

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

**RECEIVED**  
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 JUN 27 2011 OMB NO. 0938-0391  
 OFFICE OF INSPECTOR GENERAL  
 DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185175	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/09/2011
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NAME OF PROVIDER OR SUPPLIER  TREYTON OAK TOWERS	STREET ADDRESS, CITY, STATE, ZIP CODE 211 WEST OAK STREET LOUISVILLE, KY 40203
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F 000	INITIAL COMMENTS	F 000		
F 248 SS=E	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy for the Activity Program, it was determined the facility failed to provide an ongoing activities program in the evening designed to reflect the needs, schedule, and choice for two (2) of fifteen (15) sampled residents (Resident #5 and #8), and five (5) unsampled residents.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Activity Program, dated 06/09/11, revealed individualized and group activities are provided that reflect the schedules, choices, and rights of the residents; are offered at hours convenient to the residents, including evenings, holidays, and weekends. Reflect the cultural and religious interests of the residents; and appeal to both men and women as</p>	F 248	<p>F 248</p> <p>Resident's #5 and #8 were interviewed individually and with other resident's to determine the types and frequency of evening activities are desired. An updated activity calendar was developed to include these resident's requests. Completed 6/30/11 the Activity Director. Residents who are able to express their needs/desires were interviewed and suggestions for types and frequency of evening activities were included in the updated activity calendar. Completer 6/30/11. The Activity Department staffing pattern was re-evaluated regarding provision of evening activity programs and adjusted to consistently be available to provide evening activities as scheduled. Completed 6/30/11. The Director of Activities will approve all activity schedules and calendars to assure that desired activities are available in evening hours. She will also audit resident participation in evening activities to provide revisions as deemed necessary. These audits will be conducted weekly x 4 weeks then monthly x 3 months. If the schedule is deemed satisfactory, quarterly audits will continue to assure the calendars continue to provide for residents desires/needs. The quarterly QA committee will review audit reports and offer further recommendations if appropriate.</p>	6/30/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

*W. Derrick Moore*      *Administrator*      *6/27/2011*

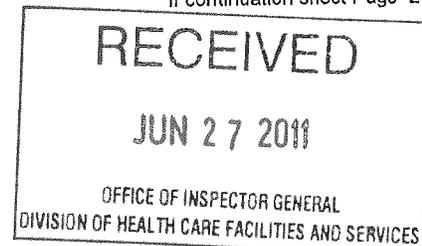
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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

*DK*

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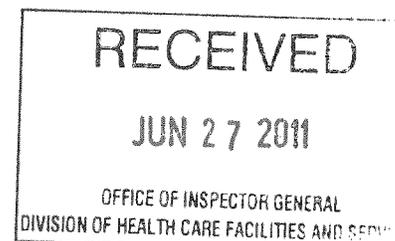
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F 248	Continued From page 1 well as all age groups of residents residing in the facility.  Review of the activities calender for April, May, and June of 2011 revealed daily activities ended as early as 1:45pm on April 12, 2011, and with most days ending scheduled activities at 3:15pm.  Interview with Resident #5 and an unsampled resident during the Quality of Life Assessment Group Interview, on 06/07/11 at 2:30pm, revealed residents would enjoy having a hot chocolate social in the evenings. A follow-up individual interview with Resident #5 and the unsampled resident, on 06/09/11 at 8:55am, revealed both residents reported the facility did not have any organized or social activities planned in the evening. Resident #5 stated he/she loved activities and would attend anything the facility offered day or night.  An interview with a random sample of five (5) residents identified as interviewable by the facility, on 06/09/11 at 9:15am, revealed the facility did not provide organized social activities in the evening. The residents stated they would enjoy having an activity in the evening. They further revealed activities make them feel social, happy, and energetic.  Interview with the Activities Director on 06/09/11 at 9:35am revealed the facility had tried a movie night once a week a year ago, but had poor attendance. She further stated most residents go to bed early. The Activities Director stated she works a day shift schedule, and it would be hard to justify pulling the evening staff away from their duties to provide an activity if the attendance is	F 248		



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F 248	Continued From page 2  low. She stated "staffing is what it is" and she doesn't know how to guarantee things are done when she is not at the facility. When asked about the psychosocial impact of activities not being provided for the residents, the Activities Director stated it could make them feel lonely and depressed.  Interview with the Social Service Coordinator on 06/09/11 at 10:00am revealed activities gives the residents a sense of purpose and keeps them busy. She further revealed they have had some volunteers come in the past but the attendance was varied. There are some craft supplies available in the evening, but no organized social event.  Interview with Registered Nurse (RN) Supervisor, on 06/09/11 at 10:50am, revealed organized activities pulls people out of their shell if they are shy, encourages socialization, and keeps the residents mingling with each other. The RN Supervisor stated she had not discussed the activities provided with the residents, but feels activities offered could be improved in terms of when they are offered. Without an activities program individualized to meet the needs of the residents, they could decline and become bored.  Interview with the Director of Nursing (DON), on 06/09/11 at 3:00pm, revealed activities keep the residents active, lively, and vivacious. Without activities there is more potential to become withdrawn and regress. She stated she does review the activities calender and reads the resident council minutes to see if there is a problem with activities, but was not aware there was a desire from the residents for the facility to	F 248			



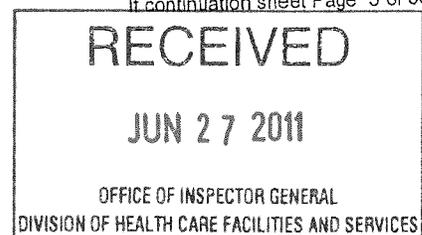


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F 274	<p>Continued From page 4</p> <p>Based on observation, interview, and record review it was determined the facility failed to complete a Significant Change Assessment for one (1) of fifteen (15) sampled residents. Resident #4 had a major decline in physical condition after a fall with a hip fracture requiring surgical intervention.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing, on 06/08/11 at 3:00pm, revealed the facility used the Resident Assessment Instrument (RAI) as a guide for completing Resident Assessments.</p> <p>Review of the Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, chapter two (2) revealed, a Significant Change in Status Assessment (SCSA) is a comprehensive assessment that must be completed when the Interdisciplinary Team (IDT) determines a resident meets the significant change guidelines for either improvement or decline. A "significant change" is a decline.....that is not "self-limiting", impacts more than one areas of the residents health status, and requires a revision of the care plan. The nursing home may take up to fourteen (14) days to determine whether the criteria are met to complete a Significant Change Assessment. Continued review of the RAI manual Chapter 2, guidelines for determining a Significant Change Assessment revealed, an example of "Hip Fracture" stating that a condition may not be permanent but would have such an impact on the residents overall status for more than two weeks and affecting more than one area in functional status.</p>	F 274	<p>The DON will review each entry/re-entry assessment documentation from the MDS LPN x 4 weeks. If 100% compliance is achieved, a random review will continue monthly. The DON will continue to review MDS's for completeness and sign accordingly.</p>	



