominal palpation to assess for abdominal distention or complaints of nausea, vomiting or pain.	F 309	F309 1. Resident #4's has had a bowel movement, at least every 3 days since 3/18/15; there was no negative effect associated with this finding. The facility does follow its established procedure for monitoring and initiating interventions to maintain regular bowel function. 2. An audit was completed by DON and RN Unit Managers on 5/4/15 to ensure that each resident has not gone longer than 3 days without having a bowel movement without intervention by the nursing staff/MD. Licensed nursing staff utilizes the facilities electronic health record (Point Click Care -- PPC) to review documentation of resident's bowel movement at least once per shift to follow up accordingly and ensure regular bowel function. Licensed nurses document interventions to ensure follow up for effectiveness. 3. Additional education will be taught by 5/20/15 to all direct care nursing staff by the DON, ADON, and/or RN Unit Managers on survey results including but not limited to bowel movement monitoring, communication of bowel movement	

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F 309	<p>Continued From page 14</p> <p>Furthermore, results of the assessment were to be documented in the nurses notes by the nurse, and the Physician was to be notified of abnormal findings.</p> <p>Review of the of the medical record revealed the facility admitted Resident #4 on 01/28/15 with diagnoses which included Cerebral Vascular Accident (Stroke), Diabetes Type II, Osteoporosis, and Hypertension. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 03/17/15, revealed a Brief Interview for Mental status (BIMS) score of fifteen (15), which indicated Resident #4 was cognitively intact and interviewable.</p> <p>Review of the Order Recap Report for 03/01/15 through 04/30/15 revealed Resident #4 was to receive Docusate Sodium 100 milligram (mg) twice daily for constipation. Continued review revealed the resident could receive Lactulose fifteen (15) milliliters (ml) every six (6) hours if needed for constipation. Further review revealed an order for Dulcolax suppository rectally every twenty-four (24) hours if needed for constipation.</p> <p>Review of the electronic BM records revealed no documented evidence Resident #4 had a BM on 03/10/15 through 03/17/15.</p> <p>Review of the Medication Administration Record (MAR) for March 2015 revealed no documented evidence Lactulose or a Dulcolax suppository were administered after three (3) days with no BM as ordered and per the "Bowel Monitoring" policy. Continued review of the MAR revealed Lactulose and a Dulcolax suppository were administered on 03/15/15; however, there was no documented evidence of follow-up monitoring by</p>	F 309	<p>monitoring, and facility policy for bowel monitoring. In addition, licensed nurse's education will include electronic medical record (Point Click Care - PCC) and clinical documentation reviews each shift. Evidence of learning will be demonstrated by verbalization and Q&A.</p> <p>4. A PI worksheet is being completed to monitor resident care plan interventions implementation including bowel movement monitoring. A copy of the worksheet is attached as EXHIBIT F. This PI worksheet is being completed by the DON, ADON, RN unit Managers and/or Team Lead Nurses weekly X 4 then monthly thereafter. If issues are noted the DON, ADON, RN unit Managers and/or Team Lead Nurses or designee will take appropriate action at the time the concern is noted. Results of the PI worksheet will be reported to the QA committee for a determination of the need for further ongoing formal monitoring. The QA Committee meets at least quarterly and consists of the Medical Director, DON, Administrator and at least three (3) Departments Heads.</p>	

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F 309	Continued From page 15 the nurse to determine if the medications were effective. Further review of the MAR revealed no documented evidence Resident #4 received any other "as needed" medications throughout the eight (8) day period with no BM. Review if the nursing Progress Notes, dated 03/15/15 at 2:53 PM, revealed Resident #4 complained of constipation and requested medication. Continued review of the Progress Notes revealed no other documentation related to the residents failure to have a BM for eight (8) consecutive days, no documented evidence of follow-up monitoring or abdominal assessment, and no documented evidence the Physician was notified. Interview with Licensed Practical Nurse (LPN) #3, on 04/16/15 at 3:01 PM, revealed an alert appeared on the facility's computer documentation program when no BM was documented for three (3) consecutive days. LPN #3 stated the Unit Manager passed the information along to the staff nurses. Continued interview revealed she did not know how the system had failed, or why Resident #4 did not receive his/her medication for constipation as ordered by the Physician. She further stated there should have been follow-up after the medication was administered to indicate whether it was effective or not. Further interview revealed staff did not follow the facility's policy when they did not notify the Physician regarding Resident #4's constipation and she stated untreated constipation could cause the resident to become ill and possibly suffer a fecal impaction. Interview with Registered Nurse (RN) #2, on 04/16/15 at 3:41 PM, revealed she was the Unit	F 309	5. The DON will monitor by observation, interview and review of audits. Date of Compliance:	5/20/15	

