



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

PRINTED: 03/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  02/24/2011
NAME OF PROVIDER OR SUPPLIER  RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 ISLAND FORD ROAD MADISONVILLE, KY 42431	
(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 157	<p>Continued From page 1</p> <p>regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to consult with the resident's physician regarding a significant change in the resident's physical status for one resident (#4), in the selected sample of 22, related to delayed identification of a pressure sore and deterioration of the pressure sore.</p> <p>Findings include:</p> <p>A review of the facility's policy "Skin Care", dated 10/25/05, revealed wound conditions would be inspected and evaluated by assessment of wound location and size, color of the wound bed, wound drainage, and odor. The wound would be assessed and staged from I to IV, or unstageable. Orders were to be obtained for appropriate treatment and re-evaluate the response to treatment, as well as factors that could impede healing. The physician should be contacted and the plan of care revised, as needed, if the wound was not healing satisfactorily. The policy revealed the physician should be notified of any significant change or lack of improvement in wound healing.</p> <p>A record review revealed Resident #4 was admitted to the facility on 07/28/10 with diagnoses to include Hip Fracture, Muscle Weakness, Kyphosis, and Peripheral Vascular Disease. A</p>	F 157	<p>F157</p> <ol style="list-style-type: none"> <li>It is the Policy of Ridgewood Terrace Health &amp; Rehabilitation Center to immediately inform the resident's physician and family member of any change in the resident's physical status.</li> </ol> <p>Resident # 4: On 03/10/11 the RN Unit Nursing Manager notified the resident's physician and interested family members of the significant changes relative to an open area found on the resident's spine and the treatments that had been initiated on 09/07/10; 09/11/10; and 09/16/10.</p> <ol style="list-style-type: none"> <li>Each resident benefits from having</li> </ol>	

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F 157	<p>Continued From page 2</p> <p>review of the significant change Minimum Data Set (MDS), dated 12/21/10, revealed the facility identified the resident as cognitively intact and required total dependence for bed mobility, hygiene, and bathing. The MDS revealed Resident #4 was frequently incontinent of bowel and bladder. A review of the care plan "At Risk for Skin Breakdown", revealed an intervention to notify the physician of skin breakdown.</p> <p>A review of the "Nurse's Notes", dated 09/11/10, revealed a treatment was applied to the "open area" on the resident's spine. No further documentation related to the assessment of the wound was found. The facility was unable to provide documentation of an order for the treatment provided.</p> <p>A review of the "Weekly Skin Assessment", dated 09/16/10, revealed a "red" area to the resident's spine was identified as "open." No further information regarding the "open" area was available from the assessment.</p> <p>An interview with RN #2, on 02/24/11 at 5:30 PM, revealed if the floor nurse identified an open area when the treatment nurse was not available, the area should be assessed and measurements written in the nurse's notes. The physician and family should be notified. She documented the resident's red area was "open" on 09/11/10 and 09/16/10, but revealed the area was in fact "open" when the treatment was initiated on 09/07/10. She revealed the treatment was not initiated by her, therefore the treatment nurse, LPN #2, should have assessed the wound and notified the physician.</p> <p>An interview with Licensed Practical Nurse (LPN)</p>	F 157	<p>his/her physician and interested family member notified of a significant change to pressure areas.</p> <p>The RN Unit Nursing Manager conducted a skin audit and medical record audit of all other residents having pressure areas to ensure that the resident's respective physicians and family members were notified of significant changes to pressure areas on 03/10/11.</p> <p>3. All licensed nurses received in-service education provided by the RN Corporate Compliance Officer on 03/11/11 regarding state and federal requirements as well as facility policy for notification of a resident's physician and family</p>	

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F 157	<p>Continued From page 3</p> <p>#2, on 02/24/11 at 6:20 PM, revealed she was the treatment nurse in September 2010, and initiated the treatment for Resident #4 on 09/07/10. She revealed the area to the resident's spine was red because the bony prominence protruded, but the area was not open.</p> <p>A review of the "Weekly Pressure Ulcer Healing Record", dated 2010, revealed the facility identified a Stage II pressure sore to the resident's spine on 10/05/10, with measurements of 0.6 cm length by 1.0 cm width. The wound bed was beefy red with normal colored surrounding skin. No odor or drainage was noted. On 10/14/10, the wound had increased in size (1.8 cm length by 1.7cm width by 0.1 cm in depth), and was identified as a Stage III with 20 percent slough to the wound bed. A scant amount of serous exudate was noted. On 10/20/10, the length of the wound had increased in size (2.0 cm length by 1.5 cm width), and continued to be identified as a Stage III with 20 percent slough. The surrounding skin was pink in color, with a small amount of serous exudate noted. There was no evidence of physician notification related to the deterioration of the wound.</p> <p>An interview with LPN #3, on 02/24/10 at 3:35 PM, revealed the physician should be notified of any change to a pressure wound, but they typically would not change the treatment order if less than 40 percent slough was noted. She assessed the resident's wound on 10/14/10 and 10/20/10, but did not notify the physician. On 10/14/10, the decision was made to monitor the wound for another week. She stated "That was the first time I had observed the wound". She did not recall what happened on 10/20/10. She revealed the physician should have been notified.</p>	F 157	<p>member for any change to pressure areas.</p> <p>Further, pressure areas and changes will be discussed during the morning nursing meetings to ensure that proper notification is made.</p> <p>4. The Unit Nursing Managers will conduct and report weekly audits of residents with pressure areas to ensure notification of the resident's physician and family member for any change in condition to the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS</p>		

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F 157	Continued From page 4	F 157		
F 226 SS=D	<p>An interview with the Interim Director of Nursing (DON), on 02/24/11 at 3:55 PM, revealed she would expect staff to notify the physician of wound changes, unless they were giving the current wound treatment a chance to work. Ideally, the same staff member should measure the wounds weekly, because "Everyone measured differently". If there was a "true deterioration" of a wound, the nurse would be expected to notify the physician.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents for one resident (#23), not in the selected sample.</p> <p>Findings include:</p> <p>A review of the policy "Resident Abuse, Neglect, and Exploitation", undated, revealed if an incident involved alleged abuse to a resident by a staff member, the incident should be reported immediately to the employee's immediate supervisor and the Administrator and/or designee, at which time an investigation would begin. The Administrator and/or designee would follow the facility protocols for reportable incidents. Alleged</p>	F 226	<p>Coordinators, Food Services Manager, Therapy Services, Business Office Manager, Activities Director, Social Services, Payroll Manager, Scheduling Coordinator, Housekeeping Director, and Maintenance Director. The Quality Assurance Committee will review the audit results as submitted on an ongoing basis to ensure continued compliance.</p> <p>5. Completion date: 03/14/11</p> <p>F226</p> <p>1. On 02/23/11, the employee alleged to have verbally abused Resident #23 was placed on</p>	03/14/11

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F 226	<p>Continued From page 5</p> <p>abuse that involved an employee against a resident, that employee would be suspended immediately pending further investigation by the Administrator and/or designee.</p> <p>A record review revealed Resident #23 was admitted to the facility on 08/27/02 with diagnoses to include Cerebral Palsy, Dysphagia, Voice Disturbance, Barrett's Esophagus, Neurogenic Bladder, and Anxiety. A review of the quarterly Minimum Data Set (MDS), dated 01/31/11, revealed the facility identified Resident #23 as cognitively intact and frequently incontinent of bowel and bladder.</p> <p>An interview with Certified Nurse Aide (CNA) #1, on 02/23/11 at 4:10 PM, revealed Resident #23 reported an allegation of verbal abuse against CNA #2. The resident allegedly stated, "If you don't quit peeing on yourself, I'm going to start working 100 Hall again." CNA #1 reported the incident to LPN #1, but she revealed this was "awhile back."</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 02/23/11 at 5:20 PM, revealed the incident had been reported to her and to LPN #2 during shift change. The incident had allegedly occurred on dayshift. She assumed LPN #2 would take care of the situation, because it happened on her shift. She was not able to recall any details of the incident. She revealed she should have made her supervisor aware of the allegation.</p> <p>An interview with CNA #2, on 02/23/11 at 6:20 PM, revealed Resident #23 wanted to get out of bed. She told the resident he/she would have to wait his/her turn, because she had other residents to get up first. She revealed the allegation was</p>	F 226	<p>administrative leave by the Interim Director of Nursing pending completion of the investigation of the allegation of verbal abuse.</p> <p>2. Each resident has a right to be free of abuse, neglect and misappropriation.</p> <p>To identify other residents having potential to be verbally abused by the alleged perpetrator, all other residents, as able to respond, under the care of the alleged perpetrator were interviewed by and tendered written statements to the nursing supervisors and social worker on 02/23/11. There were no allegations of verbal abuse</p>	