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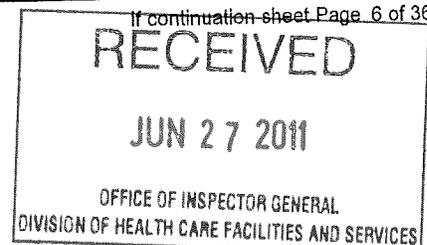
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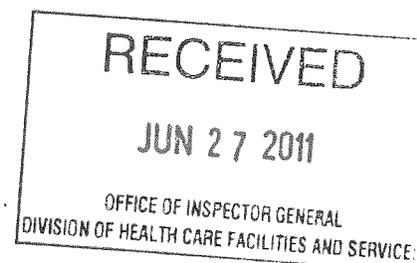
F 274	<p>Continued From page 5</p> <p>Observation of Resident #4, on 06/07/11 at 10:40am, revealed the resident laying on a low air loss mattress with bolsters in place bilaterally. The resident had a tab alarm and bilateral heel lift boots in place.</p> <p>Observation of Resident #4, on 06/07/11 at 11:54 am, revealed the resident sitting up in a high back wheelchair by the nurse's station. The resident had an alarming self releasing seat belt in place. Conversation with the resident revealed the resident was hard of hearing.</p> <p>Review of the medical record for Resident #4 revealed the facility admitted the resident on 10/27/08 with diagnoses including Hypertension, Osteoporosis, Dementia, and Anemia. Resident #4 had a fall on 05/01/11 in the resident's room and was transferred to the hospital with a Diagnosis of Left Hip Fracture that required surgical intervention. Resident #4 returned to the facility on 05/09/11.</p> <p>Review of the Nursing Assessment completed on 05/09/11 for Resident #4 revealed no pressure areas, or reddened areas documented on the Skin Condition portion of the Assessment.</p> <p>Review of the facility Skin Assessment completed on 05/13/11 for Resident #4 revealed, documentation of 'redness, left heel, 1.0 centimeter, right heel, 4.0 centimeter, incision to left hip, fifteen (15) staples, and left lower extremity bruise'.</p> <p>Review of the Annual Minimum Data Set (MDS) completed on 11/30/10 revealed the facility</p>	F 274		
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F 274	<p>Continued From page 6</p> <p>assessed the resident with severe impairment in Cognition. The facility assessed the resident as limited assistance of one person for bed mobility, transfers, ambulation and dressing. The facility further assessed the resident as extensive assistance in bathing and supervision with set up help in eating. There was no documentation of any assessed skin conditions for Resident #4.</p> <p>Review of the Quarterly MDS Assessment for Resident #4 completed on 02/11/11 revealed consistent scores and coding in the same area's of assessment as the Annual Assessment completed on 11/30/10.</p> <p>Review of the facility's Quarterly Assessment completed for Resident #4 on 05/30/11 with an Assessment Reference date of 05/16/11 revealed the facility assessed Resident #4 as severely impaired in cognition. The facility further assessed the resident as declining in bed mobility, transfers and dressing to now requiring extensive assistance. The facility determined the resident no longer ambulated and was dependent on staff for bathing. In addition, the facility was now providing extensive assistance with eating. There was no evidence of any assessed skin conditions for Resident #4.</p> <p>Interview with the MDS Licensed Practical Nurse (LPN) Coordinator, on 06/09/11 at 1:10pm, revealed she did not complete a Significant Change Assessment for Resident #4. She acknowledged if there was a change in two (2) or more areas on the assessment, that would indicate a need for a Significant Change Assessment. Continued interview with the MDS LPN revealed she obtained her information from</p>	F 274		



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F 274	Continued From page 7 the medical record and other documentation and assessments completed by nursing staff to complete the MDS Assessment. She stated she did not see the skin assessment for Resident #4 completed on 05/13/11. The MDS LPN coordinator went on to say she was not sure if she would have coded this skin assessment as a Stage one (1) because it was not documented as non blanchable. The MDS LPN coordinator did not complete a Skin Assessment on Resident #4 for the Assessment Reference Date of 05/16/11, Quarterly Assessment, she stated "I go by the information from the skin assessments completed by the nurses and the wound nurse". The MDS LPN coordinator acknowledged she was responsible to ensure accuracy of the MDS Assessment.  Interview with the Director of Nursing (DON), on 06/09/11 at 3:00pm, revealed the MDS LPN coordinator was responsible for the MDS Assessment of the residents. However, the DON reviewed the MDS Assessments when completed. The DON stated there should have been a Significant Change Assessment for Resident #4, because the residents goals are going to be greater and the facility needs to ensure the residents goals are met.	F 274		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced	F 282		