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F 309	Continued From page 16 Manager where Resident #4 resided. She stated all medications should be administered according to the Physician's orders. She further stated each nurse was responsible for following the "Bowel Monitoring" policy. Continued interview revealed Resident #4's needs were not met and the failure could have led to a complete bowel obstruction. Interview with the Director of Nursing (DON), on 04/17/15 at 10:27 AM, revealed it was her expectation for all nurses, including the Unit Manager, to follow the facility's bowel regimen according to the Physician's orders and the "Bowel Monitoring" policy. Continued interview revealed ordered medications should have been administered after three (3) days with no BM, and on the fourth day if the medication was not effective the Physician should have been notified. The DON further stated the nurses were to follow-up with the aides to ensure they were documenting resident BMs correctly. The DON acknowledged there was a failure within the system, with a potential outcome of a complete bowel obstruction. Interview with the Administrator, on 04/17/15 at 10:34 AM, revealed he expected the nursing staff to follow computer alerts related to bowel monitoring, and respond according to the facility's policy.	F 309			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and Infection.	F 441	F441 1. Each facility whirlpool tub was disinfected and cleaned including the tub jets on 4/15/15 by RN Unit Manager; each tub disinfectant was checked/replenished on 4/15/15 by RN Unit Manager. Resident #21 infection resolved on 4/17/15 and no longer resides in the facility. Resident # 10 has dressing changes completed as ordered by physician. Licensed nursing staff utilizes proper hand washing and infection control practices; wound is healing with no signs/symptoms of infection. Resident #14 had PPE placed outside of door and biohazard collection bags inside the door on 4/17/15. Resident #14 infection resolved on 4/19/15. Resident's sitter service was contacted by the DON on 4/16/15 to communicate need for their agency staff to abide by facility isolation precautions and reinforce there is to be no direct care provided by sitter per facility policy. Resident #19 had PPE placed outside of door and biohazard collection bags inside the door on		

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F 441	<p>Continued From page 17</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: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to have an effective</p>	F 441	<p>4/17/15. Resident #19 infection resolved on 4/19/15 and is no longer in isolation.</p> <p>Resident #11 indwelling urinary catheter drainage bag was adjusted on 4/16/15 by RN Unit Manager to assure tubing/bag did not touch the floor; this continues to be done each shift; resident is free of signs/symptoms of UTI.</p> <p>2. Each resident who has received a whirlpool bath in the past 30 days will be assessed by RN staff for signs/symptoms of infection including but not limited to nosocomial C-diff, VRE, MRSA, ESBL by 5/13/15. None were noted.</p> <p>Each resident with dressing changes will be assessed by RN staff by 5/15/15 for signs and symptoms of infection. RN#1 was educated by the DON on 5/8/15 on proper infection control/ hand washing procedures and the requirement to wash their hands after each direct resident contact for which hand washing is indicated by professional accepted practice, including but not limited to dressing changes.</p>

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F 441	<p>Continued From page 18</p> <p>Infection Control Program in place to monitor the disinfection of the facility's whirlpool (w/p) tubs and failed to develop and implement effective policies and procedures for the disinfection of the w/p tub.</p> <p>Observation and interviews on 04/04/15 revealed two (2) whirlpool tubs were currently being used for residents' baths in the facility. Record review revealed Resident #21 utilized the w/p tub on 04/02/15, while diagnosed with Clostridium Difficile (C-Diff), a very contagious bacterial organism that causes an infection of the intestinal tract.</p> <p>Observation of the facility's w/p disinfecting system on the second floor revealed no disinfecting solution was present in the system. Interviews with facility staff revealed housekeeping or maintenance staff were responsible for maintaining the disinfection system. However, interviews with the maintenance and housekeeping staff revealed they did not check or refill the disinfectant in the system. Interviews with Certified Nursing Assistants (CNAs) and licensed nurses revealed they were not knowledgeable on how to disinfect the w/p tubs per the manufacturer's instructions. Furthermore, there was no documented evidence staff were educated upon hire, and no evidence of ongoing education, related to proper disinfection of the w/p tubs.</p> <p>Also, observation of a dressing change for Resident #10 revealed the nurse completed the dressing change and changed her gloves; however, she failed to wash her hands prior to touching other objects in the room.</p>	F 441	<p>Each resident with isolation precautions were audited by the ADON on 4/30/15 to ensure isolation precautions are properly care planned, Kardex is updated, isolation precautions magnet placed on door frame, and PPE equipment was available outside/inside room.</p> <p>Licensed nurse will be audited by the DON, ADON, and/or RN Unit Managers by 5/20/15 to ensure proper infection control/ hand washing procedures and the requirement to wash their hands after each direct resident contact for which hand washing is indicated by professional accepted practice, including but not limited to dressing changes.</p> <p>Each resident with urinary catheters were assessed for sign/symptoms of Urinary Tract infections by the RN staff on 5/13/15; each residents drainage bag/tubing were placed in privacy bags and are not touching the floor.</p> <p>The nursing supervisors and nursing management team perform periodic informal observational rounds, as a component of their daily duties, observing the direct care staff in rendering care for the residents including the operationalization of the facilities effective infection control program.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185447	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/17/2015
NAME OF PROVIDER OR SUPPLIER VILLASPRING OF ERLANGER			STREET ADDRESS, CITY, STATE, ZIP CODE 630 VIOX DRIVE ERLANGER, KY 41018		
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F 441	<p>Continued From page 19</p> <p>Additionally, the facility failed to ensure residents in contact isolation had Personal Protective Equipment (PPE) in use. Observation revealed PPE was not utilized during the provision of care for Resident #14, who was in contact isolation for an Extended Spectrum B Lactamases (ESBL) Urinary Tract Infection (UTI). Also, interview with the caregiver (sitter) for the resident revealed she had not been educated related to the resident's need for contact isolation, although the caregiver was assisting the resident with incontinence care. There was no PPE readily available for staff to utilize outside Resident #14's door, and no biohazard collection bags inside the door.</p> <p>In addition, Resident #19 had a diagnosis of MRSA (Methicillin Resistant Staphylococcus Aureus) UTI and was in contact isolation. (MRSA is a strain of staph bacteria that has become resistant to the antibiotics commonly used to treat ordinary staph infections.) Observation revealed no PPE outside the door according to policy.</p> <p>Furthermore, Resident #11 was observed to have an indwelling urinary catheter drainage bag dragging on the floor under the resident's wheelchair.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility's policy titled "Arjo Tub and Lift Cleaning", undated, revealed the Arjo w/p tub was to be cleaned following each resident use. Continued review revealed the disinfectant was to be kept in the locked compartment at the back of the tub and was to be checked monthly by the Unit Manager. Further review revealed the recommended procedure for cleaning the w/p tub included draining the whirlpool, spraying the tub 	F 441	<p>If concerns are noted, the nursing supervisor or manager takes appropriate interventions at that time, including additional one-on-one reeducation of the team member.</p> <p>Transmission based precautions procedure was reviewed and revised as seen in EXHIBIT G.</p> <p>Nurse aide orientation checklist was revised to include cleaning and disinfection of whirlpool jets as seen in EXHIBIT H.</p> <ol style="list-style-type: none"> 3. Additional education of all direct care nursing staff will be completed by 5/20/15 by the DON, ADON, and /or RN Unit Mangers on the survey results. The education will include but not be limited to: proper whirlpool/jets cleaning and disinfection including manufacturing recommendations, communication of infections/isolation on Kardex; review of transmission based precautions procedure, PPE use and availability; standard precautions; proper hand washing/hand hygiene; urinary catheter bags/tubing care and the overall goals of the facility's infection control program. Evidence of learning will be measured via written post-test. 		

