

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

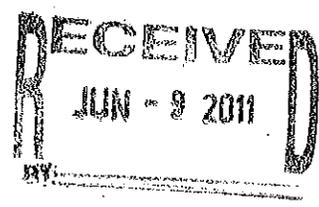
PRINTED: 05/06/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/22/2011
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203
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F 000	INITIAL COMMENTS	F 000	<p>The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because of federal and state law.</p>	
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure care was provided in a manner that enhanced or maintained each resident's dignity for one (1) of twenty-two (22) sampled residents (Resident #7) and for two unsampled residents (Unsampled Resident A and Unsampled Resident B).</p> <p>Unsampled Resident A was observed to receive a Finger Stick Blood Sugar (FSBS) and an insulin injection in the hallway. In addition, Unsampled Resident B and Resident #7 were observed to have urinary drainage bags which were uncovered.</p> <p>The findings include:</p> <p>1. Observation of medication pass on 04/19/11 at 4:10 PM revealed Licensed Practical Nurse (LPN) #1 obtained a FSBS for Unsampled Resident A in</p>	F 241		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Raymond A. D. [Signature]</i>	TITLE Executive Director	(X8) DATE 6/8/11
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	<p>Continued From page 1</p> <p>the hallway while there were other residents sitting in wheelchairs in the hallway. LPN #1 then proceeded to pull Unsampled Resident A's blouse up exposing the resident's abdomen and administer a Novolin 70/20 twenty-five (25) units mixed with Novolin R two (2) units Insulin injection at the site of the resident's left abdominal area.</p> <p>Interview on 04/19/11 at 4:50 PM with LPN #1 revealed it was "definitely a dignity issue" to obtain a FSBS and administer an injection in the hallway. Further interview revealed she should have asked the resident to go to her/his room prior to obtaining the FSBS and administering the insulin injection.</p> <p>Interview on 04/22/11 at 11:15 PM with the Director of Nursing (DON) revealed the resident should have been asked to go to her/his room prior to the FSBS and the injection for privacy.</p> <p>2. Record review revealed the facility admitted Resident #7 on 10/14/09 with diagnoses which included Urinary Retention and Renal Failure. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 03/18/11, revealed the facility scored Resident #7 as thirteen (13) out of fifteen (15) on the Brief Interview for Mental Status (BIMS), indicating Resident #7's cognition was intact.</p> <p>Review of the facility's policy, "Quality of Life-Dignity", dated 2001, revealed demeaning practices and standards of care that compromise dignity are prohibited and staff should promote dignity by keeping urinary catheter bags covered.</p>	F 241	<p>1) This facility does and will continue to have policies in place related to the quality of life and dignity of our residents. Providing dignity to the residents is included in the existing employee orientation as part of our education on resident's rights. In addition, staff are re-educated annually on dignity standards during our resident' rights training session. LPN#1 was re-educated and counseled on April 28, 2011 related to providing dignity and privacy when performing any treatments on any resident. Resident #7 and unsampled resident B had a privacy cover placed on the indwelling catheter on April 25, 2011. On April 28, 2011, Resident #7's indwelling catheter was discontinued. Unsampled resident A will receive her injections in a private area.</p> <p>2) An audit of all current residents was completed on May 6, 2011 to ensure privacy and dignity was being provided to all residents in their receipt of care and services (EXHIBIT #3). All residents will receive their injections in a private area.</p> <p>3) An educational offering to include all areas of providing dignity and privacy will be provided to all nursing staff by the Director of Nursing (DON) (EXHIBIT #4). An indicator will be incorporated into the existing QA program related to the dignity and privacy provided to residents to include the covering of indwelling catheter bags and injection administration. This will be a concurrent indicator collected through observation by</p>	

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F 241	<p>Continued From page 2</p> <p>Observation on 04/19/11 at 1:00 PM revealed Resident #7's Indwelling catheter bag suspended from the bed frame, on the side that faced the resident's doorway, without a privacy cover in place.</p> <p>Observation on 04/20/11 at 3:30 PM revealed Resident #7's Indwelling catheter bag suspended from the bed frame, on the side that faced the resident's window, without a privacy cover in place.</p> <p>Interview with Resident #7 on 04/22/11 at 12:55 PM revealed the resident didn't want to go to a facility "Luncheon" because he/she would have to drag "this old thing" down there (pointing to the catheter tubing) with him/her, so he/she would just wait until the catheter was removed in a few days.</p> <p>3. Review of the Roster Matrix completed by the facility on 04/19/11 revealed Unsamped Resident B to be cognitively impaired.</p> <p>Observation of Unsamped Resident B on 04/19/11 at 1:10 PM during the initial survey tour and again on 04/22/11 at 1:00 PM in his/her room, revealed the Resident's indwelling catheter bag was without a privacy cover in place.</p> <p>Interview with Registered Nurse (RN) #3 on 04/22/11 at 9:30 AM revealed urine collection bags should be in a privacy pouch.</p>	F 241	<p>the nursing unit managers. These audits will be done monthly for 12 months.</p> <p>4) The Director of Nursing (DON) will provide a report to the QA committee monthly for 12 months.</p> <p>Compliance Date June 6, 2011</p>	
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged</p>	F 280		

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F 280	<p>Continued From page 3</p> <p>Incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to revise the Comprehensive Care Plans for two (2) of twenty-two (22) sampled residents, (Resident #15 and #16). Residents #15 and #16 both had orders for antibiotic therapy that the facility failed to add to the Comprehensive Care Plans.</p> <p>The findings include:</p> <p>Review of the facility's "Care Plan Policy and Procedure", undated, revealed the Unit Managers review orders and clinical issues daily and update the care plan as indicated.</p>	F 280	<p>1) The facility has interim or comprehensive care plans for all residents within the facility. Each resident has multiple medically-related problems each having multiple care approaches. The facility has a system in place for updating care plans with new approaches, changes in resident's conditions and revised interventions.</p> <p>Both Resident #15 and #16 plans of care were reviewed to ensure current treatments, changes and approaches are incorporated into the care plan.</p> <p>2) A 100% sample of all resident's care plans will be completed by licensed nurses to ensure the care plan accurately reflects the resident's current condition and treatment.</p> <p>3) The unit managers, MDS RN Coordinators and Assistant Director of Nursing will be re-educated on the roles, responsibilities and system of updating care plans by the Director of Nursing (EXHIBIT #5). In addition, the facility's policy on care plans was reviewed and revised (EXHIBIT #6). An indicator will be incorporated into the existing QA program related to care plan accuracy and current reflection of the resident's condition and treatments. This will be a retrospective review collected monthly for three months, then quarterly for 12 months utilizing a 15% sample of care plans.</p>	
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F 280	<p>Continued From page 4</p> <p>1. Review of Resident #15's medical record revealed the diagnosis of a boil/abscessed sebaceous cyst on his/her back with treatment ordered on 04/14/11 of antibiotic therapy.</p> <p>Review of the April Medication Administration Record (MAR) revealed Keflex (antibiotic) three (3) times a day for ten (10) days with a start date of 04/14/11.</p> <p>Observation of Resident #15's skin assessment performed by Wound Nurse/Assistant Director of Nursing (ADON) on 04/21/11 at 10:00 AM revealed a pink/red area 10 centimeters (cm) by 6 cm with a raised area near the center that measured 1 cm by 1 cm by .5 cm on his/her back.</p> <p>Review of the Comprehensive Care Plan for 04/11 revealed no documented evidence related to a boil/abscessed cyst and/or antibiotic therapy for Resident #15.</p> <p>Interview with the ADON on 04/21/11 at 10:35 AM revealed revisions to the Comprehensive Care Plan was the responsibility of the Unit Manager. He further stated antibiotic therapy should have been care planned for Resident #15.</p> <p>Interview with the Director of Nursing (DON) on 04/21/11 at 4:05 PM revealed the Unit Manager's responsibility was to review orders each day and revise care plans. Further interview revealed the Unit Manager failed to revise the care plan reflecting initiation of antibiotic therapy for Resident #15.</p>	F 280	<p>4) The Director of Nursing will provide a report to the QA committee monthly for 3 months, then quarterly for 12 months.</p> <p>Compliance Date June 6, 2011</p>	
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F 280	Continued From page 5 2. Review of Resident #16's medical record revealed the facility admitted the resident on 04/20/04 with diagnoses which included Renal Failure and an Ileostomy. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 02/23/11 revealed the facility assessed the resident as experiencing occasional urinary Incontinence. Review of the Comprehensive Care Plan dated 12/15/10 revealed a problem of altered health maintenance related to Chronic Urinary Tract Infections (UTI's). Further record review revealed Resident #16 had a urine culture completed on 03/07/11 that identified the organism Enterobacter Cloacae. Review of the Physician's Orders dated 03/09/11 revealed an order for Cipro (antibiotic) 250 milligrams twice a day for five days. Review of the Medication Administration Record (MAR) revealed the medication was started on 03/09/11. Review of the Resident #16's Care Plan for 03/11 revealed no evidence the care plan was updated with the UTI and the ordered antibiotic on 03/09/11. Interview with the Director of Nursing (DON) on 04/21/11 at 4:05 PM revealed the Unit Manager's responsibility was to review orders each day and revise care plans.	F 280			
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281			

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F 281	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure services provided met professional standards. The facility failed to ensure Physician's orders were followed related to the bowel protocol for five (5) of twenty-two (22) sampled residents, (Resident #'s 2, 4, 11, 12 and 17). In addition, observation of a Finger Stick Blood Sugar (FSBS) on 04/19/11 for Unsampled Resident A revealed improper technique. The facility also failed to ensure Physician's orders were followed related to a dressing change on 04/21/11 for Resident #14. Observation revealed the wound was not cleaned per Physician's orders prior to the dressing change.</p> <p>The findings include:</p> <p>A review of the facility policy, "Physician Orders", undated, revealed monthly orders are reviewed by the nurse at the end of each month for accuracy and all orders received after that are written on a telephone order and transcribed to the Medication Administration Record (MAR) and Treatment Administration Record (TAR).</p> <p>A review of the facility policy, "Bowel Protocol", dated 03/2011, revealed the bowel protocol may be implemented if there is a physician's order for Bowel Protocol and a resident has not had a bowel movement for three (3) days. Further review revealed the bowel protocol stated: Administer thirty (30) cubic centimeters(cc) of Milk of Magnesia (MOM) on day shift early morning and monitor the resident during the shift for results. If MOM is ineffective, administer</p>	F 281	<p>1) The facility has policies and procedures in place for the provision of care to meet professional standards. Resident #2, #4, #11, #12 and #17 had no adverse outcomes related to the bowel protocol. All five of these residents have been monitored to ensure bowel movements are addressed. The unsampled resident A had no adverse effects from having her finger wiped with the Kleenex or from not having insulin bottle wiped with alcohol. This resident was monitored and had had glucose testing and insulin injections with the use of the correct technique. LPN #1 was re-educated and counseled on the correct technique of blood glucose testing and injection techniques.</p> <p>Resident #14's skin tears were healed as of May 3, 2011 with treatments discontinued as a result of this healing. Registered Nurse (RN) #10 was re-educated and counseled on the correct technique for dressing changes.</p> <p>2) A 100% sample of current residents was conducted to ensure all physician orders were implemented (EXHIBIT # 7). All residents had their bowel records reviewed. No residents were found to be in need of intervention with the bowel protocol.</p> <p>3) The policy on bowel protocol was revised (EXHIBIT #8). In addition, a new Treatment Administration Record (TAR) was developed for documentation of the implementation of the bowel protocol for use on all residents as indicated</p>	