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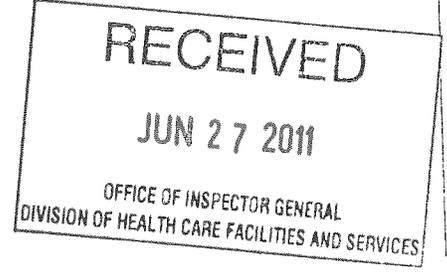
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F 282	<p>Continued From page 8</p> <p>by: Based on interview, record review and review of Policy on Skin/wound Care, it was determined the facility failed to provide the necessary care and services to attain the highest practicable level of well-being for four (4) of fifteen (15) sampled residents. Resident #4, 5, 6, and 11 did not have regular weekly head-to-toe skin assessments performed as indicated in their care plans.</p> <p>Findings include:</p> <p>1) Review of the undated facility policy titled Skin/Wound Care Program revealed a head-to-toe skin assessment was to be completed by a designated nurse weekly and documented in the Treatment Record Book, with a report of the findings to the Director of Nursing (DON).</p> <p>Record review performed on Resident #5, admitted on 09/02/10, revealed that no head-to-toe skin assessments were documented between the dates of 02/16/11 to 03/03/11. The weekly skin assessment documentation for 02/16/11 revealed that Resident #5 had a wound and it measured 3cm x 3cm. It was documented as an abrasion to the anterior left lower extremity. No head-to-toe skin assessments were documented between the dates of 03/08/11 to 03/23/11. Although the skin assessments were not completed, the resident's skin integrity did not worsen based on subsequent skin assessments.</p> <p>Record review performed on Resident #6, admitted on 09/11/10, revealed that no head-to-toe skin assessments were documented</p>	F 282	<p>F282</p> <p>Residents #5, #6, and #11 were re-assessed to assure that no skin impairment occurred during the period of untimely skin assessments. Resident #4 was reassessed and all noted skin impairments are treated and preventive measures are on-going. Head to toe skin assessments are now completed and remain timely for all residents as of 6/20/11. No unknown impairment was noted for additional residents. The skin assessment documentation forms are now filed in each residents' individual medical record to attempt to avoid failure of documentation. Re-education of licensed staff regarding the skin/wound policy and individual responsibility to follow the policy at all times has been completed by the DON 6/22/11 and 6/23/11. Staff members identified as non-compliant with timely completion of the scheduled skin assessments have been counseled in order to avoid further non-compliance in this area. This was completed 6/22/11 and 6/23/11. The RN Supervisor is responsible for audits of assigned skin assessments weekly x 4 weeks. The DON will conduct random audits weekly x 4 weeks. If 100% compliance is not achieved, audits will be completed daily according to the assessment schedule and responsible staff member(s) will receive disciplinary measures, up to and including termination. If 100% compliance is achieved, the DON random audits will continue monthly.</p>	6/23/11
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F 282	<p>Continued From page 9 between the dates of 02/24/11 to 03/24/11. The resident's skin integrity remained intact without any breakdown according to the skin assessment done on 03/24/11.</p> <p>Record review performed on Resident #11, admitted on 10/12/10, revealed that only one head-to-toe skin assessment was completed in the month of April. This was done on 04/12/11 and bruising was noted to both upper extremities and both lower extremities on the assessment.</p> <p>Interview with LPN #1 on 06/09/11 at 8:30am revealed the nurses are assigned to do weekly head to toe skin assessments. She stated she is responsible for rooms 244, 245 and 246 bed #1 (one). This assignment would include Residents # 5 and #11. LPN #1 stated she had only worked at the facility for 4 (four) months. She stated The Unit Supervisor was responsible to ensure the floor nurses are doing what they are assigned to do.</p> <p>Interview with the DON, on 06/09/11 at 2:55pm, revealed the nurses were supposed to do weekly skin assessments to identify any skin problems such as pressure areas and skin breakdown. The DON stated that she sent out a memorandum to her nurses earlier this year that if they were unable to get the skin assessments done to please let her know. The DON stated that she is ultimately responsible for making sure the assessments are completed and she did chart audits periodically to review they are being done. She was unaware that so many were being missed. She acknowledged that missing these assessments could lead to a greater amount of residents with pressure related skin</p>	F 282		
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F 282	<p>Continued From page 10 problems or other skin integrity issues.</p> <p>2) Review of the medical record for Resident #4 revealed the facility admitted Resident #4 on 10/27/08 with diagnoses including Hypertension, Osteoporosis, Dementia, and Anemia. The resident had a fall with a fracture on 05/01/11 and was admitted to the hospital for surgical repair. Resident #4 returned to the facility on 05/09/11. Resident #4 was a Do Not Resuscitate, Do Not Hospitalize, and comfort foods only. The resident was placed on palliative care on 05/29/11.</p> <p>Review of the skin assessments for Resident #4 revealed weekly skin assessments completed on 02/09/11, 02/16/11, 03/28/11 and 04/12/11. The skin assessments revealed no wounds, redness or bruising. Resident #4 was in the hospital from 05/01/11-05/09/11. Readmission skin assessment for Resident #4 revealed no pressure areas. On 05/13/11 a skin assessment was completed for Resident #4 and revealed both left and right heel with redness. The next skin assessment was not completed until 06/08/11.</p> <p>Observation of a complete skin assessment completed by LPN # 2 for Resident #4 on 06/08/11 at 9:00am revealed 1.0 cm unstagable hardened brownish yellow skin noted on both left and right heels. Sacral area with 2.0 by 2.0 reddened area, blanchable. Resident #4 lay on low air loss mattress with bolsters. Heel lift boots in place bilaterally.</p> <p>Record review with the DON revealed skin assessments for Resident #3 and #4 were located in a separate binder, not in the residents' charts. At that time, the DON discovered that the</p>	F 282		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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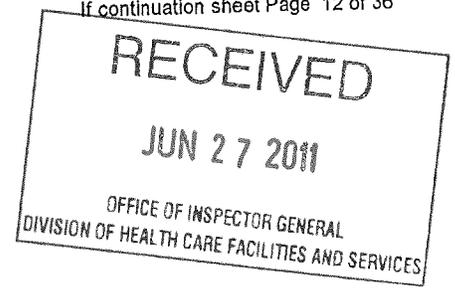
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185175	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/09/2011
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NAME OF PROVIDER OR SUPPLIER  TREYTON OAK TOWERS	STREET ADDRESS, CITY, STATE, ZIP CODE 211 WEST OAK STREET LOUISVILLE, KY 40203
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 282	<p>Continued From page 11</p> <p>skin assessments were not completed. Interview with the Director of Nursing, on 06/08/11 at 9:30am, revealed the nurses are assigned weekly skin assessments that include a head to toe assessment and documented in the skin assessment book. The DON stated that she was really disappointed that they were not being done.</p> <p>Interview with Shower Aide #1, on 06/08/11 at 2:40pm, revealed she did all the showers on the days she worked. She stated she did not do "official" skin assessments but, if she saw anything she would report it to the nurse.</p> <p>Interview with Licensed Practical Nurse(LPN) #1, on 06/09/11 at 8:30am, revealed she was employed here for four months. She stated they are assigned certain rooms to do skin assessments on every week. She stated she was the nurse who called the Physician about Resident #4 on 06/06/11. The Certified Nursing Assistant (CNA) informed her of Resident #4's heels, and she call the Physician and got an order for treatment. Although she was not assigned to do skin assessments for Resident #4 she only documented this information in the medical record because she received the order.</p> <p>Interview with LPN #4, on 06/09/11 at 10:00am, revealed she had worked at the facility over one (1) year and was responsible for weekly skin assessments for Resident #4. She stated she did not know why she did not do the weekly skin assessments because she had enough time to do them. She stated the potential complication for the residents by not doing the skin assessments would be the development of unknown areas of skin breakdown.</p>
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F 282



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F 282	Continued From page 12  Interview with the Registered Nurse Unit Supervisor, on 06/09/11 at 2:00pm, revealed she had only worked there three (3) weeks. She stated she had not worked at this facility long enough to do audits.  Interview with the DON, on 06/09/11 at 3:00pm, revealed she is responsible for doing the audits of the medical records to ensure care is being provided. She stated she was "in those charts all the time". The DON stated she thought the problem was when the skin assessment forms were put in a separate binder, instead of the residents' charts, to make it easier for staff to get to them. She stated the staff were not going to the seperated binder to document the skin assessments. She stated it was their policy to do weekly skin assessments on all the residents.	F 282		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policies: Sharps Disposal; Dietetics Services Chemical Storage; and Accident/incident Investigation and Reporting, the Material Safety Data Sheet	F 323		

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F 323	<p>Continued From page 13 (MSDS) for Greasestrip Plus, and manufacturer recommendations for Careguard specialty mattress and AiroDyne STAT 4 specialty mattress, the facility failed to properly store and secure a bottle of Greasestrip plus cleaner in the shower room, an uncapped razor and a pair of point tip scissors in the shower room, an uncapped bottle of nail polish remover, an uncapped aerosol can of nail polish dryer in the lounge area, and maintenance equipment in a resident's room. In addition, the facility failed to assess residents and utilize the manufacturer's recommendations for the use of side rails on specialty mattresses for three (3) of fifteen (15) sampled residents (Resident #3, 5, and 11). In addition, Resident #3 had a non-injurious fall after side rails were removed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Review of the facility's policy on Sharps Disposal, dated December 2008, revealed used contaminated sharps will be discarded immediately or as soon as feasible into designated containers. Contaminated sharps will be discarded into containers that are: closable; puncture resistant; leakproof on sides and bottom; labeled or color-coded in accordance with established labeling system; and impermeable and capable of maintaining impermeability through final waste disposal.</li> <li>Review of the facility's policy on Dietetics Services Chemical Storage, which is not dated, revealed the dietetic services department is to ensure the safety of the residents and staff that all chemicals are locked in a secure closet that only the dietary staff are able to open.</li> </ol>	F 323	<p>F 323</p> <p>Residents #3, #5, and #11 as well as all other residents currently using specialty mattresses have been reassessed to assure that appropriate measures are in place for each regarding need/use of alternate air-flow mattress and use of appropriate siderails/assist rails based on resident needs and clinical condition as well as the manufacturer's users' manual information (ie, "some beds need rails, some do not"). Resident's whose need for use of the alternate air-flow mattress has been met have been changed to an alternative pressure relieving/reduction mattress. Individual care plans have been reviewed/revised to assure that appropriate measures are in place for each resident. Resident's who continue to benefit/need the alternate air-flow mattress have been provided safety assist rails, as appropriate, during use of these mattresses to prevent adverse safety effects. Residents will be routinely re-assessed regarding need for specialty mattresses every 3 months and with any significant change of status. Although there are no actual recommendations offered by the mattress manufacturer/distributor, a facility policy is being developed to include identified risk factors, etc. Nursing staff has been inserviced related to purpose, proper use, types of safety precautions to be used for individual residents with specialty mattresses. This was completed 6/30/11.</p>	6/30/11
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If continuation sheet Page 14 of 36  
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F 323	Continued From page 14  Review of the MSDS for Greasestrip plus, issued November 4, 2005, revealed hazards identified as corrosive to eyes, corrosive to the skin, severely irritating to the respiratory system, and harmful if swallowed causing burns to mouth, throat, and stomach. Accidental release measures include prevent entry into sewers, water courses, basements or confined areas. Handling and storage included do not ingest, do not get in eyes, on skin or on clothing. Keep container closed. Use only with adequate ventilation. Avoid breathing vapor or mist. Wash thoroughly after handling. Keep container in cool, well-ventilated area. Do not store above 50 degrees Celsius. Exposure Controls, Personal Protection include provide exhaust ventilation or other engineering controls to keep the airborne concentrations of vapors below their respective occupational exposure limits. Use chemical splash goggles. For continued or severe exposure wear a face shield over the goggles. Use chemical resistant, impervious gloves. Use synthetic apron and other protective equipment as necessary to prevent skin contact.  Observation of the only shower room for the long term care unit, on 06/07/11 at 11:40am, revealed a grated white plastic storage basket sitting on the counter which contained an uncapped razor. An unlocked drawer contained a pair of point tipped scissors without a protective cover. A spray bottle of Greasestrip Plus, with the nozzle in the on position, was found sitting on the outside ledge of the shower stall.  Interview with shower aide #1, on 06/07/11 at 11:40am, revealed razor and scissors are used	F 323	All residents who utilize the shower room have the potential to be affected by improper storage of chemicals. All departments have been audited to assure that all chemicals are secured within each department. Each department, (housekeeping/dietary/maintenance) has revised method of securing and permitting use of all pertinent chemicals as of 6/23/11. All chemicals are secured in locked closets, etc. and appropriate use of these chemicals by staff is being approved by the supervisors of each department. Systems are now in place to monitor the safety and security of these chemicals. Sharps container for razors is secured in locked cabinets/drawers in the shower room for immediate disposal of used razors, etc. No scissors of any type are permitted in the shower room. All 2 <sup>nd</sup> floor staff has been inserviced regarding hazardous practices by the DON and department supervisors. This was completed on 6/30/11. Random department audits will be completed by each department head every 30 days or sooner if non-compliance is observed. Repeated non-compliance of staff will be met with counseling for first episode, then disciplinary measures will be warranted. Department supervisors will report to the quarterly QA committee regarding ongoing compliance, further changes in systems, etc. for further recommendations, if appropriate.	6/30/11