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F 441	<p>Continued From page 20</p> <p>with the hose labeled disinfectant, disinfecting for three (3) minutes, scouring debris from the w/p as needed, and spraying with water to rinse out the disinfectant. Further review revealed the policy did not instruct staff related to cleaning the hydromassage system (jets).</p> <p>Review of the "Disinfection/Cleaning Instructions" for the Arjo whirlpool from the manufacturer, undated, revealed it contained detailed directions of the proper procedure for disinfection of the w/p system. Continued review revealed for hydromassage (jet) systems, the jets were to be disinfected daily before the first bath of the day and after each resident. Further review revealed the recommended contact time for the disinfectant was ten (10) minutes.</p> <p>Medical record review revealed Resident #21 was admitted by the facility on 04/01/15 with diagnoses which included End Stage Renal Disease requiring Hemodialysis, Diabetes, and Clostridium Difficile (C-Diff) colitis, a highly contagious infection of the intestinal tract.</p> <p>Review of the Admission Orders revealed the facility was to follow its policy related to maintaining contact isolation precautions related to C-Diff infection for Resident #21. Review of the Comprehensive Care Plan, initiated on 04/03/15, revealed specific precautions for Resident #21 included the following: wipe down all contact areas immediately, disinfect all equipment used before it leaves the room, wipe items down after toileting or incontinence care; and educate the resident, family, and staff regarding preventive measure to contain the infection.</p>	F 441	<p>4. A PI worksheet is being completed to monitor the facility infection control program including but not limited to: tub disinfection, Isolation Precautions, dressing changes, hand washing/hygiene, and urinary catheters. A copy of the worksheet is attached as EXHIBIT I. This PI worksheet is being completed by the DON, ADON, RN unit Managers and/or Team Lead Nurses weekly X 4 then monthly thereafter. If issues are noted the DON, ADON, RN unit Managers and/or Team Lead Nurses or designee will take appropriate action at the time the concern is noted. Results of the PI worksheet will be reported to the QA committee for a determination of the need for further ongoing formal monitoring. The QA Committee meets at least quarterly and consists of the Medical Director, DON, Administrator and at least three (3) Departments Heads.</p> <p>5. The DON will monitor through observation, interview and review of audits. Date of Compliance:</p>	5/20/15	

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F 441	<p>Continued From page 21</p> <p>Review of the admission Minimum Data Set (MDS) assessment, dated 04/13/15, revealed Resident #21 was assessed to be frequently incontinent of bowel and diagnosed with a Multi-Drug Resistant Organism.</p> <p>Review of bathing records revealed Resident #21 received a w/p bath on 04/02/15, the day after admission with the diagnosis of C-Diff infection.</p> <p>Multiple attempts to interview Resident #21 were unsuccessful due to out-of-facility appointments and the resident's medical condition.</p> <p>Interview with RN #3, on 04/17/15 at 11:05 AM, revealed she was the Unit Manager for the second floor. She stated it would be okay for a resident with C-Diff to use the w/p tub if it was sanitized correctly.</p> <p>Observation of the second floor w/p tub, and interview with RN #2 on 04/15/15 at 4:55 PM, revealed the nurse attempted to provide a demonstration on how to clean the whirlpool; however, he noticed there was no cleaning fluid in the whirlpool. He stated he did not know who was responsible for ensuring the w/p had sanitizer.</p> <p>Interview with CNAs #12, on 04/14/15 at 5:00 PM, revealed she normally cleaned the whirlpool on the second floor by rinsing it out with a disinfectant. She reported she was not certain how the jets were cleaned.</p> <p>Interview with CNAs #10, on 04/14/15 at 5:10 PM, revealed she was assigned to care for residents on the second floor of the facility. She stated she had been employed at the facility "a few months"</p>	F 441			