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F 281	<p>Continued From page 7</p> <p>Dulcolax suppository early during the evening shift and monitor for results. After supper, if the suppository is ineffective, administer a Fleet's Enema and monitor for results. If no results by the end of shift notify physician for further interventions.</p> <p>1. Review of Resident #2's medical record revealed diagnoses which included Immobilization Syndrome, Dementia and Failure to Thrive.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 03/17/11 revealed the facility assessed Resident #2 as being cognitively impaired, as having total bowel incontinence, and being totally dependent on staff for incontinence care.</p> <p>Record review of Resident #2's Monthly Physician Orders, dated 04/2011, revealed an order for "Bowel Protocol".</p> <p>Review of the Resident #2's Bowel Shift Chart revealed no documented evidence of bowel elimination from 04/04/11 through 04/11/11, eight (8) days and from 04/12/11 through 04/17/11, six (6) days.</p> <p>Review of the April Medication Administration Record (MAR) revealed no documented evidence that the prescribed "bowel protocol" medications were given to Resident #2 during the eight (8) day and six (6) day periods with bowel elimination.</p> <p>Interview with the Unit Manager on 04/21/11 at 5:48 PM confirmed there was no documented evidence in Resident #2's medical record that</p>	F 281	<p>(EXHIBIT #9). Blood glucose monitoring will be added to the nurse's orientation and annual competency demonstration assessment. Education will be provided by the Director of Nursing (DON) for all nurses on the implementation of physician's orders according to the professional standards of practice to include medication pass, bowel protocol, glucose monitoring, dressing changes and infection control (EXHIBIT #10). An indicator will be incorporated into the facility's existing QA program to verify the implementation of physician's orders according to professional standards. This indicator will be a concurrent review of at least 15% monthly for three months, then quarterly for 12 months (EXHIBIT #11). In addition, an existing QA program indicator related to medication pass observation will be revised to include the observation of injection administration and glucose monitoring. This indicator will be a concurrent review collected monthly for 12 months (EXHIBIT # 12).</p> <p>4) The Director of Nursing will provide a report on these indicators to the QA committee monthly for 3 months, then quarterly for 12 months.</p> <p>Compliance Date June 6, 2011</p>	

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F 281	<p>Continued From page 8</p> <p>Physician's orders for bowel protocol were followed 04/07/11 through 04/11/11 or 04/15/11 through 04/17/11.</p> <p>Interview with Director of Nursing (DON) on 04/22/11 at 9:00 AM revealed the facility had failed to follow the facility policy for Bowel Protocol, dated 03/2011. She further stated Resident #2's physician's orders for bowel protocol were not followed on two (2) different occasions in April.</p> <p>2. Review of Resident #4's medical record revealed diagnoses which included Alzheimer's Dementia. Review of the Annual MDS Assessment dated 03/25/11 revealed the facility assessed the resident as having moderate impairment in cognitive skills for decision making, requiring limited to extensive assistance with Activities of Daily Living, as being occasionally incontinent of bladder, and continent of bowel.</p> <p>Review of the Monthly Physician Orders, dated 02/2011, revealed an order for "Bowel Protocol". Further review revealed Orders for Milk of Magnesia 400 Milligrams/ 5 milliliters oral suspension/Administer thirty (30) milliliters once daily as needed for constipation (medication used for constipation).</p> <p>Review of the Bowel Shift Chart revealed no documented evidence of bowel elimination from 02/10/11 through 02/20/11, eleven (11) days.</p> <p>Review of the Medication Administration Record (MAR) dated February 2011, revealed no documented evidence the Milk of Magnesium medication was administered as ordered for</p>	F 281		
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F 281	<p>Continued From page 9 constipation until 02/20/11 at 8:00 PM.</p> <p>Interview with Licensed Practical Nurse (LPN) #4 who was consistently assigned to Resident #4, revealed the resident would take herself/himself to the bathroom at times and staff would be unaware if the resident had a bowel movement. Further interview revealed the day shift supervisor printed out a list daily from the computer of residents who had not had a bowel movement in three (3) days. She further stated the supervisor would bring a list to each nurses station daily and alert the nurses of which residents needed laxatives. She stated the Certified Nursing Assistants (CNA's) documented the bowel movements in the kloske which was in the hallway; and she was unaware of the resident having any problems with constipation.</p> <p>Interview on 04/21/11 at 3:30 PM with CNA #6 revealed she was assigned to the resident and the resident had to be tolleted before and after meals and before bed. She further stated the resident never tried to take self to the bathroom and had no Incontinent episodes.</p> <p>Interview on 04/22/11 at 3:00 PM with CNA #7 who was assigned to the resident, revealed she was consistently assigned to the resident and the resident did not take self to the bathroom. She further stated the resident sometimes went several days without a bowel movement and she would tell the nurses.</p> <p>Interview on 04/22/11 at 11:15 AM with the Director of Nursing (DON) revealed Resident #4 had shown no signs of constipation such as abdominal distention in 02/11. She stated there</p>	F 281			

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F 281	<p>Continued From page 10</p> <p>was a documentation issue related to the staff using the kloske to document bowel movements. She further stated the facility had identified there was a concern with the documentation of bowel movements and in March 2011 the facility started having the day shift supervisor take lists to the units to alert the nurses of residents who had not had a bowel movement in three days.</p> <p>3. Record review revealed the facility admitted Resident #11 on 10/24/10 with diagnoses which included Failure to Thrive, Hyponatremia, Difficulty Walking, Metabolic Alkalosis and Colon Cancer.</p> <p>Review of the Quarterly MDS Assessment, dated 01/25/11 revealed the facility assessed Resident #11 as being cognitively intact. Resident #11 was also assessed as being frequently incontinent of bowel.</p> <p>Review of the bowel record revealed no documented evidence Resident #11 had a bowel movement from 03/07/11 through 03/18/11 a total of eleven (11) days.</p> <p>Review of the March, 2011 MAR revealed no documented evidence the bowel protocol had been initiated during this time frame.</p> <p>Review of the Nursing Notes revealed there was no documented evidence the bowel protocol had been initiated during this time frame.</p> <p>Interview with the DON on 04/21/11 at 10:23 AM revealed every morning the unit managers will go through the whole building and ask residents</p>	F 281		
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F 281	<p>Continued From page 11</p> <p>whether or not they have had a bowel movement. She stated the facility does not document in the medical record if the resident states they have or have not had a bowel movement or the action taken. She further indicated for residents who were incapable of responding to this question the facility would probably go ahead and treat them as though they had not and initiate the bowel protocol if there was no documented evidence of a bowel movement in the past three (3) days.</p> <p>Interview with the DON on 04/21/11 at 4:00 PM revealed the bowel protocol process was to be implemented for a resident who went nine (9) shifts with no bowel movement. She confirmed through interview there was no documentation on the MAR, the bowel protocol had been initiated for Resident #11.</p> <p>4. Review of Resident #12's medical record revealed the facility admitted the resident on 12/02/08 with diagnoses which included Symbolic Dysfunction, Other Specified Organic Brain Symptoms, Alzheimer's, and Depression. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 01/21/11 revealed the facility assessed the resident as always continent of bowel.</p> <p>Review of the Physician's orders revealed an order for "Bowel Protocol" dated 10/10/10 and an order for a medication Senokot S (Laxative) dated 10/23/10 for constipation.</p> <p>Review of the bowel records for Resident #12 revealed no documented bowel movements for the following intervals: 02/19/11 thru 02/28/11, a total of nine (9) days; 03/10/11 thru 03/16/11 a</p>	F 281		
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F 281	<p>Continued From page 12 total of seven (7) days; and 03/20/11 thru 03/25/11 a total of six (6) days. Further review of Resident #12's MAR for February and March 2011 revealed the Bowel Protocol medications were not administered during these months. Further review revealed no evidence the Senokot was given as ordered.</p> <p>Review of the Nurse's Notes for February and March 2011 revealed no documentation of assessment for constipation problems or physician notification.</p> <p>Interview with Unit Manager #1 on 04/21/11 at 5:30 PM regarding the facility's process for identifying residents with constipation problems revealed the current process was that a report was run that listed residents who had not had a bowel movement for three days. The day shift supervisor would ask if the resident had a bowel movement to determine if any follow-up action was needed. Further interview with Unit Manager #1 revealed Resident #12 was independent in toileting and didn't always report his/her bowel movements.</p> <p>5. Review of Resident #17's medical record revealed diagnoses which included Parkinsons Disease, Paranoid Psychoses, and Alzheimers.</p> <p>Resident #17 had been assessed on 03/07/11, during an Admission MDS Assessment performed by the facility as being cognitively intact and being continent of bowel.</p> <p>Record review of Resident #17's Physician's Orders dated 04/11 revealed an order for "Bowel Protocol."</p>	F 281		
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F 281	<p>Continued From page 13</p> <p>Review of Resident #17's Bowel Shift Chart revealed no documented evidence of bowel elimination from 02/28/11 through 03/09/11, a period of nine (9) days, from 03/16/11 through 03/23/11, a period of six (6) days, from 03/23/11 through 03/31/11, a period of seven (7) days, and from 03/31/11 through 04/13/11, a period of thirteen (13) days.</p> <p>Review of the MAR for the months of 02/11 through 04/11 revealed no documented evidence that the prescribed "bowel protocol" medications were given to Resident #17.</p> <p>6. Review of the facility's "Blood Glucose Monitoring" Policy which was undated, revealed: wipe resident's finger with alcohol and let dry. Choose a site on the side of the finger to minimize pain. Grasp the outer edge of the lancet. Twist cap and remove. Place lancet against side of the fingertip and press button firmly. Obtain a blood sample.</p> <p>Review of the facility's "Subcutaneous Medication Administration Policy" which was undated, revealed: prepare syringe and needle, swab rubber cap with alcohol sponge. Pull back plunger to draw a volume of air into the syringe equal to volume of medication to be given. Inject air into vial. Withdraw correct amount of medication.</p> <p>Observation of medication pass on 04/19/11 at 4:10 PM revealed Licensed Practical Nurse (LPN) #1 obtained a FSBS on Unsampler Resident A. The LPN cleaned the resident's finger with an</p>	F 281			

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F 281	<p>Continued From page 14</p> <p>alcohol pad, wiped the finger with a Kleenex, placed the lancet on the fingertip and pressed the button to obtain a blood sample. The LPN then squeezed the resident's finger to obtain a drop of blood, cleaned the resident's finger with a Kleenex, and again squeezed the resident's finger to obtain a drop of blood for the test strip.</p> <p>Interview with LPN #1, on 04/19/11, after the observation revealed she was taught to dry the finger after wiping with alcohol prior to a finger stick and also was taught not to use the first drop of blood because there could be tissue in the blood sample.</p> <p>Further observation revealed LPN #1 proceeded to inject air into the Novolin 70/30 Insulin vial, inject air into the Novolin R Insulin vial, draw up Novolin R two (2) units and then Novolin 70/30 Insulin twenty-five (25) units with an Insulin syringe. However, the vials were not cleaned with an alcohol pad prior to injecting air into the vials and drawing up the medication.</p> <p>Interview with LPN #1, after the observation, revealed she forgot to clean the Insulin vials prior to injecting air and drawing up the Insulin.</p> <p>7. Review of Resident #14's medical record revealed diagnoses which included Organic Brain Syndrome and Diabetes Mellitus.</p> <p>Review of the Physician's Orders dated 03/11/11 revealed orders for Silvadene Cream to the bilateral lower extremities every twelve hours, cleanse first with Normal Saline, then cream, then secure with Kerlex and paper tape.</p>	F 281		
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F 281	<p>Continued From page 15</p> <p>Observation of a skin assessment and dressing change on 04/21/11 at 5:00 PM revealed the resident had two (2) skin tears which were described by Registered Nurse (RN) #10 as a five (5) centimeter (cm) x seven (7) cm skin tear to the right anterior tibia and a ten (10) cm x nine (9) cm granulating tissue area to the left anterior tibia. Observation of the dressing changes to the areas revealed the RN #10 removed the soiled dressing from the right anterior tibia wound, wiped the wound with a dry Telfa Pad, applied silvadene with a cotton applicator, applied Telfa Dressing, and wrapped the wound with Kerlex. RN #10 proceeded to removed the soiled dressing from the left anterior tibia wound, wipe the wound with a dry Telfa Pad, apply Silvadene with a cotton applicator, apply a Telfa Dressing, and wrap the wound with Kerlex. Observation revealed the wounds were not cleansed with Normal Saline prior to applying Silvadene Cream and the dressing as per the Physician's Orders.</p> <p>Interview with RN #10 on 04/21/11 at 6:30 PM revealed he should have checked the Physician's Orders prior to performing the dressing change because he was unaware there were orders to clean the wound sites with Normal Saline prior to applying the Silvadene and the new dressing.</p> <p>Review of the facility "Dressings/Dry/Clean" Policy dated 06/05, revealed the preparation included verifying there was a Physician's Order for the procedure.</p>	F 281		
F 282 SS=D	<p>483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility</p>	F 282		