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F 226	Continued From page 6 months ago. She avoided the resident's room for a couple of weeks afterwards. She stated "Nobody from administration ever addressed me about it."  An interview was attempted with Resident #23, on 02/24/11 at 9:20 AM and at 11:55 AM, without success. The resident was at the hospital for a procedure.  An interview with the interim Director of Nursing (DON), on 02/24/11 at 3:55 PM, revealed she expected the staff to report alleged abuse to the supervisor. The supervisor should remove the staff from care, and then call the DON. The DON would then call the Administrator.	F 226	reported by the other residents interviewed.  Additionally, two licensed Charge Nurses and one Certified Nurse Assistant were interviewed by and submitted written statements to the nursing supervisors and social worker during the investigative process relative to the allegation of verbal abuse. None of the three employees witnessed the alleged perpetrator as having verbally abused Resident #23 or from acting unprofessionally.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure one resident #11, in a sample selection of 22, was provided care in a manner that maintained resident dignity, related to a catheter drainage collection bag overflowing to the point of bursting and draining onto the floor.  Findings include:  A record review revealed Resident #11 was admitted to the facility on 07/16/11 with diagnoses	F 241	3. On 02/23/11, all employees were in-serviced on the facility's Policy on	

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F 241	<p>Continued From page 7</p> <p>to include Gastrointestinal Bleed, Renal Failure, Paraplegia, Neurogenic Bowel and Bladder, Hypertension, Seizure disorder, Hypothyroidism, Peripheral Vascular Disease, Depression and Anxiety.</p> <p>An interview with Resident #11, on 02/22/11 at 5:50 PM, revealed staff had not been emptying his/her supra-pubic catheter bag as often as they should and that the bag had burst on 4-5 occasions, the last time occurring approximately one week ago. The resident reported he/she was afraid of an emergency situation if his/her bladder became too full. Resident #11 stated the bag he/she currently used had a 2000 cc capacity and on one occasion, "They emptied 4000 cc from the bag". Visitor #1, who was present in the room during the interview, stated he/she was present at that time and alerted staff to the situation "because the catheter bag looked like a basketball and I thought it was going to blow". Visitor # 1 stated this occurred at approximately 6:00 PM, sometime before 01/05/11 but he/she could not recall the exact date. The resident stated he/she had complained to staff on more than one occasion that his/her catheter bag needed to be emptied more frequently, but nothing had changed until he/she filed a grievance and requested that Certified Nurse Aide (CNA) #5 not be assigned to provide his/her care.</p> <p>An additional interview with Resident #11, on 02/24/11 at 11:00 AM, revealed he/she felt embarrassed when the bag burst and "pee was running on the floor", and was worried about getting a urinary tract infection.</p> <p>A review of the annual Minimum Data Set (MDS),</p>	F 241	<p>Resident Abuse, Neglect, and Exploitation by the Corporate Nurse Educator to ensure that proper protocol is followed when abuse, neglect or misappropriation is reported.</p> <p>Alleged perpetrators will be suspended immediately at time of allegation, and immediate initiation of an internal investigation and that the internal investigation was initiated immediately.</p> <p>4. The Interdisciplinary Team consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators, Food Services Manager, Therapy Services,</p>	

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F 241	<p>Continued From page 8</p> <p>dated 03/01/10, revealed Resident # 11 as totally dependent for toileting related to having a colostomy and an indwelling supra-pubic catheter. The Comprehensive Care Plan, dated 03/01/10, included interventions to change the colostomy bag every other day, gloves to be used for contact with the colostomy or the supra-pubic catheter, to measure and record intake and output every shift and to report any lack of urinary output to the charge nurse per shift.</p> <p>A review of Care Plan Conference Summaries, dated 08/19/10 and 01/25/11, revealed Resident #11 reported his/her catheter bag was not being emptied often enough. The Nursing Assistant Care plan, dated 02/11, included an intervention for catheter care every shift and as needed (prn), and to check the supra-pubic catheter bag every two hours and prn to ensure it was emptied as needed.</p> <p>An interview with CNA #6, on 02/23/11 at 10:25 AM, revealed the catheter bag filled quickly and should be emptied every two hours. She reported no knowledge of the bag ever rupturing.</p> <p>An interview with Licensed Practical Nurse #5/Unit Manager, on 02/23/11 at 10:50 AM, revealed after Resident #11 filed a grievance with the social worker, she initiated an intervention on the CNA care plan to check the bag every two hours and empty it prn. She stated she did not revise or update the comprehensive care plan. There was no system in place to monitor if the catheter bag was being emptied prn. She denied any knowledge of the catheter bag having ruptured.</p> <p>An interview with Registered Nurse Applicant</p>	F 241	<p>Business Office Manager, Activities Director, Social Services, Payroll Manager, Scheduling Coordinator, Housekeeping Director, and Maintenance Director will review any occurrences of abuse, neglect, or misappropriation during each morning meeting. Any occurrences of alleged caregiver abuse will result in immediate suspension of the alleged employee during the investigative period.</p> <p>All investigations of alleged resident abuse, neglect or misappropriation will be reported by the Social Services Director to the</p>		

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F 241	<p>Continued From page 9</p> <p>(RNA), on 02/23/11 at 10:15 AM, revealed Resident's #11's catheter bag needed to be emptied "quite regularly" due to filling quickly.</p> <p>An interview with the Social Worker, on 02/23/11 at 12:00 PM, revealed Resident #11 filed a grievance because his/her catheter bag "was not emptied to his/her liking" and that the resident had voiced a preference in the type of drainage bag to be used. She stated the facility now had the bags the resident preferred in stock.</p> <p>A review of a grievance, filed 02/14/11 by Resident #11, related to an incident on 02/12/11 revealed CNA# 5 did not empty his/her catheter drainage bag during the shift, causing it to burst.</p> <p>An interview with CNA #5, on 02/24/11 at 10:30 AM, revealed she could not recall the catheter bag being full enough to rupture on 02/12/11. She stated she was in-serviced after the incident to check the bag every two hours because of the resident's large output.</p> <p>An interview with LPN #6, on 02/23/11 at 4:15 PM, revealed she was called to the room of Resident #11 on 02/12/11 at approximately 6:00 AM to find the resident's catheter drainage bag completely inflated and filled well above the 2000 cc mark and leaking urine at the seams onto the floor. She stated she clamped the tubing and replaced the drainage bag with a new bag and noticed an immediate 100 cc drain from the resident's bladder. She stated the resident did not appear to be upset or distressed during the process. She stated there was no system in place to monitor if the catheter bag was checked every two hours.</p>	F 241	<p>Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators, Food Services Manager, Therapy Services, Business Office Manager, Activities Director, Social Services, Payroll Manager, Scheduling Coordinator, Housekeeping Director, and Maintenance Director immediately for monitoring by the Quality Assurance Committee to determine if further interventions are necessary. This review will be ongoing to ensure continued compliance.</p>	
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F 241	Continued From page 10 An interview with the Night Shift Supervisor, on 02/23/11 at 6:50 PM, revealed there was no reason for not checking the catheter drainage bag because CNAs were in the room every two hours for rounds and the drainage bag faced the door and she would expect them to observe the bag at that time.  An interview with the Director of Nursing, on 02/23/11 at 4:40 PM, revealed it was the nursing staff's responsibility to monitor the urinary output and ensure CNAs checked the drainage bag. She expected them to visualize the drainage bag once a shift.  A review of the facility policy on catheter care, dated 03/26/10, revealed interventions for routine catheter care only and did not address the individual care needs of Resident #11.	F 241	5. Completion Date: 02/25/11	02/25/11
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279	F 241  1. Resident #11: The Minimum Data Set Coordinator revised the resident's care plan to include individualized protocols to maintain the resident's dignity and respect while receiving care and services for a supra-pubic catheter on 03/10/11. The Comprehensive Care Plan revisions include: Licensed Nurses to visualize the catheter collection drainage bag; check around the site for infection,	