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F 441	<p>Continued From page 22 and had not been trained on cleaning or disinfecting the w/p tub.</p> <p>Interview with CNAs #13, on 04/14/15 at 5:20 PM, revealed he had given w/p baths on the second floor in the past. He reported he cleaned the second floor whirlpool by draining the water out and spray into the tub. Continued interview revealed he turned the jets on so they would spray into the tub. CNAs #13, while demonstrating, did not attach the disinfectant correctly in order for the sanitizer to get into the "jet" system. CNAs #13 reported he was not sure who trained him on the cleaning of the whirlpool.</p> <p>Interview with CNAs #7, on 04/15/15 at 8:45 AM, revealed she was assigned to residents on the first floor and had been employed at the facility since January 2015. She stated she had not received any training related to the cleaning and disinfection of the w/p tubs.</p> <p>Observation of the first floor w/p tub, and interview with CNAs #5, on 04/15/15 at 9:00 AM, revealed she could not remember if she had been trained on disinfecting the w/p bath but stated she thought you just had to spray the tub with the disinfectant hose. Continued interview revealed she was unaware of the need to lock the disinfectant hose into the hydromassage inlet to allow the jet system to be disinfected. CNAs #5 was able to demonstrate how to check the level disinfecting solution, and observation revealed the solution was seventy (70) percent full. She stated she did not know how to replace the solution, and thought housekeeping was responsible.</p> <p>Interview with the Unit Manager for the first floor,</p>	F 441		
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F 441	<p>Continued From page 23</p> <p>on 04/15/15 at 9:30 AM, revealed she assumed her position in January 2015, and had just received training on how to disinfect the w/p tub by maintenance staff on the morning of 04/15/15. She stated she did not receive the training upon hire. Continued interview revealed she did not check or replace the disinfectant and would call housekeeping or maintenance to replace it when needed.</p> <p>Interview with the Assistant Director of Nursing(ADON)/Infection Control Nurse (ICN), on 04/15/15 at 10:00 AM, revealed the w/p tub was to be cleaned and disinfected with the sanitizer hose which was connected to the tub after each use. She stated she did not know how to clean the jets. Further interview revealed there was no Staff Development Nurse (SDN) at the facility, and the Staffing Coordinator handled the new employee orientation and provided training to CNAs on the floors related to disinfection of the w/p tubs. Continued interview revealed the Unit Managers and the housekeeping staff checked the disinfectant levels. She stated the facility did not put residents who were in isolation in the whirlpool tubs, as it would be an infection control concern if staff failed to properly disinfect the tubs after each use.</p> <p>Interview with the Staffing Coordinator, on 04/15/15 at 10:30 AM, revealed new employees completed on-line inservices which did not included education related to cleaning the w/p tubs. She stated she did not provide education on the topic but reported the CNAs preceptors provided on the job instruction on cleaning the w/p tubs. Continued interview revealed the housekeepers and the Unit Managers were responsible checking the disinfectant levels and</p>	F 441			

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F 441	<p>Continued From page 24 refilling when needed.</p> <p>Interview with the Maintenance Assistant, on 04/15/15 at 10:45 AM, revealed the facility did not currently have a Maintenance Director. He stated he had been trained on disinfecting the w/p tubs, and was able to demonstrate the procedure in accordance with the manufacturer's instructions. Continued interview revealed he did not check the chemical solution levels on a routine basis and was not sure where the chemical was kept in case of the need for a refill.</p> <p>Interview with Housekeeper #1, on 04/15/15 at 2:00 PM, revealed the nursing staff did the cleaning and disinfecting of the w/p tubs. She stated she had not been trained on the process, and did not check or refill the disinfectants in the w/p tubs.</p> <p>Interview with the Housekeeping Supervisor, on 04/15/14 at 2:15 PM, revealed she had been employed in her position since September 2014. She stated she had no formal training related to cleaning the w/p tubs and just sprayed them down with disinfectant spray when cleaning the rest of the bathroom. She further stated she did not check chemical disinfectant levels or replace the chemicals.</p> <p>Interview with the Director of Nursing (DON), on 04/15/15 at 2:25 PM, revealed she had been the DON at the facility since March 2013. She stated the CNAs were to disinfect the w/p tubs after use and reported they received training on the job by demonstration from their preceptors. She further stated the facility did not perform observations or audits to ensure the CNAs and nurses knew how to properly clean the tubs, and she did not believe</p>	F 441		
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F 441	<p>Continued From page 25</p> <p>this training was included with the annual competency in-services. Continued interview revealed the CNAs should check the chemical levels prior to giving a bath to ensure the disinfectant was ready for use after the bath, and the Unit Managers were to check the chemical levels monthly and replace as needed. Further interview revealed it was important for all of the CNAs and nurses to know how to properly clean the w/p tubs, and should know how to refill the disinfectant when empty. She further stated if the w/p tubs were not properly disinfected, it would be an infection control concern due to contagious infections.</p> <p>Subsequent interview with RN #2, on 04/16/15 at 3:15 PM, revealed he had been made aware he was responsible for ensuring the w/p had sanitizer. Continued interview with revealed he was not certain how long the w/p had been without the sanitizer necessary to disinfect the tub.</p> <p>Interview with the Administrator, on 04/16/15 at 4:00 PM, revealed he had noted the facility's policy was not all-inclusive on how to disinfect the w/p tubs, when compared to the manufacturer's recommendations. He stated it was important for the facility to have a system in place to ensure the staff knew how to properly disinfect the w/p tubs, and to ensure the disinfectant chemical was checked and replaced as needed.</p> <p>2. Review of the facility's "Hand Hygiene Policy and Procedure", undated, revealed effective handwashing reduced the incidence of healthcare-associated infections. Continued review revealed handwashing was required routinely for decontaminating hands after contact</p>	F 441		