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F 282	<p>Continued From page 16</p> <p>must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, intervention, and record review it was determined the facility failed to follow the Comprehensive Plan of Care for three (3) of twenty-two (22) sampled residents (Resident's #2, #4, and #11). Resident #2 had a care plan intervention for no briefs while in bed and was observed to be in bed wearing briefs. Resident #4's care plan was not followed related to following the dieticians recommendations for a speech referral as indicated. Resident #11's plan of care included repositioning the resident every two hours, however, observation revealed the resident was not repositioned every two (2) hours.</p> <p>The findings include:</p> <p>Review of the facility's "Care Plan Policy and Procedure", undated, revealed a comprehensive care plan is developed and maintained for each resident that identifies the highest level of function the resident may be expected to attain. Each care plan should incorporate: problem areas, goals and interventions.</p> <p>1. Review of Resident #2's medical record revealed diagnoses which included Immobilization Syndrome, Dementia, Chronic Urinary Tract Infections and Failure to Thrive.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment dated 03/17/11 revealed the</p>	F 282	<p>1) All residents in the facility have interim or comprehensive care plans. Care is provided per the resident's plan of care. On April 20, 2011, a physician's order was given to allow Resident #2 to again utilize incontinence briefs. She is utilizing briefs per the updated comprehensive and C.N.A. care plans. Skin assessments are completed weekly by licensed nurses. The certified nursing assistants (CNAs) are instructed to inform the nurse of any changes to a resident's skin condition. Resident #11 had a skin assessment on April 15, 2011 and at that time had no pressure sores. The next skin assessment to be completed by the nurse was scheduled for April 22, 2011. The Stage I skin area was assessed on April 20, 2011. Immediate skin treatment interventions were implemented on Resident #11 and her care plan was revised to include the Stage I skin area interventions. Resident #11's Stage I skin area has healed. In addition, Resident #11 is being encouraged to allow staff to assist her to reposition and turn per her updated comprehensive and C.N.A. care plans. Resident #4 has been on the facility's Clinical-At-Risk program for weight loss since March 25, 2011. New interventions to include a diet consistency change, addition of supplements, x-ray analysis and medication changes were implemented at the time of the resident's weight loss. Resident #4's weight has increased to 154.2 pounds and her care plan interventions have been updated and are being followed.</p>	
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F 282	<p>Continued From page 17</p> <p>facility assessed Resident #2 as being cognitively impaired and total dependent on staff for activities of daily living, toileting, and dressing.</p> <p>Record review of the Comprehensive Plan of Care, dated 04/01/11, revealed Resident #2 was to not wear adult incontinence briefs.</p> <p>Record review of the Nurse Aide Care Plan/Assignment Sheet, dated 04/18/11, revealed "NO BRIEFS" for Resident #2.</p> <p>Record review of the Physician's orders, dated 04/01/11, revealed an order for "no briefs for now" for Resident #2.</p> <p>Observation on 04/20/11 at 9:30 AM revealed Resident #2 in bed clothed with briefs in place.</p> <p>Interview with State Registered Nurse Aide (SRNA) #1 on 04/20/11 at 12:05 PM, who was assigned to Resident #2, revealed when she checked Resident #2 to see if he/she was dry, the resident was noted to be wearing briefs. The resident was dry so she left Resident #2 in his/her briefs and failed to follow the written plan of care for "no briefs".</p> <p>Interview with Unit Manager on 04/20/11 at 3:55 PM revealed the resident had a skin breakdown that had resulted in the Physician's order for "no briefs" while in bed to further promote healing. Further interview revealed the resident's comprehensive care plan reflected that order, it just wasn't followed.</p> <p>2. Review of Resident #11's clinical record revealed diagnoses which included Delusional</p>	F 282	<p>2) All residents have the potential to be affected. Skin assessments were performed on 100% of current residents to identify any other skin areas on May 6, 2011 (EXHIBIT # 13). In addition, the C.N.A. assignment sheet will be revised as necessary by the unit manager to include a skin alert communication related to any resident with pressure sore interventions or status changes.</p> <p>3) All residents are being weighed weekly for the first 3 weeks of their residence to obtain a baseline for weight loss monitoring. In addition, a report showing any resident with an average meal intake of less than 50% for the last three meals and a report showing any significant changes with any resident will be completed daily for review and immediate interventions as indicated. The policy on the documenting and communicating of registered dietitian recommendations was written (EXHIBIT #14) and will be communicated by the Director of Nursing (DON) to the unit managers, registered dietitian, therapy director and Assistant DON. Re-education was provided to all nursing staff related to the implementation of the care plans and usage of the C.N.A. assignment sheets (EXHIBIT #15). An indicator will be incorporated into the facility's existing QA program to verify the resident's plan of care is being implemented as directed. This indicator will be a retrospective review of a 15% sample collected monthly for 3 months, then quarterly for 12 months.</p>	
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F 282	<p>Continued From page 18</p> <p>Disorder, Failure to Thrive, and Muscle Weakness. Review of the Quarterly Minimum Data Set Assessment dated 01/25/11 revealed the facility assessed the resident as requiring limited to extensive assistance with Activities of Daily Living and as having no pressure sores.</p> <p>Review of the Comprehensive Plan of Care dated 11/05/10 revealed the resident had the potential for alteration in skin integrity related to decreased mobility and the need for assistance with bed mobility, transfers, and ambulation. The approaches included ensuring a change of position for comfort and pressure relief every two hours.</p> <p>Observation of the resident on 04/19/11 at 11:00 AM, 04/19/11 at 4:15 PM, 04/20/11 at 11:00 AM, 2:00 PM, 4:00 PM, and 4:30 PM revealed she/he was sitting up in bed with the head of the bed at a forty-five (45) degree angle and her/his back against the bed.</p> <p>Observation of a skin assessment on 04/20/11 at 4:00 PM and 4:30 PM performed by Registered Nurse (RN) #10 revealed the resident had a reddened area to the lower back which remained red and non-blanchable after thirty minutes lying on her/his side. The RN described the area as a stage I circular two (2) centimeter (cm) x 2 cm red non-blanchable area. Interview at the time of the skin assessment with RN #10/wound nurse revealed the area was a Pressure Sore which had not been identified by the facility.</p> <p>Review of the facility Weekly Skin Assessments and the Nurse's Notes revealed there was no indication the facility was aware of the</p>	F 282	<p>4) The Director of Nursing will provide a report related to this indicator to the QA committee monthly for 3 months, then quarterly for 12 months.</p> <p>Compliance Date June 6, 2011</p>	
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F 282	<p>Continued From page 19</p> <p>Stage I Pressure Sore to the resident's lower back.</p> <p>Review of the Physician's Orders dated 04/11 revealed there was an Order for Remedy Nutrashield cream to be applied topically to the back curvature and coccyx twice a day. Review of the new Physician's Orders obtained by RN #10 dated 04/20/11 revealed orders to continue Remedy Nutrashield to the back and apply a Panacea mattress to the bed.</p> <p>Interview on 04/21/11 at 2:30 PM with Certified Nursing Assistant (CNA) #5 revealed she was assigned to the resident the first time that day and she had received no information in report regarding the resident having a Pressure Sore. Further interview revealed she was unaware the resident was to be assisted or encouraged to turn and reposition because the Aide Assignment Sheet which they carried in their pockets to refer to in order to provide care did not indicate the need for turning and repositioning</p> <p>Interview on 04/21/11 at 2:45 PM with Licensed Practical Nurse (LPN) #3 revealed she was assigned to Resident #11 and was aware the resident was to be encouraged to turn and reposition; however, she observed the resident to lie flat on her/his back most of the time. Continued interview revealed she informed the resident of the need to turn in the bed to prevent a pressure ulcer; however, did not document the teaching. Continued interview revealed she had received no information in report in reference to the resident have a Pressure Sore on the back, and had therefore not instructed to aides to ensure the resident stayed off her/his back as</p>	F 282		
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F 282	<p>Continued From page 20 much as possible.</p> <p>Interview on 04/22/11 at 10:00 AM with Certified Nursing Assistant (CNA) #9 revealed she was unaware the resident had a reddened area on the back; however, the resident layed on her/his back all day long in the bed. She stated she did not offer to assist the resident with turning and positioning or encourage the resident to move about. She further stated she had received no new information in report related to the resident having a Pressure Sore on the back.</p> <p>Interview on 04/21/11 at 3:30 PM and 04/22/11 at 11:00 AM with the Unit Manager where Resident #11 resided revealed the staff should be asking the resident to turn in the bed. Further interview revealed the staff should have received information in report related to the skin breakdown which was identified on 04/20/11.</p> <p>Interview on 04/22/11 at 11:00 AM with RN #10 revealed he had notified the nurse on duty of the residents skin breakdown which was noted on 04/20/11 and staff should have received the information in report. Continued interview revealed the nurses were responsible for ensuring the Plan of Care was followed related to the the resident changing positions, especially after a Pressure Sore was identified.</p> <p>2. Review of Resident #4's clinical record revealed diagnoses which included Alzheimer's Disease and Dysphagla. Review of the Annual Minimum Data Set (MDS) Assessment dated 03/25/11 revealed the facility assessed the resident as having moderate impairment in cognitive skills for decision making and as</p>	F 282		
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F 282	<p>Continued From page 21 requiring limited to extensive assistance with Activities of Daily Living.</p> <p>Review of the Care Area Assessment Summary (CAAS) dated 03/28/11 revealed the resident had a significant weight loss, was eating poorly, and had complaints of pain when eating. Continued review revealed a Speech Therapy referral was made for appropriate diet consistency.</p> <p>Review of the Comprehensive Plan of Care dated 03/28/11 revealed the resident had a potential alteration in nutritional status related to a diagnosis of Alzheimer's Disease, poor intake, significant weight loss, and complaints of pain when eating. Interventions included a speech therapy referral as indicated for diet consistency.</p> <p>Review of the Weight Flow Record revealed Resident #4's weight on 02/05/11 was 166 pounds. Review of the resident's weight on 03/21/11 was 149.6 pounds.</p> <p>Review of the Nutritional Progress Notes, dated 03/24/11, revealed the resident's weight was 149.6 pounds which indicated a decrease of fourteen pounds and a 10% (percent) weight loss in one month. "Will request a Complete Blood Count (CBC) and a Comprehensive Metabolic Panel (CMP)". Further review revealed the Dieticians recommendations were to add 120 milliliters of Resource 2.0 three times a day between meals and request a Speech Therapy Referral related to holding food, Clinical At Risk monitoring, and weekly weights.</p> <p>Review of the 02/11 Physician's Orders revealed orders for a Mechanical Soft Diet. Continued</p>	F 282		
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F 282	<p>Continued From page 22</p> <p>review revealed Physician's Orders dated 03/07/11 which stated, clarification to change diet to Mechanical Soft, No added Salt (NAS). Physician's Orders dated 03/25/11 revealed orders for Resource 2.0 120 milliliters three times a day as a dietary recommendation and an X-Ray of the right side of the face due to pain. Physician's Orders dated 03/28/11 revealed orders for Nystatin (anti-fungal agent) five (5) cubic centimeters (cc's) swish and swallow four times a day for ten days, oral gel (medication used for mouth pain) to the right side every four hours as needed for pain and routinely at night for two weeks.</p> <p>However, there was no documented evidence of Physician's Orders related to the dietary recommendations made on 03/24/11 for the CBC and CMP, and the Speech Therapy Referral.</p> <p>Interview on 04/21/11 at 9:00 AM with Registered Nurse #1/Unit Manager, revealed the dietician gave copies of the dietary recommendations which were on a form, to the unit manager, and the DON and she or the staff nurse on the unit were to contact the physician to notify him of dietary recommendations. Continued interview revealed she usually wrote a note in the Progress Notes when notifying the physician of the dietary recommendations and forwarded the form to the Director of Nursing (DON) after contacting the physician; however, could find no evidence the Physician was notified of the dietary recommendations from 03/24/11.</p> <p>Interview on 04/21/11 at 9:15 AM Dietician revealed she was aware Resident #4's intake was down which and she recommended the diet</p>	F 282		
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F 282	<p>Continued From page 23</p> <p>change on 03/07/11 for a Mechanical Soft, No Added Salt Diet. Further interview revealed she was unaware the recommendations written by her on 03/24/11 for the Speech Therapy referral and the labs had not been followed.</p> <p>Interview with the Director of Nursing (DON) on 04/21/11 at 9:30 AM revealed she was unable to find her copy of the Dietary Recommendation Form for 03/24/11 in her files and was unsure if the Physician had been notified of the recommendations. Further interview revealed the facility had no policy related to dietary recommendations.</p> <p>Interview on 04/21/11 at 4:00 PM with the Attending Physician revealed the nurses usually called him with dietary recommendations; however he could not remember if he was notified of the dietary recommendations from 03/24/11 for Resident #4. Continued interview revealed he probably would have ordered the labs and the Speech Therapy Consult as recommended by the Dietician if he had been notified of the Dieticians recommendation.</p>	F 282		
F 309 SS=E	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 309	<p>1) Residents are provided the necessary care and services at this facility to maintain their highest, practical well-being. There have been no negative outcomes for residents. Resident #2, #4, #11, #12 and #17 had no adverse outcomes related to the facility's bowel protocol. All five of these residents have been monitored to ensure bowel movements are addressed.</p>	