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PRINTED: 03/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  02/24/2011
NAME OF PROVIDER OR SUPPLIER  RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 ISLAND FORD ROAD MADISONVILLE, KY 42431		
(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 279	<p>Continued From page 11</p> <p>due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to develop and implement a care plan that appropriately addressed the specific needs of one resident (#11), in the selected sample of 22, related to care of an indwelling supra-pubic catheter.</p> <p>Findings include:</p> <p>A record review revealed Resident #11 was admitted to the facility on 07/16/11 with diagnoses to include Gastrointestinal Bleed, Renal Failure, Paraplegia, Neurogenic Bowel and Bladder, Hypertension, Seizure disorder, Hypothyroidism, Peripheral Vascular Disease, Depression and Anxiety.</p> <p>An interview with Resident #11, on 02/22/11 at 5:50 PM, revealed the resident drank a lot of fluid and staff had not been emptying his/her supra-pubic catheter bag as often as they should. The resident reported the bag had burst on 4-5 occasions, the last time occurring approximately one week ago. The resident stated he/she was afraid of an emergency situation if his/her bladder became too full. The resident stated the current bag had a 2000 cc capacity. On one occasion the staff emptied 4000 cc from the bag. The resident complained to staff on more than one occasion that his/her catheter bag needed to be emptied more frequently, but nothing changed until he/she</p>	F 279	<p>and palpate the bladder for distention QID at 6 am; 2 pm; 6 pm; and 2 am.</p> <p>Licensed nurses will document on the Treatment Administration Record (TAR) individualized treatments to include: (1) Notation that the drainage bag is emptied timely by the Certified Nurse Aides; (2) the bladder is palpated QID; and (3) that the amount of urine in catheter collection drainage bag not to exceed 1500 cc before the bag is emptied.</p> <p>2. Each resident having an indwelling urinary catheter benefits from receiving proper catheter care.</p> <p>On 03/10/11, the Unit Nursing</p>		

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F 279	<p>Continued From page 12</p> <p>filed a grievance and requested that Certified Nurse Aide (CNA) #5 not be assigned to provide his/her care.</p> <p>An interview with Visitor #1, on 02/22/11 at 5:50 PM, revealed he/she was present sometime before 01/05/11 at approximately 6:00 PM, and alerted staff because the catheter bag looked like a basketball and I thought it was going to blow".</p> <p>An interview with LPN #6, on 02/23/11 at 4:15 PM, revealed she was called to Resident #11's room on 02/12/11 at approximately 6:00 PM to find the resident's catheter drainage bag completely inflated and filled well above the 2000 cc mark. It was leaking urine at the seams onto the floor. She clamped the tubing, replaced the drainage bag with a new bag and noticed an immediate 100 cc drain from the resident's bladder. She revealed there was no system in place to monitor if the catheter bag was checked every two hours.</p> <p>An interview with Licensed Practical Nurse (LPN)/Unit Manger #5, on 02/23/11 at 10:50 AM, revealed after Resident #11 filed a grievance with the social worker, on 02/14/11, she initiated an intervention on the Nursing Assistant Care Plan to check the supra-pubic catheter bag every two hours and prn. She did not revise or update the Comprehensive Care Plan and no system was in place to monitor if the catheter bag was being emptied prn.</p> <p>An interview with the Director of Nursing, on 02/23/11 at 4:40 PM, revealed it was the nursing staff's responsibility to monitor the urinary output and ensure CNAs checked the drainage bag. She expected them to visualize the drainage bag once</p>	F 279	<p>Managers audited the Input/Output Records and visualized all residents having indwelling catheters to ensure that proper catheter care was given as care planned in order to maintain the dignity and respect of each resident.</p> <p>3. On 03/10/11 the Policy Committee consisting of the Registered Nurse (RN) Corporate Compliance Officer, the Director of Nursing, Medical Records Director, and the Unit Nursing Managers revised the Policy on Indwelling Catheter Care to include the practice of having Licensed Nurses palpate the bladder for distention at least every 6 hours at 6 am; 2 pm; 6 pm</p>	

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F 279	Continued From page 13 a shift.  An interview with the Minimum Data Set Coordinator, on 02/23/11 at 12:00 PM, revealed checking the catheter bag every two hours had been addressed in the January Care Plan meeting; however, the Comprehensive Care Plan was not revised.  A review of Care Plan Conference Summaries, dated 08/19/10 and 01/25/11, revealed Resident #11 had reported his/her catheter bag was not being emptied often enough.  A review of the annual MDS, dated 03/01/10, assessed Resident #11 as totally dependent for toileting related to having a colostomy and an indwelling supra-pubic catheter.  A review of the Comprehensive Care Plan, dated 03/01/10, revealed interventions to measure and record intake and output every shift and to report any lack of urinary output to the charge nurse per shift.  A review of the Nursing Assistant Care Plan, dated 02/11, revealed an intervention for catheter care every shift and as needed (prn), and to check the supra-pubic catheter bag every two hours and prn to ensure it was emptied as needed.	F 279	and 2 am and to record the results on the Treatment Administration Record (TAR). Also in the Policy, Certified Nurse Aides will visually check the catheter collection bag every two hours and empty at least once per shift or as needed; not to allow the catheter collection bag content to exceed 1500 cc; and/or to empty upon request of the resident to prevent overfilling.  The Corporate Nurse Educator provided mandatory nursing in-service education to all licensed nurses and Certified Nursing Assistants on the Policy on Indwelling Catheter Care on		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced	F 281			

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F 281	<p>Continued From page 14</p> <p>by: Based on observation, interview and record review, it was determined the facility failed to ensure one resident (#8), in the selected sample of 22, was provided care and services that meet professional standards of quality related to two missed doses of Antibiotics.</p> <p>Findings include:</p> <p>A review of the facility's policy for Medication Pass, dated 03/18/10, did not address the methods of procuring medication not available on the medication cart; however, a review of the list of drugs available in the Emergency Drug Box for PO meds (dated 08/28/08) revealed Amoxicillin (Augmentin) 875 mg was stocked.</p> <p>A record review revealed Resident #8 was admitted the facility on 01/19/11 with diagnoses to include, Acute Respiratory Failure, Rhabdomyolysis, Acute Renal Failure, Diabetes Mellitus II, Hypothyroidism, Hypertension, Hyperlipidemia, Anxiety and Reflux.</p> <p>An observation, on 02/22/11 at 9:00 AM, revealed Resident #8 was in bed positioned on his/her right side with the head of the bed elevated 35-45 degrees. The resident had oxygen in place by way of a nasal cannula at 3 liters per minute. The resident's eyes were closed and respirations were labored. Resident #8's family member was at the bedside and stated staff was aware of the resident's condition and was awaiting the results of a chest x-ray and laboratory results. The family member stated Resident #8 had been in the Emergency Room on Thursday, 02/17/11 and returned to the facility with orders for an antibiotic that was not given on Saturday 02/19/11 and part</p>	F 281	<p>03/05/11 and 03/06/11.</p> <p>On 03/11/11 the RN Corporate Compliance Officer provided education to all staff on the procedures for providing indwelling catheter care to ensure dignity and respect.</p> <p>4. The Unit Nursing Managers will audit and monitor the documentation on the Treatment Administration Record (TAR) relative to indwelling catheter care to ensure compliance with the Policy on Catheter Care weekly beginning 03/09/11 and submit audit results to the Quality Assurance Committee consisting of the</p>	

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F 281	Continued From page 15 of Sunday 02/20/11. He/She stated the medication nurse had informed him/her that the medication was not available.  A review of a physician's orders, dated 02/18/11, revealed an order for Augmentin 875 mg po twice a day for 14 days.  A review of the Medication Administration Record, dated February 2011, revealed two missed doses of the Augmentin 875 mg po on 02/19/11 at 8:00 AM and 8:00 PM.  An interview with the Director of Nursing, on 02/24/11 at 11:55 AM, revealed she expected the medication nurse to get the medication from the Emergency Drug Box (EDB). She stated the medication was available and the medication nurse on 02/20/11 obtained the medication from the EDB to give to the resident. The DON stated the medication nurse was written up for failure to administer the prescribed medication.	F 281	Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators, Food Services Manager, Therapy Services, Business Office Manager, Activities Director, Social Services, Payroll Manager, Scheduling Coordinator, Housekeeping Director, and Maintenance Director for review.		
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.  This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews, it was determined the facility failed to ensure each resident receives the necessary care	F 309	The Quality Assurance Committee will review the catheter care audits as presented to determine if further interventions are necessary. Ongoing review will be performed to ensure continued compliance.		