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F 441	<p>Continued From page 26</p> <p>with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings, even if the hands were not visibly soiled.</p> <p>Review of Resident #10's medical record revealed the facility admitted the resident on 08/08/11 with diagnoses which included Dementia with Behavioral Disturbance and Chronic Kidney Disease. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 03/19/15, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fourteen (14) which indicated the resident was cognitively intact.</p> <p>Observation of a skin assessment performed by Registered Nurse (RN) #1, on 04/15/15 at 12:00 PM, revealed the nurse removed the soiled dressing from the resident's sacral ulcer, and washed her hands. She donned new gloves and cleansed and measured the ulcer. RN #1 then performed the dressing change to the resident's sacral ulcer by packing the ulcer with packing strip, and applying a gauze pad and Ecofix tape. Further observation revealed the nurse then removed her soiled gloves; however, she failed to wash her hands, but applied new gloves and handed the resident his/her telephone.</p> <p>Interview with RN #1, on 04/15/15 at 12:10 PM, revealed she had a recent inservice related to dressing changes and knew she should have washed her hands after completing the dressing change instead of just changing gloves. She explained she could have contaminated objects in the room such as the resident's telephone.</p> <p>Interview with the DON, on 04/16/15 at 3:00 PM,</p>	F 441		

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F 441	<p>Continued From page 27</p> <p>revealed her expectation was for the facility's policy to be followed. She stated nurses were to wash their hands after a dressing change, prior to applying new gloves and prior to touching items in the room.</p> <p>3. Review of the facility's policy titled "Isolation Transmission Based Precautions: Contact Precautions", dated 03/18/99, revealed staff were to wear gloves when they entered the room of a resident on contact precautions. Continued review revealed gloves were to be changed after any encounter with infective material, e.g. fecal matter or wound drainage. In addition, staff were to remove their gloves and wash their hands before leaving the room.</p> <p>Review of the facility's policy titled "MRSA and ESBL Management", dated February 2015, revealed the facility would follow infection control guidelines to prevent acquisition and spread of Methicillin Resistant Staph Aureus (MRSA) and Extended Spectrum Beta Lactamase (ESBL) producers. Further review of the policy revealed contact precautions were to be implemented immediately to prevent person-to-person transmission of MRSA and ESBL. Specific interventions included: placement of an "Isolation Precaution" magnet outside the resident's room and placement of PPE, including gloves, gowns and masks outside the room. Continued review of the policy revealed a gown was to be worn when entering the room if staff anticipated that their clothing would have substantial contact with the patient, environmental surface, or items in the patient's room, or if the patient was incontinent or had diarrhea, an ileostomy, a colostomy, or wound drainage not contained by a dressing.</p>	F 441			

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F 441	<p>Continued From page 28</p> <p>Review of the facility's policy titled "Standard Precautions", undated, revealed Standard Precautions were to be used in the care of all residents, regardless of their diagnoses, or suspected or confirmed infection status. Further review revealed proper hand hygiene was to be performed before and after the use of gloves.</p> <p>Review of clinical record revealed Residents #14 was readmitted by the facility on 12/17/13 with diagnoses which included Multidrug Resistant Organism, and Urinary Tract Infection. Review of the Annual MDS Assessment, dated 03/12/15, revealed the facility assessed Resident #14 to have impaired cognitive skills, with a BIMS score of five (5). Continued review of the MDS assessment revealed Resident #14 required extensive assistance of one person for toileting, and was frequently incontinent of urine and occasionally incontinent of bowel. Review of laboratory test results, dated 04/10/15, revealed Resident #14's urine culture confirmed Escherichia Coli ESBL produced organisms. Review of the resident's Comprehensive Care Plan dated 04/10/15 revealed no evidence of interventions for isolation precautions related to the ESBL.</p> <p>Observation, on 04/14/15 at 1:19 PM, revealed Resident #14 was under Isolation Precautions, indicated by a magnetic sign at the door to the resident's room. Continued observation revealed no PPE was available for use at the entrance to the room. Further observation revealed CNAs #7 entered the room carrying a lunch tray without utilizing PPE. Additionally, observation revealed CNAs #7 failed to use hand sanitizer or perform handwashing before leaving the resident's room.</p>	F 441			