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F 323	<p>Continued From page 15</p> <p>on residents for trimming and shaving. The shower aide stated she normally keeps the items in a locked drawer but had not done it on the day of the observation. The shower aide further revealed that residents could potentially cut or harm themselves with the scissors and razor by not properly securing and storing items. She also stated the bottle of GreaseStrip Plus was left in the shower room by the housekeeping department, possibly the floor technicians. she further stated the cleaner could be harmful to the residents if they were to pick it up and spray themselves in the mouth or the eyes. The shower aide was unaware of the warnings listed on the label.</p> <p>Interview with floor technician, on 06/07/11 at 12:05pm, revealed the floor technicians do not use Greasestrip plus to clean the floors, and is not sure what the product is or what it is used on.</p> <p>Interview with the Director of Environmental Services, on 06/08/11 on 9:25am, revealed Greasestrip Plus is used in the Dietary Department. He further stated the housekeeping department utilize an aerosol degreasing spray and did not store or stock Greasestrip plus.</p> <p>Interview with the Food Service Manager, on 06/08/11 at 11:00am, revealed Greasestrip Plus was used to clean the grill and ovens in the dietary department. He further reveled none of the kitchen staff are cross-trained to work in the nursing department and did not know how, or why the cleaner would be in the shower room.</p> <p>Observation of the shower room, on 06/09/11 at 10:20am, revealed a coded lock on the shower</p>	F 323		
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F 323	<p>Continued From page 16</p> <p>room door. A resident was sitting in a wheelchair in the hall outside of the door. Inside the shower room, the shower aide was assisting one resident with hygiene.</p> <p>Interview with shower aide #1, on 06/09/11 at 10:25am, revealed two (2) residents are brought to the shower room at a time. One resident waits in the hall while the other is being bathed. She stated the residents are not left unattended. When asked how long the cleaner had been in the shower room, the Shower aide stated she did not know, it has been there for "a while". She was not aware of the the cleaners purpose or warnings on the label. She again stated she did not know why the Greasestrip Plus cleaner was in the shower room and thought it belonged to the housekeeping department and never said anything to the housekeeping staff or nursing staff to notify them that the cleaner was in the shower room.</p> <p>Interview with the housekeeper, on 06/09/11 at 10:50am, revealed she had been employed with the facility for a year and started working on the long term care floor four months ago. She stated she is normally assigned to clean the shower room. The housekeeper stated the bottle of Greasestrip Plus cleaner had been in the shower room since she began working the floor four months ago. She further revealed she thought the cleaner belonged to the nursing department to clean the wheelchairs and never mentioned to the nursing staff that it was in the shower room.</p> <p>Interview with the Registered Nurse (RN) Supervisor, on 06/09/11 at 10:50am, revealed she had been employed by the facility for three</p>	F 323		
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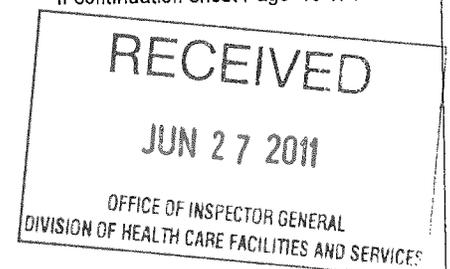
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F 323	Continued From page 17 weeks. The RN Supervisor reported making occasional checks on the shower room to monitor how showers are being done; to ensure razors are secured and put away, to ensure there are no items that do not belong such as cleaning supplies, and no community supplies being used in the shower room. She reported the last round on the shower room was completed a week ago. The RN Supervisor revealed the razors are a one use item and each resident must have their own razor. She further stated razors should not be left uncapped due to the potential for someone cutting themselves. She reported scissors should not be in the shower room and any sharp item should not be unsecured. The RN supervisor revealed the Greasestrip Plus cleaner could impair health and create a hazard. She stated the residents could potentially get a hold of it and spray themselves or drink it. She further stated the current monitoring system of the shower room is not working and stated she is responsible for monitoring the safety of the room and safety of the residents.  Interview with the Food Service Director, on 06/09/11 at 1:30pm, revealed cleaners that are used in the kitchen area are not signed out on a sign out sheet or monitored for when an item is removed from the storage closet and returned. He further reported the Greasestrip Plus and the stainless steel cleaner are the only two (2) items in an individual bottle and not connected to kitchen equipment. MSDS in-services are given to kitchen staff when a new product arrives or an update is received. No in-services had been provided on keeping cleaners used in kitchen within the department and not in residential areas.	F 323			