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F 309	Continued From page 16 and services to attain and maintain regular bowel function for one resident (#3), in the selected sample of 22, who failed to have a recorded bowel movement (BM) for seven days, 02/16-23/11.  Findings include:  A review of the Protocol for Monitoring Bowel Elimination, dated 09/24/10, revealed all resident BM sheets were to be reviewed daily. A list was to be made of all residents who had no BMs recorded for the last 48 hours and given to the charge nurse. A glass of prune juice was to be given to each resident on the list and were to be monitored for results. If no results for 24 hours after giving prune juice, the information was to be passed on to the on-coming shift for follow-up. Any resident who had no BM for 72 hours should be assessed for bowel sounds and given a laxative. If there was no order for a laxative, the staff members were instructed to call the physician and get an order. If there was no results from the laxative in 12 hours, the physician was to be called for further orders.  Record review revealed Resident #3 was admitted on 03/27/10 with diagnoses to include Severe Alzheimer's Disease, Constipation and General Muscle Weakness. A quarterly assessment, dated 02/15/11, revealed the resident had short and long term memory deficits, was rarely or never understood and never or rarely made decisions. The care plan for incontinence, dated 09/13/10 and reviewed 02/16/11, revealed the resident required a brief check and change schedule and staff members were required to monitor and document the number of incontinent episodes on the flow sheet.	F 309	5. Completion Date: 03/14/11  F 279  1. Resident #11: The Comprehensive Care Plan was revised on 03/10/11 to meet the resident's medical, nursing, mental and psychosocial need on an individualized basis to ensure proper supra-pubic catheter care.  2. The Minimum Data Set (MDS) Coordinators reviewed and revised, as necessary, the Comprehensive Care	03/14/11	

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F 309	<p>Continued From page 17</p> <p>A review of the Nursing Assistant Care Plan, for February 2011, revealed the Certified Nurse Aides (CNAs) and the Nurse Aides (NAs) were to report any bowel movement to the nurse and document. A review of the Hospice Nurse's Interdisciplinary Care Plan, dated 10/19/10, revealed the resident was to have a bowel movement of normal consistency within a normal pattern for this resident, which was specified to be every three days.</p> <p>An observation of Resident #3, on 02/22/11 at 10:40 AM, revealed the resident was lying in a geri-chair across from the nurses station, with his/her legs elevated. The resident was restless and moved his/her legs over the side of the geri-chair and made crying gestures, without tears, and starred at the ceiling.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 02/22/11 at 10:40 AM, revealed the resident was a "Hospice patient" due to the Severe Alzheimer's Dementia that had started at a young age and progressed. The resident was non-verbal and had rare episodes of garbled speech</p> <p>A review of Resident #3's BM record, for February 2011, revealed the resident had no BMs since 02/16/11, when it was recorded on the 6:00 PM to 6:00 AM shift, that the resident had one large, soft formed stool.</p> <p>A review of the physician orders, for February 2011 and a review of the Medication Administration Records (MARs) for February 2011, revealed an order for pudding thick prune juice, 180 milligrams, by mouth, daily PRN, or as needed for constipation. There were no orders</p>	F 309	<p>Plans of all residents having indwelling catheters to ensure that their medical, nursing, mental and psychosocial needs are met relative to catheter care on 03/10/11.</p> <p>3. Any needed revisions to an individual's indwelling catheter care plan will be made immediately by the nurse on duty and a copy of the report will be given to the Minimum Data Set (MDS) Coordinators for further revision if needed. The nurse on duty will immediately notify the physician and family of any changes to the provision of catheter care beginning 03/11/11.</p>	

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F 309	<p>Continued From page 18</p> <p>for any other PRN laxative and the order for PRN prune juice had not been initialed for the month of February. Taped to the back of the chart front was an order from the Hospice Nurse, dated 10/18/10, for Glycerin Rectal Suppositories and Milk of Magnesia (MOM) PRN constipation. A review of the nurses notes, for 02/02/11 through 02/23/11, revealed no mention of an assessment of the resident's BM status and no mention of any laxatives administered or auscultation of bowel sounds.</p> <p>Interviews with CNAs #2 and #4, on 02/23/11 at 10:40 AM and at 11:35 AM, revealed the resident did not have a BM in the past week during their 12 hour shifts and the CNAs stated they did report this to the CMA.</p> <p>An interview with CMA #1, on 02/23/11, revealed the CMA was aware the resident had not had a BM since 02/16/11 and stated the resident was given prune juice 02/22/11 and 02/23/11 but she had not documented on the MAR that it had been given. The CMA stated she checked the BM list everyday she worked and reported to the next shift CMA the results of the prune juice she had given. CMA #1 failed to notify the charge nurse that additional laxatives were needed and stated the resident did not have orders for MOM or suppositories on the MAR.</p> <p>An interview with LPN #4, on 02/24/11 at 9:50 AM, revealed the Hospice Nurse worked closely with the nurse on the 100 wing and both nurses shared information necessary for the resident's care. The LPN was unaware of an order from the Hospice Nurse for additional laxatives, that was not taken off on the resident's MAR, and had never seen the order for MOM and suppositories.</p>	F 309	<p>The Minimum Data Set (MDS) Coordinators will attend the morning nursing report meeting of the Interdisciplinary Team consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators, Food Services Manager, Therapy Services, Business Office Manager, Activities Director, Social Services, Payroll Manager, Scheduling Coordinator, Housekeeping Director, and Maintenance Director to ensure that Comprehensive Care Plans for all residents requiring catheter care includes the proper interventions</p>		

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F 309	Continued From page 19  An interview with the Hospice Nurse, on 02/24/11 at 10:45 AM, revealed the nurse was unaware the MOM and suppositories had not been transcribed to the physician's order or the MARs and that the facility had not been utilizing these medications, as they were on the hospice records.  An interview with the DON, on 02/24/11 at 5:40 PM, revealed the resident's intake was poor and the output was not expected to be much either.  An observation and skin assessment, on 02/23/11 at 10:40 AM, revealed the resident was incontinent of a moderate amount of pasty, light brown stool.	F 309	to meet the resident's medical, nursing, mental and psychosocial needs 03/10/11.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, it was determined the facility failed to ensure a resident having pressure sores received necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing for one resident (#4), in the selected sample of 22. The facility delayed	F 314	4. Results of the catheter care plan audits by the MDS Coordinators will be submitted to the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators, Food Services Manager, Therapy Services, Business Office Manager, Activities Director, Social Services, Payroll Manager, Scheduling Coordinator, Housekeeping Director, and Maintenance Director weekly to determine	

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F 314	Continued From page 20 identification, assessment, and physician notification of a pressure sore; and did not notify the physician after the pressure sore had deteriorated.  Findings include:  A review of the policy "Skin Care", dated 10/25/05, revealed wound conditions would be inspected and evaluated by assessment of wound location and size, color of the wound bed, wound drainage, and odor. The wound would be assessed and staged from I to IV, or unstageable. Orders were to be obtained for appropriate treatment. Evaluate the response to treatment, as well as factors that could impede healing. Nutrition Services would be notified of wounds staged from I to IV, and Rehab Services for wounds staged as III or IV. The physician should be contacted and the plan of care revised, as needed, if the wound was not healing satisfactorily. The policy revealed the physician should be notified of any significant change or lack of improvement in wound healing.  Observation of wound care, on 02/23/11 at 9:40 AM, revealed a pressure sore with measurements of 3.0 centimeters (cm) in length and 1.5 cm width located in the middle of the spine. A moderate amount of brown drainage was observed from the old dressing. The wound was light pink in color with a scant amount of bloody drainage noted. The surrounding tissue was dark pink/red and blanchable. Registered Nurse (RN) #1 assessed the wound as a Stage III. A small area of irritation was visualized to the right of the wound (caused by adhesive, per RN #1). The wound was cleansed with normal saline and dried with a 4x4 gauze. A small amount of DuoDerm	F 314	if further interventions are necessary. This will be ongoing to ensure continued compliance.  5. Completion Date: 03/14/11	03/14/11
		F 281	1. Resident #8: This resident no longer resides at Ridgewood Terrace Health and Rehabilitation Center.  2. Ridgewood Terrace Health & Rehabilitation Center adheres to Nursing Standards for	