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F 309	<p>Continued From page 24</p> <p>by: Based on observation, interview, and record review it was determined the facility failed to ensure residents were provided the necessary care and services to maintain the highest physical well being. The facility failed to follow the bowel protocol for Resident #2, #4, #11, #12 and #17. In addition the facility allowed volunteers to trim residents' fingernails without proper education.</p> <p>The findings include:</p> <p>A review of the facility's policy "Bowel Protocol", dated 03/2011, revealed the bowel protocol may be implemented if there is a physician's order for bowel protocol and a resident has not had a bowel movement for three (3) days. Further review revealed the bowel protocol stated to administer thirty (30) cubic centimeters(cc) of Milk of Magnesia (MOM) on day shift early morning and monitor the resident during the shift for results. If MOM is ineffective administer Dulcolax suppository early during the evening shift and monitor for results. After supper, if the suppository is ineffective, administer a Fleets Enema and monitor for results. If no results by the end of the shift notify the physician for further interventions.</p> <p>1. Review of Resident #2's medical record revealed diagnoses which included Immobilization Syndrome, Dementia and Failure to Thrive.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 03/17/11 revealed the facility assessed Resident #2 as being cognitively impaired, as having total bowel incontinence, and</p>	F 309	<p>The facility has a policy on the care of nails (EXHIBIT #18). In addition, the facility has an organized volunteer program that includes an applicable orientation to the volunteer's permissible roles. Per the facility's existing policy, the volunteers were to be doing only filing and painting of fingernails. The facility has never given a volunteer permission to trim resident's fingernails. An appropriate facility staff member was assigned to assist the volunteers as needed immediately on the day referenced in the survey.</p> <p>2) A 100% sample of all residents was conducted to ensure all physician's orders were implemented per the plan of care (EXHIBIT #16). All residents had their bowel records reviewed. No residents were found to be in need of intervention with the bowel protocol.</p> <p>3) The facility revised the bowel protocol policy (EXHIBIT #8). In addition, a new Treatment Administration Record (TAR) was developed for documentation of the implementation of the bowel protocol for use by all facility residents as indicated (EXHIBIT #9).</p> <p>The facility's volunteer coordinator will re-educate the volunteers on the facility's policy for the care of nails and will provide closer monitoring of their activities to ensure compliance.</p>	
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F 309	<p>Continued From page 25 being totally dependent on staff for incontinence care.</p> <p>Record review of Resident #2's Monthly Physician Orders, dated 04/2011, revealed an order for "Bowel Protocol".</p> <p>Review of the Resident #2's Bowel Shift Chart revealed no documented evidence of bowel elimination from 04/04/11 through 04/11/11, eight (8) days and from 04/12/11 through 04/17/11, six (6) days.</p> <p>Review of the April Medication Administration Record (MAR) revealed no documented evidence that the prescribed "bowel protocol" medications were given to Resident #2 during the eight (8) day and six (6) day periods with bowel elimination.</p> <p>Interview with the Unit Manager on 04/21/11 at 5:48 PM confirmed there was no documented evidence in Resident #2's medical record that Physician's orders for bowel protocol were followed 04/07/11 through 04/11/11 or 04/15/11 through 04/17/11.</p> <p>Interview with Director of Nursing (DON) on 04/22/11 at 9:00 AM revealed the facility had failed to follow the facility policy for Bowel Protocol, dated 03/2011. She further stated Resident #2's physician's orders for bowel protocol were not followed on two (2) different occasions in April.</p> <p>2. Review of Resident #4's medical record revealed diagnoses which included Alzheimer's Dementia. Review of the Annual MDS Assessment dated 03/25/11 revealed the facility</p>	F 309	<p>The nursing staff will be educated by the Director of Nursing on the revised bowel protocol and revised recording system for documenting resident's bowel movements.</p> <p>An indicator will be incorporated into the facility's, existing QA program to monitor residents that have had no bowel movement after 3 days are receiving the bowel protocol interventions with supporting documentation. This audit will be done monthly for 12 months.</p> <p>4) The Director of Nursing will provide a report to the QA committee monthly for 12 months.</p> <p>Compliance Date June 6, 2011</p>	

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F 309	<p>Continued From page 26</p> <p>assessed the resident as having moderate impairment in cognitive skills for decision making, requiring limited to extensive assistance with Activities of Daily Living, as being occasionally incontinent of bladder, and continent of bowel.</p> <p>Review of the Monthly Physician Orders, dated 02/2011, revealed an order for "Bowel Protocol". Further review revealed Orders for Milk of Magnesia 400 Milligrams/ 5 milliliters oral suspension/Administer thirty (30) milliliters once daily as needed for constipation (medication used for constipation).</p> <p>Review of the Bowel Shift Chart revealed no documented evidence of bowel elimination from 02/10/11 through 02/20/11, eleven (11) days.</p> <p>Review of the Medication Administration Record (MAR) dated February 2011, revealed no documented evidence the Milk of Magnesium medication was administered as ordered for constipation until 02/20/11 at 8:00 PM..</p> <p>Interview with Licensed Practical Nurse (LPN) #4 who was consistently assigned to Resident #4, revealed the resident would take herself/himself to the bathroom at times and staff would be unaware if the resident had a bowel movement. Further interview revealed the day shift supervisor printed out a list daily from the computer of residents who had not had a bowel movement in three (3) days. She further stated the supervisor would bring a list to each nurses station daily and alert the nurses of which residents needed laxatives. She stated the Certified Nursing Assistants (CNA's) documented the bowel movements in the kloske which was in the</p>	F 309		

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F 309	<p>Continued From page 27 hallway; and she was unaware of the resident having any problems with constipation.</p> <p>Interview on 04/21/11 at 3:30 PM with CNA #6 revealed she was assigned to the resident and the resident had to be tolleted before and after meals and before bed. She further stated the resident never tried to take self to the bathroom and had no Incontinent episodes.</p> <p>Interview on 04/22/11 at 3:00 PM with CNA #7 who was assigned to the resident, revealed she was consistently assigned to the resident and the resident did not take self to the bathroom. She further stated the resident sometimes went several days without a bowel movement and she would tell the nurses.</p> <p>Interview on 04/22/11 at 11:15 AM with the Director of Nursing (DON) revealed Resident #4 had shown no signs of constipation such as abdominal distention in 02/11. She stated there was a documentation issue related to the staff using the kioske to document bowel movements. She further stated the facility had identified there was a concern with the documentation of bowel movements and in March 2011 the facillity started having the day shift supervisor take lists to the units to alert the nurses of residents who had not had a bowel movement in three days.</p> <p>3. Record review revealed the facillty admitted Resident #11 on 10/24/10 with diagnoses which included Failure to Thrive, Hyponatremia, Difficulty Walking, Metabolic Alkalosis and Colon Cancer.</p> <p>Review of the Quarterly MDS Assessment, dated</p>	F 309		
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F 309	<p>Continued From page 28</p> <p>01/25/11 revealed the facility assessed Resident #11 as being cognitively intact. Resident #11 was also assessed as being frequently incontinent of bowel.</p> <p>Review of the bowel record revealed no documented evidence Resident #11 had a bowel movement from 03/07/11 through 03/18/11 a total of eleven (11) days.</p> <p>Review of the March, 2011 MAR revealed no documented evidence the bowel protocol had been initiated during this time frame.</p> <p>Review of the Nursing Notes revealed there was no documented evidence the bowel protocol had been initiated during this time frame.</p> <p>Interview with the DON on 04/21/11 at 10:23 AM revealed every morning the unit managers will go through the whole building and ask residents whether or not they have had a bowel movement. She stated the facility does not document in the medical record if the resident states they have or have not had a bowel movement or the action taken. She further indicated for residents who were incapable of responding to this question the facility would probably go ahead and treat them as though they had not and initiate the bowel protocol if there was no documented evidence of a bowel movement in the past three (3) days.</p> <p>Interview with the DON on 04/21/11 at 4:00 PM revealed the bowel protocol process was to be implemented for a resident who went nine (9) shifts with no bowel movement. She confirmed through interview there was no documentation on the MAR, the bowel protocol had been initiated</p>	F 309		
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F 309	<p>Continued From page 29 for Resident #11.</p> <p>4. Review of Resident #12's medical record revealed the facility admitted the resident on 12/02/08 with diagnoses which included Symbolic Dysfunction, Other Specified Organic Brain Symptoms, Alzheimer's, and Depression. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 01/21/11 revealed the facility assessed the resident as always continent of bowel.</p> <p>Review of the Physician's orders revealed an order for "Bowel Protocol" dated 10/10/10 and an order for a medication Senokot S (Laxative) dated 10/23/10 for constipation.</p> <p>Review of the bowel records for Resident #12 revealed no documented bowel movements for the following intervals: 02/19/11 thru 02/28/11, a total of nine (9) days; 03/10/11 thru 03/16/11 a total of seven (7) days; and 03/20/11 thru 03/25/11 a total of six (6) days. Further review of Resident #12's MAR for February and March 2011 revealed the Bowel Protocol medications were not administered during these months. Further review revealed no evidence the Senokot was given as ordered.</p> <p>Review of the Nurse's Notes for February and March 2011 revealed no documentation of assessment for constipation problems or physician notification.</p> <p>Interview with Unit Manager #1 on 04/21/11 at 5:30 PM regarding the facility's process for identifying residents with constipation problems revealed the current process was that a report</p>	F 309		
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F 309	<p>Continued From page 30</p> <p>was run that listed residents who had not had a bowel movement for three days. The day shift supervisor would ask if the resident had a bowel movement to determine if any follow-up action was needed. Further interview with Unit Manager #1 revealed Resident #12 was independent in toileting and didn't always report his/her bowel movements.</p> <p>5. Review of Resident #17's medical record revealed diagnoses which included Parkinson's Disease, Paranoid Psychoses, and Alzheimer's.</p> <p>Resident #17 had been assessed on 03/07/11, during an Admission MDS Assessment performed by the facility as being cognitively intact and being continent of bowel.</p> <p>Record review of Resident #17's Physician's Orders dated 04/11, revealed an order for "Bowel Protocol."</p> <p>Review of Resident #17's Bowel Shift Chart revealed no documented evidence of bowel elimination from 02/28/11 through 03/09/11, a period of nine (9) days, from 03/16/11 through 03/23/11, a period of six (6) days, from 03/23/11 through 03/31/11, a period of seven (7) days, and from 03/31/11 through 04/13/11, a period of thirteen (13) days.</p> <p>Review of the MAR for the months of 02/11 through 04/11 revealed no documented evidence that the prescribed "bowel protocol" medications were given to Resident #17.</p> <p>6. Review of the facility's policy titled "Nail Care,"</p>	F 309		
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203
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F 309	<p>Continued From page 31</p> <p>not dated, revealed the guidelines were nails were to be cleaned and clipped on shower days and diabetic toe nails are clipped by a Nurse or Podiatrist only. It further revealed the facility's procedure was to clean under nails with orange stick, clip nails to maintain short length or per resident preference, diabetic toe nails were to be clipped by a Nurse or Podiatrist and the clippers were to be cleaned between patient's with wipes.</p> <p>Observation on 04/20/11 at 10:30 AM revealed volunteers who were assisting residents with nail care (painting and filing) in the sitting area on the first floor of the facility. It was also noted the volunteers were asking for a Nurse to assist them with cutting finger nails and staff continued to walk by without acknowledging the Volunteer's request for a period of thirty (30) minutes.</p> <p>Interview with Volunteer #17 on 04/20/11 at 10:45 AM revealed they are always scheduled to come on the third Wednesday of every month and they have never had to wait on a Nurse before to cut nails. She further indicated Volunteer #18 is a retired Registered Nurse (RN) and had always cut the residents' nails for them. She stated both herself and Volunteer #18 were told that morning they would need a Nurse to cut nails for them.</p> <p>Interview on 04/20/11 at 10:55 AM with the DON revealed she stated she was "too busy to go do it," and she would try to find someone who could.</p> <p>Interview on 04/22/11 at 10:13 AM with the DON revealed she was unaware volunteers cut residents' fingernails. She further indicated in a discussion she had with the Activities Director revealed she had seen the volunteers trying to cut</p>	F 309		
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F 309 Continued From page 32
nails and had redirected them and told them they could not cut residents' nails. She stated the volunteers have not been trained to cut finger nails.