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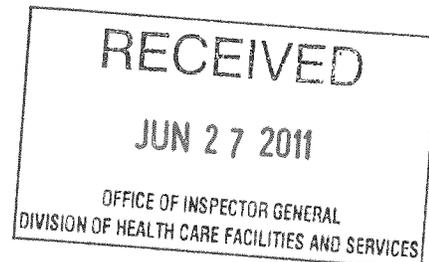
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F 323	<p>Continued From page 18</p> <p>Interview with the Director of Nursing, on 06/09/11 at 3:00pm, revealed razors are one time use for one person, and there should not be a need for scissors in the shower room. She stated she monitored the shower room to make sure the shower aide had properly disinfected the shower chair and standard precautions were being used. She further stated she had never noticed the razors, scissors, or cleaner in the shower room. She did report the GreaseStrip Plus had a potential for the resident to get a hold of and be dangerous. The DON stated there is not sufficient monitoring of the shower room for potential hazards to the residents.</p> <p>2. The facility did not produce a policy on safe storage and use of nail care items.</p> <p>Observation of the lounge area, on 06/07/11 at 11:50am to 11:55am, revealed an uncapped bottle of nail polish remover and an uncapped can of aerosol nail polish dryer sitting on a table in front of Unsampled Resident #1, who was sitting in a wheelchair at the table. Resident #10 and Unsampled Resident #2 were also in the room, sitting in wheelchairs, listening to music. No staff members were present in the room, leaving the residents unattended with uncapped chemicals for five minutes. The DON then entered the room and remained there until the Activities Director returned.</p> <p>Review of the labels on the nail care items, on 06/09/11 at 9:30am, revealed Swan brand nail polish remover with warnings to keep out of eyes, harmful if swallowed, and to contact a Medical Doctor if this occurred. Beauty Secrets brand</p>	F 323		
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F 323	<p>Continued From page 19 aerosol nail polish dryer label revealed item is fatal if inhaled.</p> <p>Review of the clinical record for Resident #10, in the lounge area, revealed the facility assessed the resident on the MDS dated 03/10/11 as being severely impaired in cognition, requiring one (1) to two (2) person assist with the activities of daily living, and no impairment to the upper extremities in range of motion.</p> <p>Review of the clinical record for an Unsampled Resident, sitting at the table, revealed the facility had assessed the resident on the Minimum Data Set (MDS) dated 05/20/11 as moderately impaired in cognition, requiring a one (1) person physical assist with activities of daily living, and impairment on both sides of upper extremities in range of motion.</p> <p>Review of the clinical record for a second Unsampled Resident, in the lounge area, listening to music at the time of the observation, revealed the facility assessed the resident on the MDS dated 04/29/11 as being severely impaired in cognition. The resident required one (1) to two (2) person assist with the activities of daily living. He/she was impaired in both upper extremities in range of motion.</p> <p>Interview with the Activities Director, on 06/09/11 at 9:35am, revealed she had left the residents unattended in the lounge area during nail care to transport another resident to the dining room. She stated she was aware of there being a potential risk to the residents, but if it had been different residents in the room she would not have left. When asked if there are residents in the facility</p>	F 323		

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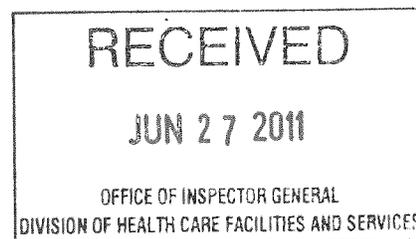
F 323

Continued From page 20  
that are ambulatory or wander, the Activities Director stated there is only one resident that wanders and she had not seen him/her all day. The Activities Director acknowledged the potential for harm to the residents if they picked up the nail polish remover and ingested the chemical or sprayed the nail polish dryer in their eyes. She stated she is responsible for ensuring nail care items are not left opened and unattended.

Interview with the DON, on 06/09/11 at 3:00pm, revealed residents could have gotten a hold of the nail polish remover and drank it causing potential harm to the residents.

3. Review of facility policy on speciality mattress revealed the facility only had manufacturer Recommendations for the AiroDyne Alternating Pressure/Low Air Loss system. Based on information requested and received from RecoverCare, the AiroDyne is the same as the Stat 4 mattress. On Day 3 (06/09/11) of the survey the facility did supply the surveyor with Manufacturer Recommendations for two (2) of the speciality air mattress used in the facility, Stat 2 and Stat 3. Review of the Manufacturer Recommendations for Stat 2 and Stat 3 low Air Loss systems safety precautions reveal "when leaving a patient unattended make sure the bed side rails are locked in the high position". Review of the Manufacture Recommendations for the AiroDyne/Stat 4 mattress reveal Warnings: Patient Falls: Failure to use bed rails in raised position could lead to accidental patient falls. Air mattresses have soft edges that may collapse

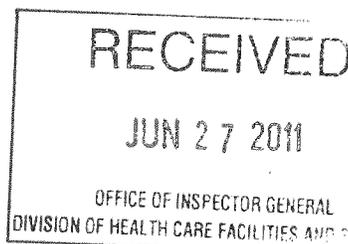
F 323



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NAME OF PROVIDER OR SUPPLIER  TREYTON OAK TOWERS			STREET ADDRESS, CITY, STATE, ZIP CODE 211 WEST OAK STREET LOUISVILLE, KY 40203	
(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 323	<p>Continued From page 21</p> <p>when patients roll to the edge. Review of the Manufacture Recommendations for the AiroDyne/Stat 4 mattress reveal Warnings: Entrapment: When using side rails and/or assist devices, use a mattress thick enough and wide enough so that the gap between the top of the mattress and the bottom of the side rails and .....Failure to do so could result in serious patient injury or death.</p> <p>Observation of Resident #5, on 06/07/11 at 2:25pm, revealed the resident lying in bed on her back with her eyes closed. Resident was resting on a low air loss mattress. The name on the pump was Care Guard by Invacare CG8000. Mattress is a Stat 4 AP mattress. The setting on the controls was set to 6. No side rails were in use.</p> <p>Interview with Resident #5, on 06/08/11 at 8:45am, regarding her low air loss mattress revealed the resident was very pleased with it. He/She stated it was very comfortable, as he/she had severe rheumatoid arthritis which was very painful.</p> <p>Observation of Resident #5, on 06/08/11 at 10:05am, revealed the resident lying in his/her bed on his/her low air loss mattress for his/her head-to-toe skin assessment with no side rails in use. The setting on the controls remained at a 6.</p> <p>Record review of Assist Rails assessment for Resident #5 dated 09/02/10 revealed the resident was assessed by the facility as requiring assist rails up times two to increase mobility and assist with transfer in/out of bed. A review was done on 12/17/10 and 03/25/11 which stated that the</p>	F 323		