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F 441	<p>Continued From page 29</p> <p>Subsequent observation, on 04/14/15 at 5:19 PM and on 04/15/15 at 8:30 AM, revealed no PPE was available at the door to Resident #14's room or anywhere in the direct vicinity of the room, despite the magnetic indicator for isolation precautions.</p> <p>Interview with CNAs #7, on 04/14/15 at 1:19 PM, revealed Resident #14 had Isolation Precautions due to ESBL in the urine. She stated she should have worn protective clothing when she entered the resident's room. Continued interview revealed her failure to do so made a potential for the infection to be spread to other residents.</p> <p>Interview with the Unit Manager, on 04/14/15 at 1:33 PM, revealed CNAs #7 should have worn protective clothing and gloves when she entered the resident's room. She further stated CNAs #7 should have washed her hands before she returned to the dining area to assist other residents. She concluded the potential harm to the residents was the possibility for the spread of ESBL to other residents.</p> <p>Interview with RN #1, on 04/14/15 at 5:19 PM, revealed PPE necessary to care for Resident #14 included gowns and gloves. She stated the items should have been accessible outside the resident's room.</p> <p>Interview with the Agency Sitter for Resident #14, on 04/14/15 at 5:20 PM, revealed she had not been educated by the facility related to Resident #14's Isolation Precautions, but had been provided sani-wipes to sanitize the commode seat, and was told to wash her hands, after toileting the resident. Continued interview revealed she had not worn gowns when toileting</p>	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185447	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/17/2015
NAME OF PROVIDER OR SUPPLIER VILLASPRING OF ERLANGER			STREET ADDRESS, CITY, STATE, ZIP CODE 630 VIOX DRIVE ERLANGER, KY 41018		
(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 30</p> <p>the resident. She reported, to her knowledge, the resident simply had a Urinary Tract Infection (UTI).</p> <p>Observation, on 04/15/15 at 8:44 AM, revealed the Agency Sitter provided incontinence care for Resident #14 without utilizing PPE.</p> <p>Interview with First Floor Unit Manager on 04/15/15 at 8:57 AM revealed Resident #14 was still under Isolation Precautions for ESBL. She stated the nurse aides were supposed to provide direct care for the resident, not the Agency Sitter. She further stated the nurse aides do not usually use a gown for residents with ESBL, just gloves and disinfectant wipes located in the resident's bathroom.</p> <p>Interview with CNAs #6, on 04/15/15 at 9:05 AM, revealed she did not assist Resident #14 with incontinent care at 8:44 AM, and stated the Agency Sitter provided the care at that time. She further stated a gown and gloves should be worn each time the resident required incontinence care because of isolation precautions.</p> <p>4. Record review revealed Resident #19 was admitted by the facility on 01/06/15 with diagnoses which included Chronic Kidney Disease Stage IV and Retention of Urine. Review of laboratory test results, dated 04/03/15, revealed a urine culture confirmed the presence of the MRSA organism. Review of the Annual MDS Assessment dated 01/18/15 revealed the facility assessed Resident #19 to require extensive physical assistance of two (2) persons for toileting. Continued review revealed Resident #19 was always incontinent of urine and frequently incontinent of bowel. Further review</p>	F 441			

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F 441	<p>Continued From page 31 revealed Resident #19 had an indwelling urinary catheter.</p> <p>Observation, on 04/16/15 at 10:52 AM, revealed Resident #19 was under Isolation Precautions, indicated by a magnetic sign at the door. Further observation revealed no PPE was available at the door. Continued observation revealed CNAs #8 entered the room without utilizing PPE.</p> <p>Interview with CNAs #8, on 04/16/15 at 11:00 AM, revealed Resident #19 had a urinary catheter, with a diagnosis of MRSA in the urine. She stated the resident was incontinent of bowel and bladder, and wore adult briefs. CNAs #8 further stated she wore gloves but not a gown when toileting the resident, but acknowledged an isolation cart containing PPE should be located outside the resident's room.</p> <p>Interview with the ADON, on 04/17/15 at 11:46 AM, revealed the failure to use PPE appropriately was a potential for re-infection of the resident, or spread of the infection to other residents.</p> <p>Interview with the Administrator, on 04/17/15 at 12:28 PM, revealed his expectation was for staff to follow the Isolation Precaution policy for the facility. He further stated his expectation for the prompt availability of PPE items at the door to the resident's room.</p> <p>A Post Survey Interview with the DON, on 04/21/15 at 9:15 AM, revealed it was her expectation for staff to follow the facility's Isolation Precautions protocol. She stated staff were to wash their hands before and after assisting the resident, as well as wear gloves during care. She stated if the potential for soiling was present, for</p>	F 441			

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F 441	<p>Continued From page 32</p> <p>example with incontinent care, staff were to wear a gown in addition to gloves. Continued interview revealed a failure to do so would was a potential for cross-contamination with the spread of illness to other residents. Furthermore, she stated PPE should be available and stored outside the resident's door.</p> <p>5. Record review revealed Resident #11 was re-admitted by the facility on 02/18/15 with diagnoses which included End Stage Renal Disease, Neurogenic Bladder and Urinary Tract Infection. Review of Physician's Order dated 02/19/15 revealed the resident was to have an indwelling urinary catheter.</p> <p>Observation of Resident #11, on 04/14/15 at 5:16 PM, revealed the resident was self-propelling in his/her wheelchair in the front of the nursing station. Continued observation revealed the urinary catheter tubing and drainage bag were dragging the floor beneath the resident's wheelchair.</p> <p>Interview with CNAs #2 and CNAs #3, on 04/14/15 at 5:16 PM, revealed the catheter bag should not drag the floor.</p> <p>Interview with the Unit Manager, on 04/16/15 at 2:27 PM, revealed the catheter bag should have been secured under the resident's wheelchair. She stated it was an infection control concern if the bag dragged on the floor.</p> <p>Interview with the DON, on 04/17/15 at 11:39 AM, revealed her expectation for the catheter bag were for staff to be stored securely under the wheelchair. She stated the bag should not have been on the floor due to infection control</p>	F 441		
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F 441	Continued From page 33 concerns.	F 441		
F 514 SS=D	<p>Interview with the Administrator, on 04/17/15 at 12:28 PM, revealed it was his expectation for the catheter bag to be stored securely under the wheelchair and off the floor.</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to maintain clinical records for each resident in accordance with accepted professional standards and practices which were complete and accurately documented for one (1) of twenty-four (24) sampled residents (Resident #23).</p> <p>Review of the closed record for Resident #23 of</p>	F 514	<p>F514</p> <ol style="list-style-type: none"> Resident #23's clinical record was amended on 4/17/15 for the "Provisional Report of Death" record by Medical Record Coordinator. The funeral home and Office of Vital Statistics (Kenton County Health Department) was notified on 4/17/15 by phone and by amended fax of the Provisional Report of Death to assure the resident's record was complete and accurate. An audit of each resident that had expired at the facility within the past year was conducted by the Medical Record Coordinator on 4/20/15 to ensure the "Provisional Report of Death" was completed with the accurate date of death recorded. Additional education of the licensed nurses will be completed by the DON and/or RN Unit Managers by 5/20/15 to include proper completion of the "Provisional Report of Death" with accurate the date of death recorded. Evidence of learning will be demonstrated by verbalization and Q&A. A PI worksheet is being completed to monitor resident records for complete and accurate 	