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F 314	<p>Continued From page 21</p> <p>gel was placed on the center of the wound bed with a "Q-tip". Collagen was applied to the wound, and Reston (with a cut out center) placed around the wound. The surrounding area was moistened with a skin-prep, and the Reston was secured with an adhesive dressing.</p> <p>A record review revealed Resident #4 was admitted to the facility on 07/28/10 with diagnoses to include Hip Fracture, Muscle Weakness, Kyphosis, and Peripheral Vascular Disease. A review of the significant change Minimum Data Set (MDS), dated 12/21/10, revealed the facility identified the resident as cognitively intact and required total dependence for bed mobility, hygiene, and bathing. The MDS revealed Resident #4 was frequently incontinent of bowel and bladder. A review of the "Braden Scale-For Predicting Pressure Sore Risk", dated 08/10/10 and 12/8/10, revealed the facility identified the resident as a mild risk for developing pressure sores. The care plan "At Risk for Skin Breakdown", revealed initial interventions for the licensed nurse to perform weekly skin assessments and notify the physician of skin breakdown.</p> <p>A review of the "Telephone Orders", dated 08/26/10, revealed a treatment was initiated for Reston (with a cut out center) to be applied to the bony area of the resident's back for pressure reduction. Review of the "Treatment Record", dated 09/01-30/10, revealed a treatment to cleanse the "red area" on the resident's back and apply Bacitracin before covering with the Reston (with a cut out center). The treatment was initiated on 09/07/10. The facility was unable to provide documentation of the treatment order. There was no documentation in the nurse's notes</p>	F 314	<p>medication passes and in accordance with the revised Policy on Medication Pass revised 3/10/11 by the Registered Nurse Corporate Compliance Officer.</p> <p>Per Policy on Medication Pass, Procedure #19: If medication is not on the medication cart, check the emergency drug box for needed medication. If medication is available fill out the pharmacy slip completely and send to pharmacy for replacement. Emergency Drug Box for PO meds. Procedure #20: If medication is not in the emergency drug box, call the Pharmacy and request medication</p>		

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F 314	<p>Continued From page 22</p> <p>regarding an assessment of the "red area", or the treatment initiated on 09/07/10. A review of the "Nurse's Notes", dated 09/11/10, revealed the treatment was applied to the "open area" on the resident's spine. No further documentation related to the assessment of the wound was found.</p> <p>Review of the "Weekly Skin Assessment", dated 08/26/10, 09/02/10, 09/09/10, and 09/16/10, revealed a "red" area was identified to the middle of the resident's spine on 08/26/10. The "red" area was identified on the next two weekly skin assessments. On 09/16/10, the "red area" to the resident's spine was identified as "open." No further information regarding the "open" area was available from the assessment.</p> <p>An interview with RN #2, on 02/24/11 at 5:30 PM, revealed the treatment nurse was responsible for the weekly assessment and measurements of pressure wounds. If the floor nurse identified an open area when the treatment nurse was not available, the area should be assessed and measurements written in the nurse's notes. The physician and family should be notified. She revealed there had been problems with the treatment nurse position. They had a treatment nurse, and then they did not. She stated "It's been back and forth." She documented the resident's red area was "open" on 09/11/10, and again on the weekly skin assessment 09/16/10, but did not assess and measure the wound. She revealed the area on the resident's spine was not just "red" when the treatment for Bacitracin started, it was open. She revealed she did not initiate the treatment; therefore, the treatment nurse should have assessed the wound.</p> <p>An interview with Licensed Practical Nurse (LPN)</p>	F 314	<p>to be delivered immediately. After Pharmacy hours call the emergency phone number for medication needed. Pharmacy will provide medication within an hour if needed between routine deliveries.</p> <p>3. Each resident benefits from having an emergency supply of specified PO antibiotics, including Augmentin, available when not available on the medication cart.</p> <p>Bluegrass Pharmacy provides contractual services to check at least monthly inventory of medications in the Emergency Drug Box, including Augmentin, and restock, as necessary, and was</p>	

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F 314	<p>Continued From page 23</p> <p>#2, on 02/24/11 at 6:20 PM, revealed she was the treatment nurse in September 2010, and initiated the treatment for Resident #4 on 09/07/10. She revealed the area to the resident's spine was red because the bony prominence was protruding, but the area was not open. She identified the area as a Stage II pressure sore on 10/05/10, and recorded the findings on the "Weekly Pressure Ulcer Healing Record."</p> <p>Review of the "Weekly Pressure Ulcer Healing Record", dated 2010, revealed the facility identified a Stage II pressure sore to the resident's spine on 10/05/10, with measurements of 0.6 cm length by 1.0 cm width. The wound bed was beefy red with normal colored surrounding skin. No odor or drainage was noted. On 10/14/10, the wound had increased in size (1.8 cm length by 1.7cm width by 0.1 cm in depth), and was identified as a Stage III with 20 percent slough to the wound bed. A scant amount of serous exudate was noted. On 10/20/10, the length of the wound had increased in size (2.0 cm length by 1.5 cm width), and continued to be identified as a Stage III with 20 percent slough. The surrounding skin was pink in color, with a small amount of serous exudate noted. There was no evidence of physician notification related to the deterioration of the wound.</p> <p>An interview with LPN #3, on 02/24/10 at 3:35 PM, revealed the physician should be notified of any change to a pressure wound, but they typically would not change the treatment order if less than 40 percent slough was noted. She assessed the resident's wound on 10/14/10 and 10/20/10, but did not notify the physician. On 10/14/10, the decision was made to monitor the wound for another week. She stated, "That was</p>	F 314	<p>completed during the Consulting Pharmacist's visit on 03/10/11.</p> <p>On 03/11/11, the Director of Nursing in-serviced all Licensed Nurses and Certified Medication Technicians on the procurement of PO antibiotics 24 hours a day, including Augmentin, according to the revised Policy for Medication Pass when the drug is not available on the medication cart so that PO antibiotics are given to all residents as prescribed.</p> <p>Per facility policy, Licensed Nurses and Certified Medication Technicians will receive disciplinary action by the Director of Nursing or the</p>		

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F 314	Continued From page 24 the first time I had observed the wound". She did not recall what happened on 10/20/10. She revealed the physician should have been notified.  An interview with the Interim Director of Nursing (DON), on 02/24/11 at 3:55 PM, revealed she expected staff to notify the physician of wound changes, unless they were giving the current wound treatment a chance to work. Ideally, the same staff member should measure the wounds weekly, because "Everyone measured differently". If there was a "true deterioration" of a wound, the nurse would be expected to notify the physician.	F 314	Assistant Director of Nursing if antibiotics, including Augmentin, are not given to residents as prescribed by their physician by utilizing the supply of medication provided in the Emergency Drug Box or as supplied per Agreement with Bluegrass Pharmacy.		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure one resident # 11, in the selected sample of 22, was provided appropriate care and services related to an indwelling supra-pubic catheter.  Findings include:	F 315	4. Licensed Nurses and Certified Medication Technicians will notify Unit Nursing Managers per shift report and Bluegrass Pharmacy by pharmacy slip when PO antibiotics, including Augmentin, are not available on the medication cart and must be procured from the Emergency Drug Box to ensure that there		