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F 323	<p>Continued From page 22</p> <p>resident should have assist rails up times two.</p> <p>Record review of nurses' notes for Resident #5 did not reveal any fall or injury related to the use of the low air loss mattress.</p> <p>Observation of Resident #11, on 06/08/11 at 2:15pm, revealed the resident lying in bed on his/her back with eyes closed and wearing his/her glasses. Resident was resting on a low air loss mattress. The name on the pump was Stat 4 AP (Airodyne) with the setting on the controls set at 115. No side rails were in use.</p> <p>Observation of Resident #11, on 06/08/11 at 3:35pm, revealed the resident was still lying in bed with his/her eyes closed. No side rails were in use.</p> <p>Observation of Resident #11, on 06/09/11 at 9:20am, revealed the resident was lying in bed covered with a blanket with his/her eyes closed. A low air loss mattress was on the bed with the setting at 115. No side rails were in use.</p> <p>Record review of the Assist Rails assessment for Resident #11 dated 02/15/11 revealed that the resident was assessed by the facility as requiring assist rails up to increase mobility and assist with transfer in/out of bed. A review was completed on 05/06/11 which stated the resident should have assist rails in place.</p> <p>Record review of the Accident/Incident Reports for Resident #11 from 02/20/11 to 05/05/11 did not reveal any fall or injury related to the use of the low air loss mattress.</p>	F 323		
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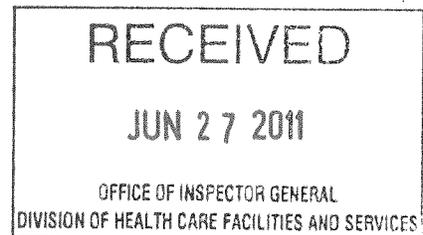
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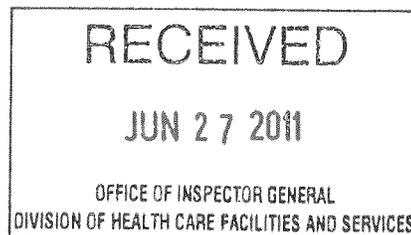
F 323	<p>Continued From page 23</p> <p>Observation, on 06/07/11 at 10:40am, of Resident #3 revealed a well groomed appearing resident sitting up in a chair at the bedside. The resident was alert, pleasant, but very shaky. Resident #3's room revealed a Stat 3 low air loss mattress on the bed. There was a quarter side rail on the left side of the bed and a middle side rail on the right side of the bed.</p> <p>Observation, on 06/07/11 at 3:30pm, of Resident # 3 revealed the resident up and walking in the hallway with a walker independently.</p> <p>Observation on 06/08/11 at 8:00am, of Resident #3 revealed the resident sitting on the side of the bed. A floor mat was noted to the left side of the bed. There was a quarter side rail on the left side of the bed and a middle side rail on the right side of the bed.</p> <p>Review of the medical record for Resident #3 revealed the facility admitted the resident on 03/02/11 with diagnoses including Weakness, Debility, Sacral Decubitus, Non-insulin Dependent Diabetes Mellitus, Pacemaker, and Dementia-Alzheimer's type.</p> <p>Review of the admission Minimum Data Set (MDS) For Resident #3 revealed the facility assessed the resident as moderately impaired in cognition, extensive assistance with one person physical assist for bed mobility, transfer, ambulation, hygiene and bathing.</p> <p>Review of the Admission Falls Risk Assessment for Resident #3, completed on 03/02/11 revealed</p>	F 323		
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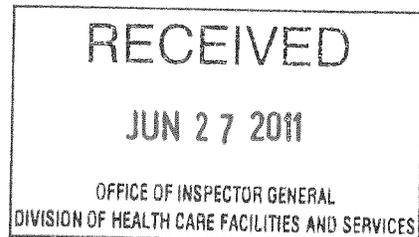
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F 323	<p>Continued From page 24</p> <p>the facility assessed the resident as not having a high falls risk. There were no other Falls Risk Assessment documented for Resident #3.</p> <p>Record review of the Assist Rails assessment for Resident #3 dated 06/06/11 revealed the resident was assessed by the facility as requiring assist rails up times two to increase mobility and assist with transfer in/out of bed. There were no other side rail assessments for Resident #3.</p> <p>Review of the Care Plan for Resident #3 revealed the facility put in place, risk for falls, on 03/22/11. Continued review of the Care Plan revealed an order for a low flow air loss mattress added on 03/24/11 related to sacral wound. On 04/26/11 Bolsters were added to the low flow air loss mattress.</p> <p>Review of the Accident Investigation for Resident #3 revealed the resident had a fall on 06/01/11. The resident was found on the fall mat on the floor in an upright position. The resident stated "I rolled over and forgot their were no side rails". Resident #3 did not have an injury.</p> <p>Interview with Certified Nursing Assistant #3, on 06/07/11 at 2:30pm, revealed that Resident #3 had side rails and bolsters at first, but they took them off. CNA #3 did not know the date, or why the side rails and bolsters were removed, but stated they put the side rails back on after the resident had a fall. Continued interview with CNA #3 on 06/08/11 at 10:00am revealed she was responsible for notifying the contract company when a resident no longer needs a specialty mattress or when an order is received for a resident to get an speciality mattress. CNA #3</p>	F 323		



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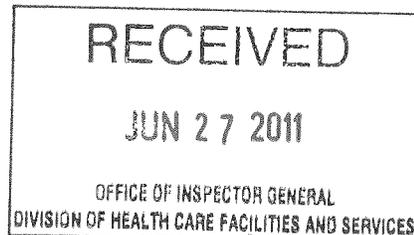
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F 323	<p>Continued From page 25</p> <p>stated she did not know if there were any manufacturer recommendations for the air mattress used for Resident #3 or other speciality mattress used in the facility.</p> <p>Interview, on 06/08/11 at 2:15pm, with the speciality mattress representative revealed they brought the beds in, set them up, and set the settings on the beds based on the residents weights. He stated some beds require side rails and others don't. He went on to say that they inservice and supply manufacturer recommendations to the facility upon request. The representative stated he did not have any manufacturer recommendations for the beds because he was not driving his regular van.</p> <p>Interview with Licensed Practical Nurse #1, on 06/09/11 at 8:30am, revealed the system for getting a speciality mattress when they see a resident has a need they would notify the Physician, get an order, and notify the contract company. LPN #1 stated the Physician determines what kind of mattress is needed. She was not familiar with the manufacturer recommendations for side rails on air mattress used in the facility. The Director of Nursing completed an inservice "last week" on the air mattresses.</p> <p>Interview with LPN #2, on 06/09/11 at 9:00am, revealed she had not been inserviced on the air mattresses used in the facility. At some point Resident #3 had bolsters and side rails on the bed because the resident was a falls risk. Someone, she did not know who, removed the bolsters and side rails because the resident was no longer a falls risk. After Resident #3 fell out of</p>	F 323		



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F 323	<p>Continued From page 26</p> <p>bed, the facility maintenance staff put the side rails back on. She didn't know what the manufacturer recommendations were for side rails on the air mattress for Resident #3. LPN #3 stated she can see why it is important to know what the manufacturer recommendation to ensure proper safety measures are followed.</p> <p>Interview with the Unit Supervisor, on 06/09/11 at 2:00pm, revealed she had worked at the facility for about three weeks. She did not know what the manufacturer recommendations were for side rail use on the air mattresses that is used in the facility. She stated the facility staff would need to know that to protect the residents from harm.</p> <p>Interview with the Director of Nursing (DON), on 06/09/11 at 3:00pm, revealed side rail assessments are done on each resident upon admission and as needed. The DON had assessed the resident for assist rails and bolsters upon admission. Since Resident #3 had an improvement in mobility they removed the side rails and bolsters. The facility felt she would be safer without them. They did not take into consideration the speciality mattress/air mattress manufacturer recommendations when the facility assessed Resident #3 for side rails. They put the side rails back on because the resident requested the side rails be put back on. " If we don't do side rails and they fall we have problems, if we do use them and something happens we get into problems". The facility did not provide the survey team with any evidence of staff training on the air mattresses.</p> <p>4. Observation, on 06/07/11 from 8:05am to</p>	F 323		



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F 323	Continued From page 27 8:34am, revealed a ladder and light cover left in Room 242 laying against the closet door unattended. A resident observed in a wheelchair rolled into the room and ran into the ladder. The resident then came out of the room, as it was not their room.  Interview with the Maintenance Coordinator, on 06/09/11 at 10:10am, revealed he had left the ladder and light cover in the room. He stated there was not a resident in the room at the time he left the equipment in the room. When told that a resident had been observed going in the room and running into the ladder, he stated "oh, I see there is a potential for injury".  Interview with the DON, on 06/09/11 at 4:00pm, revealed she had called maintenance before when they had left maintenance equipment unattended. She stated it was a hazard when equipment was left unattended and someone could get hurt.	F 323		
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.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		