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F 514	<p>Continued From page 34</p> <p>the "Provisional Report of Death", revealed the resident was noted to have expired on 03/03/15. However, further review of the medical record revealed Nurse's Notes which documented Resident #23 to have expired on 04/03/15 at 2:50 AM.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Medical Records Department Medical Record System", revised September 2009, revealed it was the policy of the facility for residents' medical records to be maintained, in accordance with accepted professional standards and practices. Continued review revealed residents' medical records were to be complete, accurately documented, readily accessible and systematically organized.</p> <p>Review of the facility's policy titled, "Provisional Death Certificate", revised November 2012, revealed the nurse releasing the body would provide a Provisional Death Certificate (PDC) to the funeral home director or representative when the resident had expired in the facility. Per the Policy, the PDC was a three (3) part form, and review of the "instructions" for completion of the form, revealed Part A of the form was to be completed by the facility, Coroner or Hospice Nurse.</p> <p>Review of Resident #23's closed medical record revealed the facility admitted the resident on 02/04/14, with diagnoses which included Aftercare Healing of Traumatic Fracture, Chronic Kidney Disease and Adult Failure to Thrive.</p> <p>Review of Resident #23's Nurse's Note dated 04/03/15 at 2:50 AM, revealed the nurse was</p>	F 514	<p>documentation. A copy of the worksheet is attached as EXHIBIT J. This PI worksheet is being completed by the Medical Records Coordinator weekly X 4 then monthly thereafter. If issues are noted she will bring it to the attention of the Director of Nursing for correction. Results of the PI worksheet will be reported to the QA committee for a determination of the need for further ongoing formal monitoring. The QA Committee meets at least quarterly and consists of the Medical Director, DON, Administrator and at least three (3) Departments Heads.</p> <p>5. The Medical Records Coordinator will monitor by observation, interview and review of audits. Date of Compliance:</p>	5/20/15	

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F 514	<p>Continued From page 35</p> <p>notified by a Certified Nursing Assistant (CNA) the resident was not breathing, and vital signs were performed. Continued review of the Note revealed the nurse documented there was no visible signs of life either audible or physical, the resident's family was present in the room and orders were received from the Physician to release the resident's body to the funeral home. However, review of the PDC, Part A, for Resident #23, revealed the date and time of death was documented as 03/03/15 at 2:50 AM.</p> <p>Interview, on 04/17/15 at 9:30 AM, with the Director of Nursing (DON), revealed the nurse assigned at the time of Resident #23's death was to have accurately completed Part A of the PDC. Per interview, her expectation was for nurses to ensure the accurate date of death was transcribed on the PDC.</p> <p>Interview, on 04/17/15 at 10:00 AM, with the Regional Medical Records Director, revealed the nurse wrote the wrong date of death on Resident #23's PDC, and this was not recognized until Surveyor intervention. She stated she would need to send a correction to the Commonwealth of Kentucky Department of Public Health Registrar of Vital Statistics.</p>	F 514			