Interview on 04/22/11 at 10:23 AM with the Activities Director revealed she had, on very rare occasions, heard the volunteers were clipping nails. She indicated Nursing staff should be the only ones who can cut nails.

F 312 483.25(a)(3) ADL CARE PROVIDED FOR SS=D DEPENDENT RESIDENTS

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, it was determined the facility failed to provide necessary services to maintain grooming for two (2) of twenty-two (22) residents, (Resident #2 and #13). Resident #2's fingernails were long, and Residents #2 and #13 had a dark substance under their fingernails.

The findings included:

Review of the facility's "Nail Care Policy and Procedure", undated, revealed nails are to be cleaned and clipped on shower days. Further review revealed specific instructions to clean under nails with an orange stick and clip nails to maintain short length.

F 309

F 312

1) The facility has a policy in effect of the care of nails. Resident #2 and #13 nails were clipped and cleaned.

2) A 100% sample of resident's nails will be conducted (EXHIBIT # 17). The facility identified 5 residents that requested or we determined that needed additional nail care. This nail care was provided upon identification, request or need.

3) The policy on nail care was revised (EXHIBIT #18) and nail care instructions are being added to the C.N.A. assignment sheet. In addition, all nursing staff will be re-educated by the Director of Nursing on the provision of ADL care including fingernail care. An indicator will be incorporated into the facility's, existing QA program to verify that residents are provided ADL care in accordance to the standard of practice. This indicator will be concurrent and collected by the unit managers monthly for 3 months and then quarterly for 12 months utilizing a 15% sample.

4) The Director of Nursing will provide a report to the QA committee monthly for 3 months, then quarterly for 12 months.

Compliance Date June 6, 2011

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F 312	<p>Continued From page 33</p> <p>Review of the facility's policy, "Quality of Life-Dignity", revised 2009, revealed each resident should be cared for in a manner that promotes quality of life and resident's nails shall be groomed as they wish to be groomed and that cognitively impaired residents should be assisted to maintain his/her self-worth.</p> <p>1. Record review revealed the facility admitted Resident #2 on 06/25/11 with diagnoses which included Dementia, Immobility and Failure to Thrive. A review of the Quarterly Minimum Data Set (MDS) Assessment, dated 03/17/11, revealed the facility assessed the resident's personal hygiene as "totally dependent".</p> <p>Observation of Resident #2 on 04/19/11 at 5:55 PM revealed long fingernails on both hands. Several nails extended in excess of .5 centimeters over the tips of his/her fingers. Further observation revealed a dark colored substance under the resident's fingernails.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 04/20/11 at 2:30 PM revealed she assigned someone to clean and cut Resident #2's nails after the surveyor identified the long nails with dark substance embedded under the nail tips.</p> <p>2. Resident #13 was admitted to the facility on 03/24/11 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Hypertension (HTN), and Anemia. A review of Resident #13's Admission MDS Assessment dated 04/03/11 revealed the facility assessed Resident #13 as requiring extensive assistance with hygiene.</p>	F 312		
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F 312	Continued From page 34 Observation of Resident #13 on 04/20/11 at 11:40 AM revealed a dark substance beneath his/her fingernails. Staff had already provided morning grooming care, but there was no evidence Resident #13's nails had been cared for. Interview with Registered Nurse (RN) #3 on 04/22/11 at 9:30 AM revealed the aide assigned to care for the resident on shower days was to provide nail care. She further stated nail care can be done more frequent if needed, therefore a resident's nails should never be too long.	F 312		
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 observation, interview, and record review, it was determined the facility failed to ensure resident's do not develop pressure sores unless the individual's clinical condition demonstrates it was unavoidable for one (1) of twenty-two (22) sampled residents (Resident #11). Resident #11 was observed to have an unidentified Stage I Pressure Sore to the lower back on 04/20/11; however, interviews with direct care staff and nurses on 04/21/11 and 04/22/11	F 314	1) The facility has an existing program for the prevention and treatment of pressure sores. Skin assessments are completed weekly by licensed nurses. CNAs are instructed to inform the licensed nurse of any changes to a resident's skin condition. Resident #11 had a skin assessment on April 15, 2011 and that time had no pressure sores. The next skin assessment by the licensed nurse was scheduled for April 22, 2011. The Stage I pressure area was assessed on April 20, 2011. As a result, immediate treatment interventions were implemented for Resident	

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F 314	<p>Continued From page 35 assigned to the resident revealed they were unaware of the new skin breakdown and had received no new information related to the need for the resident to be repositioned.</p> <p>The findings include:</p> <p>Review of the facility policy "Pressure Ulcers", no date noted, revealed repositioning programs are considered for residents with a pressure ulcer or who are at risk of developing one.</p> <p>Review of Resident #11's medical record revealed diagnoses which included Delusional Disorder, Failure to Thrive, and Muscle Weakness. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 01/25/11 revealed the facility assessed the resident as requiring limited to extensive assistance with Activities of Daily Living and as having no pressure sores.</p> <p>Review of the Comprehensive Plan of Care dated 11/05/10 revealed the resident had the potential for alteration in skin integrity related to decreased mobility and required assistance with bed mobility, transfers, and ambulation. The interventions included ensuring a change of position for comfort and pressure relief every two hours.</p> <p>Observation of the resident on 04/19/11 at 11:00 AM, 04/19/11 at 4:15 PM, 04/20/11 at 11:00 AM, 2:00 PM, 4:00 PM, and 4:30 PM revealed she/he was sitting up in bed with the head of the bed at a forty-five (45) degree angle and her/his back was against the bed.</p>	F 314	<p>#11. Resident #11's care plan was revised to include the Stage I pressure area and associated interventions. Resident #11's Stage I pressure area has healed.</p> <p>2) Skin assessments were completed on 100% of residents on May 6, 2011 to determine any other pressure areas (EXHIBIT #13). The facility identified one resident with one Stage I area. Immediate intervention was taken and the area has healed.</p> <p>3) Any resident with pressure areas will have a skin alert added to the C.N.A. assignment sheet by the unit manager to communicate any new pressure areas and associated interventions. In addition, education will be held with all nursing staff by the Director of Nursing (DON) related to skin assessments, skin treatments and</p>	
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F 314	<p>Continued From page 36</p> <p>Observation of a skin assessment on 04/20/11 at 4:00 PM performed by Registered Nurse (RN) #10 revealed the resident had a reddened areas to the lower back. The resident was assisted to turn to the left side, off her/his back, to relieve pressure to the reddened area. Further observation on 04/20/11 at 4:30 PM revealed the area of redness on the lower back remained red and RN #10 described the area as a Stage I, circular two (2) centimeter (cm) x 2 cm red, non-blanchable area. Interview at the time of the skin assessment with RN #10/wound nurse revealed the area was a Pressure Sore and he would notify the Physician.</p> <p>Review of the facility Weekly Skin Assessments and the Nurse's Notes revealed there was no indication the facility was aware of the Stage I Pressure Sore to the resident's lower back prior to the 04/20/11 skin assessment.</p> <p>Review of the Physician's Orders dated 04/11 revealed there was an order for Remedy Nutrashield cream to be applied topically to the back curvature and coccyx twice a day. Review of Medication Administration Record (MAR) revealed the Remedy Nutrashield cream had been signed off indicating the Cream had been applied.</p> <p>Review of the Physician's Orders dated 04/20/11 revealed orders to continue Remedy Nutrashield to the back and apply a Panacea mattress to the bed.</p> <p>Interview on 04/21/11 at 2:30 PM with Certified Nursing Assistant (CNA) #5 revealed she was assigned to the resident the first time that day.</p>	F 314	<p>communication of the resident's plan of care (EXHIBIT #15). Prevalence of skin breakdown is an existing and continuing indicator in the facility's QA program. Data on this indicator will continue to be collected monthly for 12 months.</p> <p>4) The DON will provide a report to the QA committee related to this indicator monthly for 3 months, then quarterly for 12 months.</p> <p>Compliance Date – June 6, 2011</p>	
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F 314	<p>Continued From page 37</p> <p>She stated the aides were to refer to the Aide Assignment Sheet which they carried in their pockets in order to provide care. She reviewed the Sheet and stated there was no information on the sheet in reference to turning and repositioning and she assumed the resident was independent in bed mobility. She further stated she had received no information in report regarding the resident having a Pressure Sore and the need for encouragement or assistance with turning and repositioning in the bed.</p> <p>Interview on 04/21/11 at 2:45 PM with Licensed Practical Nurse (LPN) #3 revealed she was assigned to Resident #11. She stated the resident was to be encouraged to turn and reposition; however, she observed the resident to lie flat on her/his back most of the time. She stated she educated the resident several times in reference to the need to turn in the bed to prevent a pressure ulcer; however, did not document the teaching. Continued interview revealed she had received no information in report in reference to the resident have a Pressure Sore on the back.</p> <p>Interview on 04/22/11 at 10:00 AM with Certified Nursing Assistant (CNA) #9 revealed the resident had refused her/his bath on 04/18/11 and she assisted the resident with a bed bath. She further stated she was unaware the resident had a reddened area on the back; however, the resident layed on her/his back all day long in the bed. She stated the resident was capable of positioning self and she did not offer to assist the resident with turning and positioning. She further stated she had received no new information in report related to the resident having a Pressure Sore on the back and had received no</p>	F 314		
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F 314	<p>Continued From page 38</p> <p>instruction related to ensuring the resident was encouraged to turn in the bed.</p> <p>Interview on 04/21/11 at 3:30 PM and 04/22/11 at 11:00 AM with the Unit Manager, where Resident #11 resided, revealed the staff did not go in and physically assist the resident with turning and repositioning; however, should be asking the resident to turn in the bed. She stated if the resident was non-compliant with turning and repositioning, it should have been documented in the progress note. She stated the resident should be educated to turn and reposition; however, she had not talked to the resident in reference to the need for repositioning. Continued interview revealed the staff should have received information in report related to the skin breakdown which was identified on 04/20/11.</p> <p>Interview on 04/22/11 at 11:00 AM with RN #10 revealed he had notified the nurse on duty of the residents skin breakdown which was noted on 04/20/11 and she should have informed the other staff during shift report. He further stated the aides should have been instructed to ensure they encouraged the resident to turn and reposition. He stated the nurses were responsible for ensuring the Plan of Care was followed related to the resident changing positions, especially after a Pressure Sore was identified.</p>	F 314		
F 315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>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</p>	F 315		