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F 315	<p>Continued From page 25</p> <p>A record review revealed Resident #11 was admitted to the facility on 07/16/11 with diagnoses to include, Gastrointestinal Bleed, Renal Failure, Paraplegia, Neurogenic Bowel and Bladder, Hypertension, Seizure disorder, Hypothyroidism, Peripheral Vascular Disease, Depression and Anxiety.</p> <p>An interview with Resident #11, on 02/22/11 at 5:50 PM of Resident #11, revealed staff had not been emptying his/her supra-pubic catheter bag as often as they should and that the drainage collection bag had burst on 4-5 occasions, the last time occurring approximately one week prior. The resident stated he/she was aware of the potential of an emergency situation related to being paralyzed and his/her bladder becoming too full. Resident #11 stated the drainage bag he/she used had a 2000 cc capacity and on one occasion "they'd emptied 4000 cc from the bag". The resident stated he/she had complained to staff on more than one occasion that his/her catheter bag needed to be emptied more frequently, but nothing had changed until he/she filed a grievance on 02/14/11.</p> <p>During an interview with Resident #11, on 02/23/11, he/she stated the nurses did not check my bladder for distention.</p> <p>An interview with Visitor #1, on 02/22/11 at 5:50 PM, who was present in the resident's room, revealed he/she was present on one occasion and alerted staff to the situation "because the catheter bag looked like a basketball and I thought it was going to blow". Visitor # 1 stated this had occurred at approximately 6:00 PM, sometime before 01/05/11 but he/she did not recall the exact date.</p>	F 315	<p>are no missed doses of PO antibiotics.</p> <p>Unit Nursing Managers will report this usage in the morning nursing meeting beginning on 03/11/11.</p> <p>A monthly tracking log of the procurement of PO antibiotics from the Emergency Drug Box to ensure that PO antibiotics are given as prescribed by the physician will be reported to the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators, Food Services Manager, Therapy Services, Business Office Manager, Activities</p>		

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F 315	Continued From page 26  An interview with Certified Nurse Aide (CNA) #6, on 02/23/11 at 10:25 AM, revealed the catheter bag filled quickly and should be emptied every two hours. She stated when she emptied the drainage bag, she wrote the amount down on her assignment grid for the day and then transferred the shift total onto the monthly bladder log at the end of each shift. The assignment grid was not a part of the medical record and was discarded at the end of the shift.  An interview with Licensed Practical Nurse (LPN) #6, on 02/23/11 at 4:15 PM, revealed she was called to the room of Resident #11 on 02/12/11 at approximately 6:00 AM to find the resident's catheter drainage bag completely inflated and filled well above the 2000 cc mark and leaking urine at the seams onto the floor. She stated there was no system in place to monitor if the catheter bag was checked every two hours. She stated that licensed nurses did not asses the resident for bladder distention, but they should.  An interview with LPN #5/Unit Manager, on 02/23/11 at 10:50 AM, revealed she initiated an intervention on the Nursing Assistant Care Plan to check the bag every two hours and empty it as needed (prn) after Resident #11 filed a grievance on 02/14/11. She stated she did not revise or update the comprehensive care plan and there was no system in place to monitor if the catheter drainage bag was being emptied prn.  An interview with the Night Shift Supervisor, on 02/23/11 at 6:50 PM, revealed there was no reason for not checking the catheter drainage bag. She stated the nurses completed a dressing to the supra-pubic catheter site every evening and	F 315	Director, Social Services, Payroll Manager, Scheduling Coordinator, Housekeeping Director, and Maintenance Director.  The Quality Assurance Committee will monitor monthly ongoing to ensure continued compliance.  5. Completion Date: 03/14/11	03/14/11	
		F 309	1. Resident #3: All Hospice orders were transcribed to the Medication Administration Record on 03/04/11 so that medications for bowel elimination would be given as		

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F 315	Continued From page 27 that would be "a good time" to assess for bladder distention.  An interview with the Director of Nursing, on 02/23/11 at 4:40 PM, revealed it was the nursing staff's responsibility to monitor the urinary output and ensure CNAs were checking the drainage bag. She would expect them to visualize the drainage bag once a shift; however, "at this point they were not documenting anything about bladder distention.  A review of the annual Minimum Data Set (MDS), dated 03/01/10, assessed Resident #11 as totally dependent for toileting related to having a colostomy and an indwelling supra-pubic catheter.  A review of the Comprehensive Care Plan, dated 03/01/10, revealed interventions to measure and record intake and output every shift and to report any lack of urinary output to the charge nurse per shift.  A review of the Nursing Assistant Care plan, dated 02/11, revealed an intervention for catheter care every shift and as needed (prn), and to check the supra-pubic catheter bag every two hours and prn to ensure it was emptied as needed.  A review of the facility policy on catheter care, dated 03/26/10, revealed no interventions that addressed the need to assess Resident #11 for bladder distention.	F 315	prescribed to attain and maintain regular bowel function.  Bowel Elimination Sheets for Resident #3 were reviewed by the Medical Records Director to ensure that the resident had a bowel movement within 72 hours on 03/10/11 with no other occurrences found.  2. Per facility Protocol for Monitoring Bowel Elimination, each resident benefits from receiving necessary care and services to attain and maintain regular bowel function.  By 03/15/11, the Medical Records Assistant or Designee will audit all bowel	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident	F 323		

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F 323	<p>Continued From page 28</p> <p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure one resident's (#5), in the selected sample of 22, environment was free of accidents hazards as possible. On 07/23/10, Resident #5 was found sitting on the floor of his/her bedroom and the facility failed to complete an investigation to determine the cause and put interventions in place to prevent further reoccurrence.</p> <p>Findings include:</p> <p>A review of the falls prevention policy, dated 10/21/10, revealed if a resident experienced a fall, nurses would complete an incident report and document the fall in the resident's record, and initiate the fall investigation report. The nurse would notify family and physician. Daily entries regarding the status of the resident's condition would be charted each shift for 72 hours following the incident. If a possible head injury, Neuro checks were initiated and completed for 72 hours.</p> <p>Record review revealed Resident #5 was admitted to the facility with diagnoses to include Alcohol Cirrhosis Liver, Convulsions, Dysphagia and Anemia.</p> <p>A review of the significant change Minimum Data</p>	F 323	<p>elimination records of residents on a bowel elimination program to ensure that the standards of Protocol for Monitoring Bowel Elimination are met. Bowel elimination sheets are reviewed daily by the evening shift charge nurse and a list is given to the Certified Medication Technician of all residents not having a bowel movement (BM) recorded for the past 48 hours. 180 cc of prune juice is given to each resident having no BM recorded for the past 48 hours and is documented on the Medication Administration Record. If no BM the following day, laxative given. If no</p>		

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F 323	<p>Continued From page 29</p> <p>Set (MDS), dated 01/03/11, revealed the resident had scored "6" on the Brief Interview for Mental Status (BIMS) which indicated a severe impairment in his/her cognition. Resident #5 required limited to extensive assistance of one to two staff with activities of daily living.</p> <p>A review of the nurse's notes, dated 07/23/10 at 10:45 AM, revealed the resident was sitting on the floor of his/her bedroom. The nurse questioned the resident about what he/she was doing and the resident informed the nurse that he/she was looking for his/her shoe. The nurse documented the resident denied falling and proceed to assess the resident for injuries.</p> <p>An interview with Licensed Practical Nurse (LPN) #3, on 02/23/11 at 12:34 PM, revealed the incident on 07/23/10 was not a fall but the resident was on the floor looking for a shoe. LPN #3 revealed she did not know how Resident #5 came to be on the floor. LPN #3 stated she completed an assessment on the resident after finding him/her on the floor. She voiced the incident was not a fall; therefore, she did not complete an incident report or follow-up afterwards. LPN #3 revealed she did not notify anyone about finding the resident on the floor. She now realized the incident was considered a fall because she did not know how the resident ended up on the floor. She stated she should have completed an incident report, started an investigation and put an intervention in place to prevent a repeat incident but she did not.</p> <p>An interview with LPN #4/Medical Records Director, on 02/23/11 at 12:20 PM, revealed after checking her records, she did not have an investigation of the incident. She stated if it was a</p>	F 323	<p>BM by the third day, the attending physician is notified for additional orders.</p> <p>The Charge Nurses will ensure that the Bowel Elimination Protocol is followed and will notify the physician, if needed, to ensure that the resident does not exceed 72 hours without having bowel elimination.</p> <p>3. The Corporate Nurse Educator in-serviced all Licensed Nurses on the facility Protocol for Monitoring Bowel Elimination on 03/05/11 and 03/06/11.</p> <p>On 03/11/11, the Assistant Director of Nursing re-educated all Certified Nurse Aides and Certified</p>	
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F 323	<p>Continued From page 30</p> <p>fall then there should have been an incident report completed as well as an investigation into the incident.</p> <p>An interview with the MDS Coordinator, on 02/23/11 at 12:39 PM, revealed there was not any new interventions implemented after the fall. She stated there should have been an intervention put in place after the fall and then she would have updated the care plan.</p> <p>An interview with the Interim Director of Nursing (DON), on 02/24/11 at 1:35 PM, revealed if staff found a resident on the floor, then it was considered a fall unless a resident had an identified behavior of putting themselves on the floor. The incident on 07/23/10 was considered a fall because the resident was found on the floor and the staff did not know how the resident came to rest on the floor. After a fall the staff was expected to complete an incident report, start an investigation to determine a cause, and initiate an intervention to prevent the incident from happening again.</p> <p>An interview with the Administrator, on 02/22/11 at 9:30 AM, revealed when a resident had a fall, the nurse reported the incident and completed an assessment of the resident. The nurse notified the physician and family of the incident. The nurse should complete an incident report with an investigation to follow. The team would meet and review the care plan to make the necessary changes if needed. The falls were also discussed in the quality assurance meeting. Medical Records Director/LPN #4 completed a program that tracked and trended the data then produced a graph. She brought the data she collected to the morning meetings.</p>	F 323	<p>Medication Aides on the facility bowel protocol, including initialing the administration of prune juice on the Medication Administration Record.</p> <p>4. Weekly audits will be completed by the Medical Records Director or Medical Records Assistant, or the Unit Nursing Managers in their absence for bowel elimination and will be reported to the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators, Food Services Manager, Therapy Services,</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  02/24/2011
NAME OF PROVIDER OR SUPPLIER  RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 425 ISLAND FORD ROAD MADISONVILLE, KY 42431		
(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 431 SS=D	<p><b>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</b></p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was</p>	F 431	<p>Business Office Manager, Activities Director, Social Services, Payroll Manager, Scheduling Coordinator, Housekeeping Director, and Maintenance Director for monitoring on an ongoing basis to ensure continued compliance.</p> <p>5. Completion Date: 03/16/11</p> <p>F 314</p> <p>1. Resident #4: On 02/24/11 the RN Unit Manager completed a comprehensive skin assessment and notified the resident's physician and</p>	03/16/11	