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F 441	Continued From page 28 (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies: Infection Control and Bloodborne Pathogens, it was determined the facility failed to ensure infection control practices were followed in order to provide a safe and sanitary environment and to help prevent the transmission of disease and infection for residents. Infection control guidelines were not followed during a dressing change for one (1) resident (#5) of fifteen (15) sampled residents. Communal items, including roll-on deodorant,	F 441	F 441 Resident # 5 has been assessed to assure that no negative outcomes have resulted from this deficient practice. No condition change identified. Residents with wounds requiring dressing change, receiving showers in the resident shower room, and those provided ice from the unsecured ice cooler have the potential to be affected by this deficient practice. To avoid recurrence of these deficient practices, licensed staff has been re-educated in acceptable dressing change procedure by the DON on 6/22/11 and 6/23/11. All nursing staff has been inserviced regarding prohibition of use of any communal items for residents and maintaining the resident ice cooler in a restricted location for access only to authorized staff. Completed 6/22/11 and 6/23/11. LPN #1 has been counseled by the DON on 6/22/11 and acknowledges understanding that further non-compliance with facility policy and standard nursing practice will meet with disciplinary action. Observation of dressing change with LPN #1 by the DON on 6/22/11 revealed no breach of infection control standards and facility policy. Each licensed staff member has been personally observed during dressing changes ordered by the DON/RN Supervisor on 6/22/11 and 6/23/11 to assure clinical competency. 100% compliance with facility policy and standard nursing practice was	6/23/11

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F 441	<p>Continued From page 29</p> <p>razors, and scissors were being used for multiple residents in the shower room. And, a visitor was observed scraping off excess ice from an ice pitcher, back into the ice cooler used for other residents, with his bare hands.</p> <p>The findings include:</p> <p>Review of the facility Infection Control Guidelines for All Nursing Procedures dated 2001 (MED-PASS, Inc.) and revised in 2007 stated employees must wash their hands for ten to fifteen seconds using antimicrobial or non-antimicrobial soap and water or use an alcohol-based hand rub containing 60-95% ethanol or isopropanol before and after direct contact with residents and before and after handling clean or soiled dressings.</p> <p>Review of the undated facility program outline used for training new employees titled Bloodborne Pathogens: Protecting Yourself and Others in Homecare stated hands should be washed between each glove change, before and after patient care, and after any contact with contaminated objects. This program includes information on universal precautions and personal protective equipment.</p> <p>Observation of a head-to-toe skin assessment and dressing change for Resident #5 on 06/08/11 at 10:05am, revealed Licensed Practical Nurse (LPN) #1 removed a non-adherent dressing from the resident's right calf allowing the wound to touch the pillow case underneath. After removing the dressing the nurse changed her gloves without washing her hands or using hand sanitizer. LPN#1 then pulled out a disposable</p>	F 441	<p>identified. LPN #1 will continue to be observed weekly x 4 weeks. If 100% compliance is maintained, random observations of dressing changes will continue monthly x 3 months, then randomly thereafter. The orientation of new licensed employees has been revised to include personal observation of dressing change technique by the DON/RN Supervisor and proper use/disposal of all 1-time use items (e.g. wound measuring tool, etc) to assure clinical competency. The DON will report monitoring results to the quarterly QA committee for any further recommendations deemed appropriate.</p>	

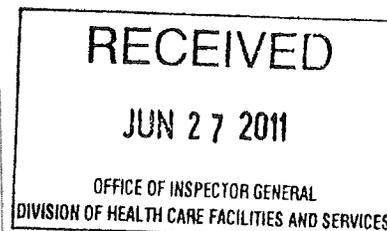
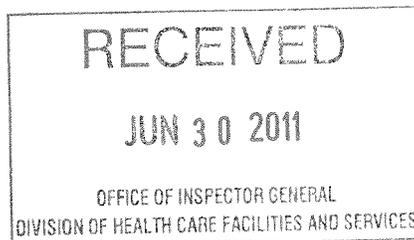
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F 441	Continued From page 30 plastic measuring tool from her pocket, which contained papers and keys, and proceeded to measure the resident's wound. The nurse then redressed the wound and wrapped the resident's leg with a bandage. While changing the wound dressing LPN#1 touched her face multiple times with her gloved hand. When measuring another wound for Resident #5 she pulled the same measuring tool out she had already used to measure the other wound. After finishing with the dressing change and the rest of the skin assessment, LPN#1 removed her gloves and did not wash her hands or sanitize hands before leaving the room.  Interview with LPN#1, on 06/08/11 at 10:45am, revealed she had worked at the facility for about four months. LPN#1 responded about handwashing during a dressing change, stating she washed her hands and applied gloves before removing the soiled dressing, Although observation revealed the LPN only changed gloves and did not wash her hands after removing the soiled dressing, she did not respond directly, but replied she washed her hands when she changed a dressing with another resident. When asked about using a clean barrier between Resident #5's wound and her pillow case she responded that she did not realize the wound was touching the pillow case and knows that it should not be. She thought the soiled dressing was between the wound and the resident's pillow case. When questioned about putting the disposable measuring tool in her pocket with keys and papers and then pulling it out to use it, she agreed that it was not a good idea to put it in her pocket and pull it out to use when measuring a resident's wound as cross-contamination can	F 441	F 441 Addendum  Shower Room The RN supervisor is responsible for audits on the shower room daily for two weeks. The DON will conduct random audits weekly times four weeks. If 100% compliance is maintained, random shower room audits will continue monthly times three months, then randomly thereafter. DON will report monitoring results to the quarterly QA committee for any further recommendations deemed appropriate.  <i>Derrick Moore</i> <i>Administrator</i> 6/30/11	6/30/11



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105175	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/09/2011
NAME OF PROVIDER OR SUPPLIER  TREYTON OAK TOWERS			STREET ADDRESS, CITY, STATE, ZIP CODE 211 WEST OAK STREET LOUISVILLE, KY 40203	
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F 441	<p>Continued From page 31</p> <p>occur. When questioned, LPN#1 stated she does was her hands between residents, although she did not wash her hands after the dressing change.</p> <p>Interview with LPN#1, on 06/09/11 at 11:30am, regarding training she had received on infection control revealed she just had an infection control inservice a couple of weeks ago given by the Director of Nursing (DON).</p> <p>Interview with LPN#2, on 06/09/11 at 1:45pm, revealed the process she used during a dressing change was as follows: check the doctor's order; gather supplies; wash hands and apply gloves; tell the resident what she is doing; maintain privacy; take off soiled dressing and assess the wound and dressing for drainage; remove gloves and wash hands; apply clean gloves; measure and assess wound; ask the resident about pain; clean and dress the wound per doctor's order; sign and date dressing; take off gloves and wash hands; clean up area; make sure resident's call light is within reach; and sign the treatment record for the resident. When asked about a wound that would possibly touch a surface when the dressing was removed, she stated that she would put a clean towel or clean pad between the wound and the surface. She stated the staff had infection control inservices at least yearly and they cover hand hygiene, preventive skin care, and assessment of wounds also.</p> <p>Interview with LPN#3, on 06/09/11 at 2:00pm, revealed the process she used during a dressing change was as follows: check the resident's treatment record for the doctor's order; gather supplies; wash hands and apply gloves; take off</p>	F 441		

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F 441	<p>Continued From page 32</p> <p>solled dressing; assess wound and drainage; wash hands; apply clean gloves; perform wound care and apply new dressing as ordered; sign and date dressing; clean up area; wash hands; and sign the resident's treatment record. She stated she received an infection control inservice when she started working here a little over two months ago as part of her orientation.</p> <p>Interview with the DON, on 06/09/11 at 2:55pm, revealed the human resources director gave an infection control inservice for new hires as part of the orientation process. The DON stated the human resource director used the information titled Bloodborne Pathogens: Protecting Yourself and Others in Homecare. The DON stated she did annual inservices on infection control and as needed. She also made rounds with the wound doctor and nurses to see wounds. If she recognized a problem with infection control practices on these rounds she educated the nurse and other nurses as necessary, on all shifts. She had not noticed any problems with dressing changes/wound care and infection control. She stated the plastic flexible measuring tools should only be used once and discarded for reasons of infection control/cross-contamination. Observation, on 06/07/11 at 8:35am, revealed an unknown person carrying a ice pitcher to the ice cooler. This person preceeded to fill the pitcher up with ice, shake the pitcher of excess ice, then when the excess ice would not come off, took his bare hand and knocked off the excess ice back into the ice cooler.</p> <p>Interview with the individual, on 06/07/11 at 8:37, am revealed he was the spouse of an unsampled resident. Further interview revealed he did this</p>	F 441		