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F 315	<p>Continued From page 39</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure incontinence care was provided in a timely manner for one (1) of twenty-two (22) sampled residents, (Resident #2). Resident #2 was observed to be left for over thirty (30) minutes wearing an adult incontinence brief which staff had identified as being wet.</p> <p>The findings include:</p> <p>Review of the facility's policy, "Incontinence-Toileting Program", dated 03/2010, revealed the objective is to prevent skin breakdown and keep residents maximally dry. Further review revealed residents who are frequently incontinent should be checked to determine if wet or dry and changed if necessary.</p> <p>Review of Resident #2's medical record revealed diagnoses which included Immobilization Syndrome, Dementia, Chronic Urinary Tract Infections and Failure to Thrive.</p> <p>Resident #2 had been assessed by the facility as being cognitively impaired on a Quarterly Minimum Data Set (MDS) Assessment dated 03/17/11. The resident was also assessed as "total dependence" related to activities of daily</p>	F 315	<p>1) The facility has a comprehensive bladder program which includes the assessment of bladder function and toileting programs as appropriate. Catheterizations are done in adherence to regulations and standards of practice. Urinary tract infections are monitored as part of the facility's existing infection control surveillance practices. Resident #2's incontinence brief was changed and perineal care was given. Resident #2 had no negative outcomes.</p> <p>2) A 100% sample of residents were checked for incontinence brief wetness. No other problems were identified. Thus, no additional corrective action was indicated.</p>	
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F 315	<p>Continued From page 40 living for toileting and dressing.</p> <p>Observation of the Resident #2 on 04/20/11 at 9:35 AM revealed Licensed Practical Nurse (LPN) #2 refastened Resident #2's adult incontinence brief which she noted to be wet with urine.</p> <p>Observation on 04/20/11 at 10:05 AM revealed State Registered Nurse Aide (SRNA) #1 entered Resident #2's room. At 10:08 AM surveyor requested Assistant Director of Nursing (ADON) have someone check and change Resident #2's adult incontinence brief. Observation on 04/20/11 at 10:10 AM revealed SRNA #1 was sitting at Resident #2's bedside getting ready to perform nail care. SRNA #1 acknowledged to the ADON she had been asked by LPN #2 to change the resident's brief and clean and cut his/her nails. In SRNA #1's discussion with the ADON she further stated she had not changed the resident's brief, but agreed to change her at that time.</p> <p>Interview on 04/20/11 at 1:40 PM with SRNA #1 revealed providing care to a resident who had been incontinent of urine would be a priority before providing routine care for that resident and she should have changed Resident #2 because she knew the resident was in a wet brief prior to starting nail care.</p> <p>Interview on 04/20/11 at 2:30 PM with LPN #2 revealed she should not have refastened the brief, knowing that Resident #2 was wet with urine.</p>	F 315	<p>3) Nurse #2 was counseled appropriately for her actions related to Resident #2's perineal care. In addition, education will be provided to the nursing staff by the Director of Nursing (DON) related to the bladder program and proper bladder incontinence care (EXHIBIT # 19). Lastly, infection control surveillance related to urinary tract infections is an existing part of the facility's QA program. An indicator will be incorporated into the facility's QA committee related to the verification of resident's incontinence briefs being changed appropriately and timely. This indicator will be a concurrent review by observation collected by the unit</p>	
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident</p>	F 323		

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F 323	<p>Continued From page 41 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 observation, interview, and record review it was determined the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one (1) of twenty-two (22) sampled residents (Resident #3). Resident #3 was observed on 04/20/11 at 12:20 PM being transported in a wheelchair, which had no foot pedals/support, a distance of over forty (40) feet, with the resident's feet dragging on the ground.</p> <p>The findings include:</p> <p>Review of the medical record revealed the facility admitted Resident #3 on 12/11/09 with diagnoses which included Dementia, Parkinson's Disease, Debility, Organic Brain Syndrome, Behavior Disturbance and Ischemic Heart Disease.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 03/17/11, revealed the facility assessed the resident as being severely cognitively impaired in making decisions regarding tasks of daily life. Further review revealed that Resident #3 required total assistance of staff for physical functioning/locomotion of his/her wheelchair.</p>	F 323	<p>managers monthly for 12 months.</p> <p>4) The DON will provide a report to the QA committee monthly for 12 months.</p> <p>Compliance Date – June 6, 2011</p> <p>1) This facility maintains an environment that minimizes accidents and the potential for accidents. Residents are assessed for needs and assistive devices are used when appropriate. Resident #3 has foot board in place and the need for this foot board is included on the C.N.A. assignment sheet.</p> <p>2) All residents with orders for adaptive equipment or assisted devices will be reviewed to ensure the appropriate equipment</p>	
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F 323	<p>Continued From page 42</p> <p>Record review of the Physical Therapy Evaluation, dated 04/20/11, noted the resident's needs for safety included a footboard for the wheelchair because of adduction of his/her legs and knees.</p> <p>Observation on 04/20/11 at 12:20 PM revealed a non-clinical staff person pushing Resident #3 in his/her wheelchair from the elevator on the ground floor to the dining area, a distance of over forty (40) feet. The resident had non-skid socks on his/her feet and they were noted to be dragging on the floor during transport.</p> <p>Interview with Non-clinical staff person #13 on 04/20/11 at 12:30 PM revealed she was unaware Resident #3 had foot pedals for support.</p> <p>Observation on 04/20/11 at 12:45 PM revealed physical therapy and the Assistant Director of Nursing (ADON) placing foot supports on Resident #3's wheelchair.</p> <p>Interview with the Director of Nursing (DON) on 04/21/11 at 4:05 PM revealed Non-clinical staff person #13, who was observed transporting Resident #3 on 04/20/11, was not trained to transport residents but had been helping that day to move residents away from the elevator and into the dining room for the noon meal, to prevent that area from becoming congested.</p> <p>Interview on 04/22/11 at 9:15 AM, with Physical Therapist #11, revealed he assessed Resident #3 and determined he/she needed a footboard to sit on top of the foot plates when being transported in the wheelchair because of safety concerns. He further stated because of the</p>	F 323	<p>is in place. All residents with orders for adaptive equipment or assisted devices were found to have the appropriate equipment or devices.</p> <p>3) The facility has designed a form for communication from rehabilitation to nursing on changes to plans of care (EXHIBIT # 20). The rehabilitation director will educate the rehabilitation staff on this new form. In addition, all facility staff will be educated on precautions of transporting residents that wheelchair-bound. Lastly, an indicator will be incorporated in to the facility's existing QA program related to the verification of the proper implementation of all resident's adaptive equipment or assistive devices onto</p>		

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F 323	Continued From page 43 resident's muscle tone, proper support of his/her feet was needed to prevent the resident from dragging his/her feet and causing injury. Observation on 04/22/11 at 9:35 AM revealed Resident #3 sitting in a wheelchair in his/her room which had no foot support in place. Interview on 04/22/11 at 9:40 AM with State Registered Nursing Assistant (SRNA) #8 revealed she was unaware that Resident #3 (assigned to her care) needed any foot equipment on his/her wheelchair. Further interview revealed there was equipment in the room, but not currently on the wheelchair. She further stated device/equipment needs would have been communicated by the nurse or on the report/assignment sheet if the resident needed foot pedals and footboard on his/her wheelchair when being transported.	F 323	the care plan and C.N.A. assignment sheet. This indicator will be a concurrent review collected by observation by the unit managers monthly for 12 months. 4) The DON will provide a report of the audit results to the QA committee monthly for 12 months. Compliance Date – June 6, 2011	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was	F 325	1) Resident #4 has been on the facility's Clinical-At-Risk program for weight loss since March 25, 2011. Interventions have included diet consistency change, addition of supplements, x-ray analysis and medication changes. Resident #4's weight	

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F 325	<p>Continued From page 44</p> <p>determined the facility failed to ensure residents maintain acceptable parameters of nutritional status for one (1) of twenty-two (22) sampled residents (Resident #4). Resident #4 was noted to have a 6% weight loss documented from 02/05/11 through 03/01/11; however, there was no documented evidence of a nutritional intervention until 03/07/11. In addition, there was no documented evidence the physician was notified of the dietician's recommendations dated 03/24/11.</p> <p>The findings include:</p> <p>Review of Resident #4's medical record revealed diagnoses which included Alzheimer's Disease and Dysphagia. Review of the Annual Minimum Data Set (MDS) Assessment dated 03/25/11 revealed the facility assessed the resident as having moderate impairment in cognitive skills for decision making and as requiring limited to extensive assistance with Activities of Daily Living.</p> <p>Review of the Care Area Assessment Summary (CAAS) dated 03/28/11 revealed the resident had a significant weight loss, was eating poorly, and had complaints of pain when eating. Further review revealed a Speech Therapy referral was made for appropriate diet consistency.</p> <p>Review of the Comprehensive Plan of Care dated 03/28/11 revealed the resident had a potential alteration in nutritional status related to a diagnosis of Alzheimer's Disease, poor intake, significant weight loss, and complaints of pain when eating. Interventions included a speech therapy referral as indicated for diet consistency.</p>	F 325	<p>has increased to 154.2 pounds representing a 4.6 pound gain.</p> <p>2) All residents have the potential to be affected.</p> <p>3) All residents are being weighed weekly for three weeks to obtain a baseline for weight loss monitoring. For any residents identified with weight loss, the registered dietitian will evaluate and recommend appropriate interventions. Any recommendations will be reported and acted upon in accordance with the facility's policy. The policy related to the documentation and communication of registered dietitian recommendations was written (EXHIBIT #14). In addition, a report showing any</p>	

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F 325	<p>Continued From page 45</p> <p>Review of the Weight Flow Record revealed Resident #4's weight on 02/05/11 was 166 pounds. Further review revealed the resident's weight on 03/01/11 was 156 pounds with a re-weight of 155.6 pounds (no date noted for the re-weight). Review of the resident's weight on 03/14/11 was 155.6 pounds. Review of the resident's weight on 03/21/11 was 149.6 pounds.</p> <p>Review of the Nutritional Progress Notes, dated 03/24/11, revealed the resident's weight was 149.6 pounds which was a decrease of fourteen pounds and a 10% (percent) weight loss in one month. The Note further stated the nursing assistants reported a decrease intake and the resident was holding food in her/his mouth at times. "Will request a Complete Blood Count (CBC) and a Comprehensive Metabolic Panel (CMP)". Continued review revealed the dietitians recommendations were to add 120 milliliters of Resource 2.0 three times a day between meals and request a Speech Therapy Referral related to holding food, Clinical At Risk monitoring, and weekly weights.</p> <p>Review of the 02/11 Physician's Orders revealed orders for a Mechanical Soft Diet. Further review revealed Physician's Orders dated 03/07/11 which stated, clarification to change diet to Mechanical Soft, No added Salt (NAS). Review of Physician's Orders dated 03/25/11 revealed orders for Resource 2.0 120 milliliters three times a day as a dietary recommendation and X-Ray of the right side of the face due to pain. Review of the Physician's Orders dated 03/28/11 revealed orders for Nystatin (anti-fungal agent) five (5) cubic centimeters (cc's) swish and swallow four</p>	F 325	<p>resident with an average meal intake of less than 50% for the last 3 meals will be completed daily for review and immediate interventions as indicated. The Director of Nursing (DON) will educate the unit managers, registered dietitian, rehabilitation director and Assistant Director of Nursing on this policy. The DON will re-educate nursing staff on the implementation of care plans and the proper usage of the C.N.A. assignment sheet (EXHIBIT #15).</p> <p>4) The DON will provide a report to the QA committee monthly for 12 months.</p> <p>Compliance Date -- June 6, 2011</p>	
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F 325	<p>Continued From page 46</p> <p>times a day for ten days, oral gel (medication used for mouth pain) to the right side every four hours as needed for pain and routinely at night for two weeks.</p> <p>Continued review revealed there were no Physician's Orders related to the dietary recommendations made on 03/24/11 for the CBC and CMP, and no orders for a Speech Therapy Referral.</p> <p>Interview on 04/21/11 at 9:00 AM with Registered Nurse #1/Unit Manager, revealed weights were received by the eighth day of the month and then re-weights were obtained if needed and the Dietician checked the monthly and weekly weights. Continued interview revealed the dietician gave copies of the dietary recommendations which were on a form, to the unit manager, and the DON and she or the staff nurse on the unit were to contact the physician to notify him of dietary recommendations. She stated she usually wrote a note in the Progress Notes when notifying the physician of the dietary recommendations and forwarded the form to the Director of Nursing (DON) after contacting the physician; however, could find no evidence the Physician was notified of the dietary recommendations from 03/24/11.</p> <p>Interview on 04/21/11 at 9:15 AM Dietician revealed she had been on the unit talking to staff and observing the residents intake and was aware Resident #4's intake was down which was why she recommended the diet change on 03/07/11 for a Mechanical Soft, No Added Salt Diet. Further interview revealed staff were to obtain weights by the 8th of the month and then</p>	F 325		