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F 431	Continued From page 32 determined the facility failed to ensure safe storage of drugs and biologicals related to multiple containers of enteral feeding and nutritional supplements that were expired and available for use.  Findings include:  An observation of the East side Medication room, on 02/24/11 at 2:40 PM, revealed two 1000 cubic centimeters (cc) bottles of 1.2 Cal Glucerna with expiration dates of 02/01/11.  An observation of the West side Medication room, on 02/24/11 at 3:30 PM, revealed two 8 ounce cans of Glucerna (nutritional supplement) with expiration dates of 10/01/10.  An observation of the Enteral Feeding Storage Room, on 02/24/11 at 3:35 PM, revealed three 1000 cc bottles of Osmolite 1.2 with expiration dates of 10/01/10.  An interview with Licensed Practical Nurse (LPN) #4, on 02/24/11 at 3:40 PM, revealed she was responsible to ensure nutritional supplies were rotated when they were delivered and had no explanation how the expired items had been missed. LPN #4 stated the expired items were stored where they would have been available for use and should have been removed. Additionally, LPN #4 stated there was no facility policy and procedure for storage of enteral feeding and nutritional supplies.	F 431	family of significant changes and to review treatment orders with the physician. The care plan was revised accordingly on 03/10/11 to correlate with current orders and wound changes.  2. On 03/08/11, the Treatment Nurse completed comprehensive skin assessments on all residents having pressure areas and notified the family and physician, if needed, of significant change to ensure treatment and		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a	F 441			

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F 441	<p>Continued From page 33</p> <p>safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (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> <p>(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.</p> <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, interviews, and record</p>	F 441	<p>services to promote healing, prevent infection and prevent new sores from developing.</p> <p>After completing the comprehensive skin assessment, the treatment nurse will measure, stage and document the findings on the Weekly Pressure Ulcer Healing Record and in the Nurses Notes as outlined by the policy. Physician orders for appropriate treatment will be obtained, and the Registered Dietitian, Therapy Services, and wound care team will be</p>		

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F 441	<p>Continued From page 34</p> <p>review, it was determined the facility failed to ensure staff washed their hands after each direct resident contact for which handwashing was indicated by accepted professional practice for one resident (#19), in the selected sample of 22.</p> <p>Findings include:</p> <p>A review of the policy/procedure "Infection Control, Universal Precautions", undated, revealed to wash hands after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves were worn. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident. Wash hands immediately after gloves are removed, between resident contacts, and when otherwise indicated to avoid transfer of microorganisms to other residents or environments.</p> <p>An observation of catheter care, on 02/24/11 at 2:30 PM, revealed Nurse Aide State Registered (NASR) #1 and Certified Nurse Aide (CNA) #3 did not wash their hands prior to donning gloves. CNA #3 assisted with turning and repositioning the resident, removed her gloves and left the room to obtain more supplies, without washing her hands. Upon return, she donned gloves without washing her hands. She assisted with positioning the resident in bed, removed her gloves, and left the room without washing her hands. NASR #1 provided catheter care to Resident #19. Afterwards, she went to the resident's bathroom and rinsed out the bath basin. She reached into her pocket for a trash bag, with soiled gloves. There were no bags in her pocket, so she removed her gloves and left</p>	F 441	<p>notified accordingly.</p> <p>The Treatment Nurse will give a summary of findings to the Wound Care Team at each morning meeting. The Wound Care Team is comprised of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Nursing Managers, Minimum Data Set Coordinators, Food Service Director, Registered Dietitian, and Therapy Services.</p>		

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F 441	Continued From page 35 the room without washing her hands.  Record review revealed Resident #19 was readmitted to the facility on 01/31/11 with diagnoses to include Intracranial Hemorrhage, Urinary Tract Infection (UTI), Pneumonia, and Acute Respiratory Failure. A review of the admission Minimum Data Set (MDS), dated 01/04/11, revealed the facility identified Resident #19 as severely cognitively impaired with an indwelling catheter.  An interview with CNA #3, on 02/24/11 at 2:50 PM, revealed she should wash her hands before donning gloves and after they were removed. She revealed she sometimes forgot to wash her hands because she was "in a hurry", but tried to "whenever she thought about it."  An interview with NASR #1, on 02/24/11 at 3:00 PM, revealed she realized she should have taken off her gloves before touching her clothing. She revealed hands should be washed before donning and after removing gloves. She stated, "My heart was racing, and I was nervous."  An interview with the interim Director of Nursing (DON), on 02/24/11 at 3:55 PM, revealed she expected staff to wash their hands before care was provided, before leaving a resident's room, and when hands were visibly soiled. She revealed the staff needed to be in-serviced on handwashing and contamination.	F 441	3. On 03/11/11 the RN Corporate Compliance Officer provided an in-service for all licensed nurses on the Policy on Skin Care.  Results of the weekly skin assessments will be reported by the Unit Nursing Managers to the Director of Nursing each week. The Director of Nursing will report results to the RN Corporate Compliance Officer for continuous auditing of skin assessment and		
F 518 SS=C	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS  The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing	F 518			

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F 518	<p>Continued From page 36</p> <p>staff; and carry out unannounced staff drills using those procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to carry out unannounced staff drills for tornado to ensure efficiency of knowledge and response time in the event of an emergency. Additionally, four staff members were unable to correctly answer questions related to the appropriate procedures in the event of a fire.</p> <p>Findings include:</p> <p>An interview with Licensed Practical Nurse (LPN) #5, on 02/24/11 at 2:40 PM, revealed she was not aware if there was ever a tornado drill conducted in the facility. LPN #5 also stated she did not know where the fire extinguishers were located in the building.</p> <p>An interview with Certified Nurse Aide (CNA) #4, on 02/24/11 at 2:55 PM, revealed she was unaware of where all the facility fire extinguishers were located. CNA #4 stated she did not remember a tornado drill ever being conducted by the facility.</p> <p>An interview with CNA #5, on 02/24/11 at approximately 3:00 PM, revealed she did not know where the emergency fire alarm pulls were located. The CNA stated there had not been a tornado drill conducted since she had been employed at the facility.</p> <p>An interview with Registered Nurse (RN) #1, on</p>	F 518	<p>treatment practices.</p> <p>4. The Director of Nursing will report results of skin audits to the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators Food Services Manager, Therapy Services, Business Office Manager,</p>	