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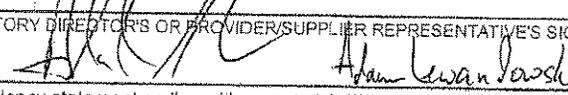
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K 000	INITIAL COMMENTS Building: 01 Plan Approval: 1999 Survey under: NFPA 101 (2000 Edition) Facility type: SNF/NF Type of structure: Two (2) Story with partial basement Type II (111) Protected Smoke Compartment: Seven (7) Fire Alarm: Complete Fire alarm System (Installed 1999) Sprinkler System: Complete Sprinkler System (Wet) Installed in 1999 Generator: Type II Diesel Installed in 1999 A Standard Life Safety Code Survey was conducted on 04/14/15. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire) requirements for participation in Medicare and Medicaid. The census on the day of the survey was one hundred and thirty-four (134). The facility is licensed for one hundred and forty (140) beds. Deficiencies were cited with the highest deficiency of a Scope and Severity at a "D" level. NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily	K 000	Without admitting or denying the validity or existence of the alleged deficiencies, including but not limited to any determinations of scope or severity, Villaspring provides the following plan of correction. This plan of correction is submitted as required by the state and federal guidelines and is not an admission or agreement with any of the cited information. This plan of correction is not meant to establish any standard of care, contract, obligation or position and Villaspring reserves all right to raise all possible contention and defenses in any civil or criminal claim action or proceeding. THIS PLAN OF CORRECTION SERVES AS Villaspring of Erlanger CREDIBLE ALLEGATION OF SUBSTANTIAL COMPLIANCE AS OF 5/20/15. K038 1. The smoke barrier door near therapy on the second floor and smoke barrier door on the first floor leading to lobby will have proper signage placed by 5/15/15 to indicate method to operate door. 2. Each facility door with delayed egress viewed on 4/27/15 by the Corporate Maintenance Director to ensure proper signage was in place. 3. Additional education of Maintenance Director, Maintenance assistant, and Administrator was completed by 5/15/15 by Corporate Maintenance Director on NFPA 101 Life Safety Code Standard K038. Evidence of learning demonstrated by verbalization and Q&A. 4. Maintenance Director audits all	
K 038 SS=D		K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 5/11/15
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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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K 038	Continued From page 1 accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors equipped with delayed egress signage had signage indicating method to operate door, according to National Fire Protection Association (NFPA). The deficiency had the potential to affect two (2) of seven (7) smoke compartments, twenty (20) residents, staff and visitors. The findings include: Observation on 04/14/15 at 1:08 PM, with the Maintenance Director, revealed the smoke barrier doors located on the second floor near therapy was equipped with delayed egress signage and did not have the proper signage which indicated proper operation to exit. Interview, with the Maintenance Director at the time observation, revealed the facility was aware the signage was required, but had not placed it on the door yet. Observation on 04/14/15 at 1:30 PM, with the Maintenance Director, revealed the smoke barrier doors located on the first floor leading to the lobby was equipped with delayed egress signage and did not have the proper signage which indicated proper operation to exit. Interview, with the	K 038	doors with delayed egress on a weekly basis for proper functioning; correct signage is included in that preventative maintenance checks. Any concerns will be brought to the Administrator and/or Corporate Maintenance Director and reported to the Quarterly Assurance Committee. A copy of TELS instructions for delayed egress is attached as EXHIBIT A. The QA Committee meets at least quarterly and consists of the Medical Director, DON, Administrator and at least three (3) Departments Heads. 5. Maintenance Director will monitor by observation and review of audits. Date of Compliance:	5/20/15

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K 038	Continued From page 2 Maintenance Director at the time of observation, revealed the facility was aware the signage was required, but had not placed it on the door yet. The findings were confirmed by the Administrator during the exit conference. Reference: NFPA 101 (2000 Edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device,	K 038		
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K 038	Continued From page 3 relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.	K 038		
K 064 SS=0	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure fire extinguishers were not obstructed from use,	K 064	K064 1. Medicine carts that were blocking fire extinguisher on second floor near linen closet #3 and on the first floor outside of room 1203 were moved immediately. 2. The Maintenance Director conducted a complete facility audit on 4/27/15 to ensure all fire extinguishers were not obstructed or obscured from view. In addition, weekly rounds are performed by the administrator, DON, Maintenance Supervisor, and Housekeeping Supervisor on each unit to assure fire extinguishers are visible and accessible. 3. Additional education of Maintenance Director, Maintenance Assistant, and Administrator conducted by 5/15/15 by Corporate Maintenance Director on NFPA 101 Life Safety Code Standard K064. Additionally each facility staff will be re-educated regarding not obstructing or obscuring the view of fire extinguishers so they are visible and accessible by 5/20/15 by Administrator Maintenance Director and/or Maintenance Assistant. Evidence of learning will be demonstrated by verbalization and Q&A.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 064	<p>Continued From page 4</p> <p>according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, thirty-six (36) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation on 04/14/2015 at 1:25 PM, with the Maintenance Director, revealed on the Second Floor a fire extinguisher near Linen Closet #3 was blocked by a medicine cart. Interview, with the Maintenance Director at the time of observation, revealed staff had been trained not to block fire extinguishers with items.</p> <p>Observation on 04/14/2015 at 1:50 PM, with the Maintenance Director, revealed on the First Floor a fire extinguisher near resident room 1203 was blocked by a medicine cart. Interview, with the Maintenance Director at the time of observation, revealed staff had been trained not to block fire extinguishers with items.</p> <p>The findings were confirmed by the Administrator during the exit conference.</p> <p>Reference: NFPA 10 (1998 Edition) 1-6.6* Fire extinguishers shall not be obstructed or obscured from view. Exception: In large rooms, and in certain locations where visual obstruction cannot be completely avoided, means shall be provided to indicate the location.</p>	K 064	<p>4. Administrator, Maintenance Director and/or Team Lead nurses will audit floor for obstructed or obscured from view of fire extinguishers weekly for 4 weeks then monthly using a PI worksheet. See attached as EXHIBIT B. If issues are noted they will be addressed at the time including unobstructing the fire extinguisher and one on one education of staff. Results of the PI worksheet will be reported to the QA committee for a determination of the need for further ongoing formal monitoring. The QA Committee meets at least quarterly and consists of the Medical Director, DON, Administrator and at least three (3) Departments Heads.</p> <p>5. The Administrator will monitor through observation, interview and review of audits. Date of Compliance:</p>	5/20/15
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