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F 325	<p>Continued From page 47</p> <p>re-weight if needed. She stated she should have been aware of the weight noted on 03/14/11 which would have been a re-weight and was not sure why she did not intervene until 03/24/11 to write dietary recommendations.</p> <p>Interview with the Director of Nursing (DON) on 04/21/11 at 9:30 AM revealed she could not find her copy of the Dietary Recommendation Form for 03/24/11 in her files and was unsure if the Physician had been notified of the recommendations. Further interview revealed the facility had no Nutrition Policy and no policy-related to dietary recommendations.</p> <p>Interview on 04/21/11 at 4:00 PM with the Attending Physician revealed the nurses usually called him with dietary recommendations. He stated he could not remember if he was notified of the dietary recommendations from 03/24/11 for Resident #4; however, if he was notified he probably would have ordered the labs and the Speech Therapy Consult as recommended.</p>	F 325		
F 328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p>	F 328	<p>1) This facility does have existing policies and procedures to ensure the residents receive proper treatment and care per professional standards. Unsampled resident A had no adverse effects from the insulin stopper not being cleaned with alcohol. Unsampled resident A has been observed receiving her injections in accordance with facility policy and with correct technique. LPN #1 was re-educated and</p>	

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F 328	Continued From page 48 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record, it was determined the facility failed to ensure residents received proper treatment and care for special services for injections for one unsampled resident (Unsampled Resident A). Observation of Insulin Administration for Unsampled Resident A revealed improper technique. The findings include: Review of the facility's "Subcutaneous Medication Administration Policy" which was undated, revealed: prepare syringe and needle, swab rubber cap with alcohol sponge. Pull back plunger to draw a volume of air into the syringe equal to volume of medication to be given. Inject air into vial. Withdraw correct amount of medication. Observation on 04/19/11 at 4:10 PM revealed Licensed Practical Nurse (LPN) #1 injected air into the Novolin 70/30 Insulin vial, injected air into the Novolin R Insulin vial, drew up Novolin R two (2) units and then Novolin 70/30 Insulin twenty-five (25) units with an insulin syringe. Further observation revealed the insulin vials were not cleaned with an alcohol pad prior to injecting air into the vials and drawing up the medication. Interview with LPN #1, after the observation, revealed she forgot to clean the insulin vials prior to injecting air and drawing up the insulin.	F 328	counseled related to the proper technique for administering injection. 2) All residents receiving insulin injectables have potential to be affected. 3) The Director of Nursing (DON) will re-educate all licensed nurses on medication administration standards including injectables. The facility's consultant pharmacist will continue to complete monthly medication pass observation audits including injectables. In addition, the results of these audits will continue to be included in the facility's existing QA program for 12 months. 4) The DON will provide a report to the QA committee monthly for 12 months.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	<p>Continued From page 49</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to prepare, store and distribute food under sanitary conditions. The facility failed to ensure proper hand sanitation, glove changing, rotten fruits stored in the refrigerator, meat stored in a cardboard box originally used to store eggs in the freezer and items stored in the dry storage in a manner which did not prevent pests.</p> <p>The findings include: Review of the facility's policy titled "Frozen Storage", not dated, revealed all frozen food will be properly wrapped, dated and labeled. Review of the facility's policy titled "Dry Storage", not dated, revealed containers with tight-fitting covers will be used for storage of broken lots of bulk food such as rice, pasta, flour, sugar and bulk cookies. It further indicated damaged canned food containers will be stored together in the storeroom in a separate and distinct area away from other food items. This area should be</p>	F 371	Compliance Date - June 6, 2011	
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F 371	<p>Continued From page 50 labeled.</p> <p>Observation on 04/19/11 at 11:14 AM revealed a Dietary Aide dropped a towel on the floor from the clean towel bin and the put it back into the clean towel bin.</p> <p>Interview with the Dietary Manager (DM) on 04/19/11 at 11:16 AM revealed the bin was used for clean towels and if a towel was dropped on the floor it should go into the bin used for dirty towels instead of clean towels. She further indicated this was secondary to the risk of contaminating the clean towels with bacteria picked up from the floor.</p> <p>Observation on 04/19/11 at 11:20 AM of the walk-in refrigerator attached to the walk-in freezer revealed two (2) rotten apples.</p> <p>Interview with the DM on 04/19/11 at 11:30 AM revealed the rotten apples should not have been stored in the refrigerator with the fresh apples.</p> <p>Observation of the walk-in freezer on 04/19/11 at 11:40 AM revealed pork ribs which were not covered well with plastic wrap leaving the meat exposed and were stored in a card board box of which the labeling indicated the box originally contained pasteurized eggs. Observation revealed a dried yellow substance on the lid of the card board box.</p> <p>Interview with the DM on 04/19/11 at 11:42 AM revealed the ribs were not covered well with the plastic wrap and the box had originally contained eggs, however, they came in plastic bags within the card board box.</p>	F 371	<ol style="list-style-type: none"> 1) All items noted in the surveyor report were corrected. 2) All residents have the potential to be affected. An audit of the facility's kitchen, food service equipment, storage areas, refrigerators, freezers, ice dispensing equipment and spice racks will be completed by the Food Service Director. Any areas of non-compliance will be addressed. 3) The Food Service Director will ensure monthly sanitation audits of the food service facilities and areas noted on the survey report are completed for 12 months. The Food Service Director will ensure any identified, non-compliant areas noted on this audit will be addressed. Lastly, on May 18, 2011 the Food Service Director will re-educate all food service staff on the storage, preparation, distribution and serving of food standards. 	

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F 371	<p>Continued From page 51</p> <p>Observation on 04/19/11 at 11:45 AM revealed ten (10) plate warmer insulators were stored wet.</p> <p>Interview with the DM on 04/19/11 at 11:45 AM revealed the plate warmer insulators should not be stored wet secondary to the risk of bacteria growth.</p> <p>Observation of the scoop drawer revealed multiple scoops turned different directions.</p> <p>Interview with the DM on 04/19/11 at 11:47 AM revealed the scoops should all be turned one (1) direction to reduce hand contact with the food contact surface.</p> <p>Observation of spice rack near the stove top range on 04/19/11 at 12:10 PM revealed taco seasoning dated 11/11/09, ground cayenne seasoning pepper dated 01/27/09, ginger dated 08/12/03 and ground thyme which was not dated all spices were in sixteen (16) ounce containers.</p> <p>Observation of the meat slicer on 04/19/11 at 12:18 PM revealed particles which were brown in color around the blade and on the surface area which catches the sliced meat.</p> <p>Interview with the DM on 04/19/11 at 12:24 PM revealed spices should not be kept for over one (1) year and should be dated when opened. She further stated the meat slicer should be cleaned after each use and it needed to be cleaned.</p> <p>Observation at 12:25 PM on 04/19/11 revealed a 128 fluid ounce plastic bottle of red wine vinegar stored on a bottom shelf of a steel table which</p>	F 371	<p>4) The Food Service Director will provide a report to the QA committee monthly for 12 months related to the audit findings and necessary interventions.</p> <p>Compliance Date: June 6, 2011</p>	
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F 371	<p>Continued From page 52</p> <p>had no lid but a wad of aluminum foil stuck in the opening of the bottle. It was noted there were open areas around the aluminum foil which did not cover the red wine vinegar.</p> <p>Interview with the DM at 12:25 PM on 04/19/11 revealed the bottle should not be stored this way because it was not sealed.</p> <p>Observation of the dry storage area on 04/19/11 at 12:35 PM revealed lasagna stored in its original box which had been opened and was not covered. Also noodle pasta which was stored in its original plastic bag had a rip in the bag which was allowing the noodles to spill onto the floor. A brown sticky substance, which covered an area of approximately two (2) by four (4) inches, was noted on the floor under the metal storage rack were the canned food items and noodles were stored. Pecans were noted to be stored in a plastic bag with a ziploc seal which were not dated. Also blueberry muffin mix was stored in a plastic bag with a ziploc seal which was ripped.</p> <p>Observation of the dry storage at 12:45 PM on 04/19/11 revealed one (1) can which was not labeled and was dented and stored with other canned items. Also a 106 ounce can of pumpkin was dented and stored with other canned items.</p> <p>Interview with the DM on 04/20/11 at 1:30 PM revealed the lasagna, noodles, pasta and blue berry mix are not covered to prevent pests from gaining access. She further indicated the brown substance appeared to be something which had been spilled and stated it should have been cleaned after it was spill. She indicated the dented cans should not be stored with the</p>	F 371		
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F 371	<p>Continued From page 53</p> <p>non-dented cans and cans which were not labeled should be treated as dented cans or labeled by staff if the label is ripped off during stocking.</p> <p>Observation on 04/20/11 at 12:00 PM revealed Dietary Aide #6 opened the refrigerator door to retrieve creamer, did not wash her hands or change her gloves and continued to assemble trays.</p> <p>Observation on 04/20/11 at 12:02 PM revealed Dietary Aide #6 opened the refrigerator door to retrieve a soda, did not wash hands or change gloves and continued to assemble trays.</p> <p>Observation on 04/20/11 at 12:17 PM revealed Dietary Aide #6 opened the refrigerator door to retrieve a soda, did not wash hands or change gloves and continued to assemble trays.</p> <p>Observation on 04/20/11 at 12:20 PM revealed Dietary Aide #7 lifted the trash can lid by taking hold of the side of the lid with fingers in contact with the underside of the lid, did not wash hands or change gloves, and continued to check trays by touching the lids which cover plates and putting plastic lids on vegetables. Observations revealed this was done for ten (10) trays before Dietary Aide #7 washed her hands and changed her gloves.</p> <p>Observation on 04/20/11 at 12:36 PM revealed Dietary Aide #7 pushed a tray cart into the hallway to be taken up onto the floor for residents and did not wash her hands or change her gloves before returning to tray line to check resident trays for accuracy and cover vegetables with lids</p>	F 371		
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F 371	<p>Continued From page 54 on resident trays.</p> <p>Observation on 04/20/11 at 12:40 PM revealed Dietary Aide #8 blowed into a glove prior to donning it and continuing to plate food for residents on tray line.</p> <p>Observation on 04/20/11 at 12:45 PM revealed water had been dripping from a ceiling vent throughout resident tray line onto the conveyor area where trays were assembled prior to being placed into carts to be delivered to residents.</p> <p>Interview with Dietary Aide #6 on 04/20/11 at 1:15 PM revealed she should have washed her hands prior to returning to tray line after opening the refrigerator door.</p> <p>Interview with Dietary Aide #7 on 04/20/11 at 1:15 PM revealed she should have washed her hands prior to returning to tray line after using the trash can and pushing the cart into the hallway.</p> <p>Interview with Dietary Aide #8 on 04/20/11 at 1:15 PM revealed he should not have blown into the glove before donning the glove to plate resident's food.</p> <p>Interview with Dietary Aide #8 on 04/20/11 at 1:20 PM revealed he had noticed the water dripping from the vent but could not say how long he had noticed it was dripping from the vent.</p> <p>Interview with the DM on 04/20/11 at 1:25 PM revealed she did not know how long water had been dripping from the vent onto the tray line, she indicated she would have to call maintenance. She further indicated the water could potentially</p>	F 371		
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F 371 F 431 SS=D	<p>Continued From page 55 get into resident's food.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</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>	F 371 F 431	<ol style="list-style-type: none"> 1) The facility has an existing system for the receipt and maintenance of pharmacologicals. The facility has existing policies and procedures for the maintenance of medications. The unlabeled ointment and saline were discarded. The sterile water on the crash cart was discarded. 2) All residents had the potential to be affected. 3) The facility's pharmacy will complete a review of all pharmacologicals to ensure each is correctly labeled and not expired. The Director of Nursing (DON) will ensure that all nurses and certified medication technicians are re-educated on the storage of pharmacologicals including standards for labeling and monitoring dates of expiration. The policy relating to the maintenance of the crash carts was revised (EXHIBIT #21). In addition, the facility will 	
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F 431	<p>Continued From page 56</p> <p>This REQUIREMENT Is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with accepted professional principles.</p> <p>The findings include:</p> <p>Review of the facility "Medication Storage In The Facility", revealed outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal".</p> <p>Observation on 04/21/11 at 10:20 AM of the first medication cart on the downstairs B Hall revealed there was a tube of Aquaphor Ointment, which was not labeled with a resident's name, in the medication drawer and a bottle of Normal Saline, which was opened and undated. Interview at the time of the observation, with Certified Medical Technician (CMT) #1 revealed she was unsure how long Normal Saline could be used after opened.</p> <p>Further observation on the downstairs B Hall revealed the crash cart contained a bottle of Sterile Water with an expiration date of 11/21/06.</p> <p>Interview on 04/21/11 at 11:00 AM with Licensed Practical Nurse (LPN) #3 revealed the tube of Aquaphor Ointment was dispensed by pharmacy and should have been labeled with a resident's name. She further stated the Normal Saline</p>	F 431	<p>continue to check the crash carts nightly in compliance with our revised policy. Lastly, the facility's pharmacy will complete a monthly audit of stored medications and pharmacologicals for 12 months.</p> <p>4) The DON will provide a report to the QA committee monthly for 12 months on the completed audits and associated actions.</p> <p>Compliance Date June 6, 2011</p>	
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F 431	Continued From page 57 should have been dated when opened and was to be discarded twenty-four (24) hours after opening.	F 431		
F 441 SS=F	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 (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	F 441	1) This facility has an infection control program in place. Monthly surveillance and infection rates are monitored and within acceptable standards. Resident #14's skin tears were healed as of May 3, 2011 and thus, his associated treatments were discontinued. Resident #14 was cleaned again utilizing the correct technique and had no adverse effects from the use of the wrong cleaning technique. RN #10 was re-educated and counseled on the correct techniques for	