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F 441	<p>Continued From page 33</p> <p>frequently as the facility often runs behind on getting the resident ice.</p> <p>Interview with the Director of Nursing (DON), on 06/09/11 at 4:00pm, revealed if she saw a resident or family member in the ice cooler she would stop them and empty the ice cooler. The DON stated the potential complications were the resident could get sick by coming in contact with contaminated ice.</p> <p>The facility did produce a policy on the use of toletry items in the shower room.</p> <p>Observation of the shower room, on 06/07/11 at 11:40am, revealed a grated white plastic basket sitting on the counter containing a bottle of Ban roll-on deodorant, three (3) razors, and one (1) uncapped razor with black and white specs on the blade. An unlocked drawer contained a pair of point tip scissors.</p> <p>Review of recent in-services on Infection control did not include the use of communal toletry items.</p> <p>Interview with Shower Aide #1, on 06/07/11 at 11:40am, revealed deodorant, scissors, and razors are used on the residents. The shower aide stated they are not supposed to use a roll-on deodorant and that an aerosol deodorant is better to use due to roll-on actually touching each resident. When asked if there was a potential risk to the resident using a roll-on deodorant, the Shower Aide stated the deodorant could cause a potential infection using it resident-to-resident. She further revealed the same thing could happen with the scissors and the razors. When</p>	F 441		

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F 441	<p>Continued From page 34</p> <p>asked the purpose of the razor and the scissors in the shower room, the Shower aide stated these items were used for trimming facial hair, or shaving the facial hair of female residents.</p> <p>Interview with Registered Nurse (RN) Supervisor, on 06/09/11 at 10:50am, revealed she had been employed by the facility for three (3) weeks. The RN Supervisor reported making occasional checks on the shower room to monitor how showers are being done, to ensure razors are secured and put away, to monitor there are no items that do not belong such as cleaning supplies and no community supplies being used in the shower room. She reported the last round on the shower room was completed a week ago. The RN Supervisor revealed the razors are a one use item each resident must have their own razor to prevent cross-contamination. She reported scissors should not be in the shower room and they have the potential to cause cross-contamination. She stated roll-on deodorant could also cause cross-contamination. The RN Supervisor stated each resident should have their own bag of toiletries which is labeled with the residents name. She stated current monitoring system of the shower room is not sufficient and acknowledged responsibility to ensure safe infection control practice in the shower room.</p> <p>Interview with the Director of Nursing, on 06/09/11 at 3:00pm, revealed employees are trained on infection control practices upon hire, annually and as needed. She further stated she had not noticed any infection control issues in the facility. When asked if the new hire education included the use of communal toiletry items, she stated it</p>	F 441			

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F 441	Continued From page 35 did not include this topic, but the staff had been in-formally told not to use items resident-to-resident due to the risk of infection control. She further revealed razors are one use for one person, and there should not be a need for scissors in the shower room. She stated she monitors the shower room to make sure the shower aide has properly disinfected the shower chair and for standard infection control practices.	F 441			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/22/2011  
FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185175	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  06/07/2011
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K 000	INITIAL COMMENTS  Amended  A Life Safety Code Survey was initiated and concluded on 06/07/2011. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".	K 000			
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were	K 018	K018  To avoid recurrence of these deficient practices, the Housekeeping staff was in-serviced that doors should not be blocked by any devices that necessitate manual releasing action to close; example the propping open the resident doors with the trash cans. All corridor doors will be checked on a daily basis for 2 weeks by the maintenance staff and then randomly checked thereafter by the maintenance staff and noted on the monthly inspection sheets and reported to the Quality Assurance committee.	6/16/11	

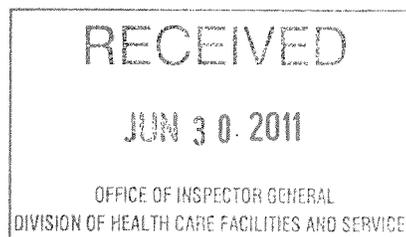
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X W. David Moore TITLE: X Administrator (X6) DATE: X 6/29/11

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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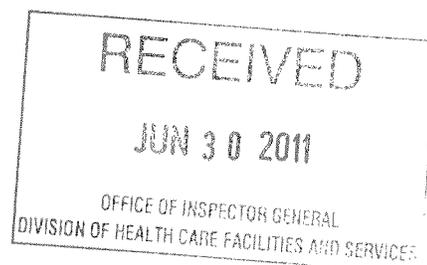
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K 018	Continued From page 1 no impediments to the closing of corridor doors, according to NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke departments, approximately ten (10) residents, staff and visitors. The facility is licensed for sixty (60) beds and the census was fifty-five (55) on the day of the survey.  The findings include:  Observations on 06/07/11 at 11:35 AM, revealed trash cans holding resident room doors 240 and 242 open.  Interview, on 06/07/11 at 12:15 PM, during the exiting conference with the Administrator and Director of Maintenance and Security, revealed they were unaware the trash cans were being used to hold open the resident room doors and would address the issue with Housekeeping.  Reference: NFPA 101 (2000 Edition)  19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.  A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at	K 025		



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K 025	<p>Continued From page 2</p> <p>least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments per NFPA standards. The facility had the capacity for sixty (60) beds and the census was fifty-five (55) on the day of the survey. The deficiency had the potential to affect each of the five (5) smoke compartments, fifty-five (55) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation on 06/07/2011 at 10:40 AM, with the Director of Maintenance and Security, revealed the smoke partition extending above the ceiling, located in the West Nursing Wing between rooms 240 and 242, was penetrated by newly installed data lines. The space around the data lines was not filled with a material rated equal to the partition and could not resist the passage of smoke. Further observation at 10:45 AM, with the Director of Maintenance and Security,</p>	K 025	<p>K025</p> <p>All smoke barriers must be maintained in order to protect the passage of smoke to the residents and the visitors at all times. This was not done and at the time this deficiency was found all penetrations in the smoke partitions extending above the ceiling were sealed by the maintenance staff with the required sealant. To ensure that this deficiency will not re-occur again, all smoke partitions will be checked on a monthly basis and noted on the monthly inspection sheets by the Director of Maintenance. Also if any work by outside contractors is done that would require pulling line through the smoke barriers, then maintenance will inspect the smoke barriers upon completion of the work to make sure the contractors have sealed up any penetrations made in the smoke barriers.</p>	6/10/11



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K 025	<p>Continued From page 3</p> <p>revealed the smoke partition extending above the ceiling, located at the West side of the elevator lobby, was penetrated by three (3), one (1) inch diameter holes.</p> <p>An interview with the Maintenance Director, on 06/07/11 at 10:40 AM, revealed that he was not aware of the penetrations and acknowledged that new data lines were recently installed above the ceiling by an outside contractor. The Maintenance staff was instructed to immediately fill the penetrations with the required sealant.</p> <p>Reference: NFPA 101 Life Safety Code (2000 Edition)</p> <p>8-2.4.4 Penetrations and Miscellaneous Openings in Smoke Partitions. 8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows: (1) The space between the penetrating item and the smoke partition shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke.</p>	K 025		