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F 518	Continued From page 37 02/24/11 at 3:05 PM, revealed no tornado drills had been conducted during her employment.  An interview with the Maintenance Supervisor, on 02/24/11 at approximately 5:30 PM, revealed no tornado drills were conducted.  The facility "Emergency Disaster Policy and Procedure Manual", no date, made no mention to unannounced staff drills for tornado.	F 518	Activities Director, Social Services, Payroll Manager, Scheduling Coordinator, House-keeping Director, and Maintenance Director weekly ongoing to ensure continued compliance.  5. Completion Date: 03/14/11	03/14/11	
		F 315	1. Resident # 11: The resident's supra-pubic catheter drainage bag is emptied by		

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			<p>Certified Nurse Aides every shift, minimally, or upon resident request, and is visually checked every two hours to ensure timely emptying.</p> <p>Licensed Nurses visually check the drainage bag and palpate the bladder for distention at 6am; 2pm; 6 pm; and 2 am.</p> <p>Nursing documentation of the palpation was placed on Resident #11's Treatment Administration Record for recording and initialing.</p> <p>2. Each resident with a catheter benefits from</p>		

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			<p>receiving appropriate treatment and services to prevent urinary tract infections and catheter care.</p> <p>The Policy on Catheter Care was revised on 03/04/11 by the Policy Committee consisting of the Registered Nurse (RN) Corporate Compliance Officer, the Director of Nursing, Medical Records Director, and the Unit Nursing Managers to include the protocol for licensed nurses to assess residents with in-dwelling</p>		

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			<p>catheters for bladder distention at least every 6 hours and to check for any sign of infection and to document and initial such treatment on the Treatment Administration Record.</p> <p>On 03/11/11, the RN Unit Nursing Manager assessed all other residents having catheters to ensure proper catheter care according to facility policy and will submit audit results to the Quality Assurance Committee consisting of the Administrator,</p>	

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			<p>Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators; Food Services Manager, Therapy Services, Business Office Manager, Activities Director, Social Services, Payroll Manager, Scheduling Coordinator, House-keeping Director, and Maintenance Director weekly ongoing.</p> <p>3. In-servicing for nursing staff on the revised Policy on Catheter Care was provided by the Corporate Nurse Educator on 03/05/11 and</p>		

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			03/06/11 and for all nursing staff by the RN Corporate Compliance Officer on 03/11/11.	
			4. The Unit Nursing Managers will report results of nursing documentation on the Treatment Administration Record (TAR), Nurse's Notes, or nursing shift reports relative to indwelling catheter care to the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of	

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			<p>Nursing, Unit Managers, MDS Coordinators; Food Services Manager, Therapy Services, Business Office Manager, Activities Director, Social Services, Payroll Manager, Scheduling Coordinator, House-keeping Director, and Maintenance Director.</p> <p>The Quality Assurance Committee will monitor audits of the provisions of catheter care monthly ongoing.</p> <p>5. Completion Date: 03/14/11</p>	03/14/11	

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			F323  1. Resident #5: The LPN Unit Nursing Manager notified the family and MD of the incident occurring on 07/23/10 and completed an Incident and Investigation Report on 03/10/11.  2. On 03/10/11, the Medical Records Director completed a review of all individuals on the Falling Star Program to ensure that Incident/Investigation Reports were completed for all documented falls	

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			<p>in accordance with the Falls Prevention Policy. Results of the audit showed no other occurrence of a fall without an accompanying Incident and Investigation Report.</p> <p>3. The MDS Coordinator reviewed the care plan of Resident # 5 to ensure interventions were effective to prevent falls on 03/10/11.</p> <p>The RN Corporate Compliance Officer will review the Falls Incident/Investig</p>	

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			<p>ation Reports</p> <p>weekly to ensure that an Incident and Investigation Report Form is completed with each fall to improve effectiveness of interventions to prevent accidents.</p> <p>The Director of Nursing will provide re-education on the Falls Prevention Policy to nursing personnel on 03/11/11.</p> <p>4. Beginning 03/11, the Medical Records Director will submit findings of the 100% audit of Incident and Investigation reports for</p>		

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			<p>residents experiencing falls on the Falling Star Program monthly to the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators; Food Services Manager, Therapy Services, Business Office Manager, Activities Director, Social Services, Payroll Manager, Scheduling Coordinator, Housekeeping Director, and Maintenance</p>		

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		F431	<p>Director. The Quality Assurance Committee will monitor results monthly ongoing.</p> <p>5. Completion Date: 03/14/11</p> <p>1. The Medical Records Director disposed of expired Glucerna 1.2, Glucerna and Osmolite 1.2 on 02/24/11.</p> <p>2. The Medical Records Director revised the Policy on Disposing of Expired Enteral Nutrition Products to include disposing of products one month prior to</p>	03/14/11

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			<p>the expiration date on 03/10/11.</p> <p>3. The Medical Records Director in-serviced Licensed Nurses and Certified Medication Technicians on the Policy on Disposing of Expired Enteral Nutrition Products and on rotating and removing expired products on 03/11/11.</p> <p>4. The Medical Records Director will submit a monthly report to the Quality Assurance Committee consisting of the Administrator,</p>		

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			Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators; Food Services Manager, Therapy Services, Business Office Manager, Activities Director, Social Services, Payroll Manager, Scheduling Coordinator, House-keeping Director, and Maintenance Director to ensure that expired enteral nutritional products are removed prior to their expiration date.	

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		F 441	<p>The Quality Assurance Committee will review the audit results monthly ongoing.</p> <p>5. Completion Date: 03/14/11</p> <p>1. The Corporate Nurse Educator monitored Infection Control /Universal Precaution Procedures during the provision of care by Certified Nurse Aides to residents receiving repositioning and catheter care to ensure that handwashing occurred prior to and after donning gloves</p>	03/14/11	

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			<p>and that gloves were disposed of appropriately prior to touching clothing on 03/11/11.</p> <p>2. The Corporate Nurse Educator will provide additional orientation and training upon hire and annually thereafter to ensure that all employees are knowledgeable in the area of Infection Control and Universal Precautions. The Corporate Nurse Educator and Nursing Administrators will also provide annual competency skills training in</p>		

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			<p>handwashing techniques.</p> <p>3. The Corporate Nurse Educator provided re-education on handwashing and Infection Control/Universal Precautions o all staff on 03/09/11; 03/10/11; and 03/11/11.</p> <p>4. The Corporate Nurse Educator will provide random monitoring each week for three months to observe proper handwashing techniques prior to donning gloves and to observe disposal of gloves without</p>		

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			<p><del>touching clothing</del></p> <p>beginning on 03/11/11.</p> <p>Results of these random observational trainings will be submitted to the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators; Food Services Manager, Therapy Services, Business Office Manager, Activities Director, Social Services, Payroll Manager, Scheduling Coordinator,</p>	

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			<p><del>House-keeping</del></p> <p>Director, and Maintenance Director.</p> <p>The Quality Assurance Committee will monitor these results. Thereafter, the Unit Managers will conduct random monitoring of peri-care weekly and report results to the Quality Assurance Committee weekly for review ongoing to ensure continued compliance.</p> <p>5. Completion Date: 03/14/11</p>	03/14/11	
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			<ol style="list-style-type: none"> <li>1. The Director of Maintenance Services conducted a Tornado Drill at approximately 7:00 pm on 02/24/11.</li> <li>2. Upon hire and at least annually thereafter, all employees will be physically oriented on the location of emergency fire alarm pulls and fire extinguishers by the Director of Maintenance.</li> <li>3. The facility Emergency Disaster Policy and Procedure</li> </ol>	

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			<p>Manual will be revised to include semi-annual unannounced staff drills for tornados on 03/11/11 by the Administrator.</p> <p>4. The Director of Maintenance provided in-service education to all staff on 03/11/11 regarding the revised Policy on Semi-Annual Unannounced Tornado Drills and on Emergency Preparedness.</p> <p>The Maintenance Director will</p>	

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			<p>continue to conduct emergency preparedness drills a minimum of one time monthly and report results monthly to the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators; Food Services Manager, Therapy Services, Business Office Manager, Activities</p>	

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			<p>Director, Social Services, Payroll Manager, Scheduling Coordinator, House-keeping Director, and Maintenance Director.</p> <p>The Quality Assurance Committee will monitor monthly on an on-going basis for compliance.</p> <p>5. Completion Date: 03/14/11</p>	03/14/11	