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F 441	<p>Continued From page 58</p> <p>direct contact will transmit the disease.</p> <p>(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, interview, and record review it was determined the facility failed to ensure an infection control program was in place to provide a safe, sanitary environment to help prevent the development and transmission of disease and infection for one (1) of twenty-two (22) sampled residents (Resident #14) and for one (1) unsampled resident (Unsampled Resident A).</p> <p>Observation of peri care for Resident #14 on 04/21/11 revealed improper infection control technique. Further observation of a dressing change on 04/21/11 for Resident #14 revealed improper infection control technique.</p> <p>Observation of medication pass on 04/19/11 at 4:10 PM for Unsampled Resident A revealed the nurse failed to clean the Insulin vials with an alcohol pad prior to injecting air into the vials and drawing up the medication.</p>	F 441	<p>completing dressing changes and male perineal care. Unsampled resident A had no adverse effects from the insulin stopper not being cleaned prior to her injection. LPN #1 was re-educated and counseled on the correct technique for completing insulin administration. Ice scoops in the dining room will be maintained per standards. C.N.A.'s hair will be kept up and off her collar.</p> <p>2) All residents have the potential to be affected.</p> <p>3) The Director of Nursing (DON) will re-educate all nursing staff on the facility's infection control policy and procedures to include medication passes, dressing changes, hand</p>	
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F 441	<p>Continued From page 59</p> <p>Additionally observation during lunch service on 04/20/11 revealed two (2) State Registered Nurse Aides (SRNA) whom left scoops in the ice containers and one (1) SRNA who's hair was observed to be in contact with a residents food.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility's policy, "Dressings, Dry/Clean", dated 06/05, revealed the steps in the procedure included: apply clean gloves, loosen tape and remove soiled dressing, pull glove over dressing and discard into plastic or biohazard bag, wash and dry your hands thoroughly, put on clean gloves, cleanse the wound, apply the ordered dressing and secure with tape. <p>Review of Resident #14's medical record revealed diagnoses which included Organic Brain Syndrome and Diabetes Mellitus.</p> <p>Observation of a skin assessment and dressing change on 04/21/11 at 5:00 PM revealed the resident had wounds to the left and right anterior tibias which were described as healing skin tears by Registered Nurse (RN) #10. Observation of a dressing change performed to the wounds revealed RN #10 removed the soiled dressing from the right anterior tibia wound, and with the same soiled gloves, wiped the wound with a dry Telfa Pad, applied silvadene with a cotton applicator, applied Telfa Dressing, wrapped the wound with Kerlex, and taped the Kerlex. The RN changed gloves; however, did not wash hands and proceeded to the left anterior tibia wound. He removed the soiled dressing from the left anterior tibia wound and with the same soiled gloves, wiped the wound with a dry Telfa Pad,</p>	F 441	<p>washing, perineal care and serving food (EXHIBIT #22). New ice carts with an attached scoop will be purchased for the dining room. The existing infection control indicators in the facility's QA program will be expanded to include surveillance of infection control techniques that include handwashing, cleaning equipment, dressing changes, serving food and passing medications. This indicator will be collected by observation monthly for 12 months by the unit managers.</p> <p>4) The DON will provide a report to the QA committee monthly for 12 months on the results of these audits.</p> <p>Compliance Date -- June 6, 2011</p>	
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F 441	<p>Continued From page 60</p> <p>applied Silvadene with a cotton applicator, applied a Telfa Dressing, wrapped the wound with Kerlex, and applied tape to the Kerlex. The nurse failed to change gloves and wash hands after removing the soiled dressings from the wounds, and prior to applying the Silvadene and the new dressing to the wounds. In addition, the nurse failed to wash his hands between wound sites.</p> <p>Interview with RN #10 on 04/21/11 at 6:30 PM revealed he was unsure if he needed to wash his hands and change gloves after removing the soiled dressings, and prior to applying the Silvadene and new dressing. Further interview revealed he was unsure if he needed to wash his hands between wound sites. However, he stated he contaminated the roll of tape because he handled it with the same soiled gloves he used to removed the soiled dressings. He stated he would throw the tape away instead of placing it back in the treatment cart.</p> <p>2. Review of the facility "Perineal Policy" dated 09/05 revealed "wash perineal area starting with urethra and working outward, retract foreskin of the uncircumcised male, wash and rinse urethral area using a circular motion, continue to wash the perineal area including the penis, scrotum and inner thighs".</p> <p>Observation of pericare on 04/21/11 at 5:30 PM for Resident #14, performed by RN #10, revealed the RN cleansed from the base of the penis towards the meatus.</p> <p>Interview with RN #10 at 6:00 PM revealed he wrapped the penis with the wipe and wiped the</p>	F 441		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/22/2011
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 820 SOUTH FOURTH 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)	(X6) COMPLETION DATE
F 441	<p>Continued From page 61</p> <p>penis from the base towards the meatus because he was attempting to wipe the pubic hair down. Further interview revealed wiping towards the meatus could cause a Urinary Tract Infection.</p> <p>3. Review of the facility "Subcutaneous Medication Administration" Policy which was undated, revealed "prepare syringe and needle, swab rubber cap with alcohol sponge. Pull back plunger to draw a volume of air into the syringe equal to volume of medication to be given. Inject air into vial. Withdraw correct amount of medication".</p> <p>Observation of medication pass on 04/19/11 at 4:10 PM for Unsampled Resident A revealed Licensed Practical Nurse (LPN) #1 injected air into the Novolin 70/30 Insulin vial, injected air into the Novolin R Insulin vial, and drew up Novolin R two (2) units and then Novolin 70/30 Insulin twenty-five (25) units with an insulin syringe. However, the nurse failed to clean the vials with an alcohol pad prior to injecting air into the vials and drawing up the medication.</p> <p>Interview on 04/19/11 at 4:20 PM with LPN #1 revealed she forgot to clean the insulin vials prior to injecting air and drawing up the insulin.</p> <p>4. Observation of the noon meal service in the main dining room on 04/20/11 revealed between 12:15 PM and 12:40 PM, two (2) State Registered Nursing Assistants (SRNA) failed to serve food under sanitary conditions. SRNA #4 was observed on numerous occasions to have left an ice scoop in an ice bowl on a trolley while serving</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203
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F 441	<p>Continued From page 62</p> <p>drinks to residents. SRNA #5 was observed to have left an ice scoop in a ice bowl on two (2) separate occasions.</p> <p>Interview with SRNA #4 on 04/20/11 at 12:35 PM revealed she knew not to leave ice scoops in the ice, but stated it was "hard to break a force of habit".</p> <p>Interview with SRNA #5 on 04/20/11 at 12:40 PM revealed she also knew not to leave ice scoops in the ice.</p> <p>5. Observation of meal service on 04/20/11 at 1:00 PM revealed SRNA #4's hair was touching pudding of an Unsampled Resident.</p> <p>Observation and interview with SRNA #4 on 04/20/11 at 1:05 PM revealed she requested a replacement for the contaminated food at the surveyor's request.</p>	F 441		
F 465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide a sanitary environment for residents, staff, and the public. Observations revealed medication carts on the downstairs B Hall were soiled.</p>	F 465	<p>1) Medication carts are to be cleaned by the nurses and certified medication technicians (CMT) immediately if a spill occurs on a daily basis. The medication carts on the B Hall were cleaned.</p> <p>2) All residents on the B Hall had the potential to be affected.</p>	

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203
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F 465	<p>Continued From page 63</p> <p>The findings include:</p> <p>Observation of medication pass on 04/20/11 at 8:30 AM revealed there was a buildup of dust on the top, sides, and base of the medication cart. Also, there were dried pink, yellow, and black streaks on the sides of the medication cart.</p> <p>Interview with Certified Medication Technician (CMT) #1 on 04/20/11 at 8:50 AM revealed she was unsure of who was responsible for cleaning the medication cart. She further stated the cart "needs scrubbed". Further interview revealed she sometimes wiped the cart down herself.</p> <p>Observation on 04/21/11 at 10:20 AM of the first medication cart on the downstairs B Hall in the medication room, revealed there were streaks of pink and yellow dried sticky substance in the bottom of the liquid medication drawer. Interview with CMT #1 at the time revealed the drawer was "dirty".</p> <p>Further observation on 04/21/11 at 11:00 AM of the second cart on the downstairs B Hall revealed the liquid medication drawer had a buildup of orange dried debris. Interview at the time of the observation, with Licensed Practical Nurse (LPN) #3 revealed there was no cleaning schedule for the medication carts and staff tried to wipe the carts down as needed.</p> <p>Interview on 04/20/11 at 3:50 PM with the Director of Nursing (DON) revealed there was no policy for cleaning the medication carts and no cleaning schedule. She further stated the staff should clean the medication carts if they spill something</p>	F 465	<p>3) All facility medication carts will be thoroughly cleaned. The Director of Nursing (DON) will educate the nurses and CMTs on the facility's standard for the cleaning of the medication carts (EXHIBIT #22). The facility's pharmacy will expand their existing, QA program, monthly inspection of all of the facility's medication carts for 12 months to ensure they are clean and free of spills (EXHIBIT #23) Lastly, on an annual basis or as needed, each medication cart will be completely emptied and thoroughly cleaned.</p> <p>4) The DON will provide a report to the QA committee monthly for 12 months on the results of these audits.</p> <p>Compliance Date – June 6, 2011</p>	
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203
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<p>F 465</p> <p>F 514</p> <p>SS=D</p>	<p>Continued From page 64 on them.</p> <p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to maintain accurate and complete clinical records for two (2) of twenty-two (22) sampled residents, (Resident #11 and Resident #12). Record review revealed several of Resident #12's Nursing Note's were located in Resident #11's record.</p> <p>The findings include: Record review revealed the facility admitted Resident #11 on 10/24/10 with diagnoses which included failure to thrive adult and debility. Review of the resident's Nursing Notes revealed Nursing Notes from Resident #12's medical record dated 10/19/10, 10/20/10, 10/21/10,</p>	<p>F 465</p> <p>F 514</p>	<p>1) This facility does maintain clinical records in accordance to professional standards. The five sheets of paper referenced in the survey report were immediately placed in the correct clinical record.</p> <p>2) All residents have the potential to be affected.</p> <p>3) An audit of all current, resident clinical records will be done to ensure all documents are in the correct clinical record. In addition, the Director of Nursing (DON) will educate nurses on the standards and maintenance of clinical record accuracy. The medical records coordinator will review each clinical record quarterly to ensure accuracy. Lastly, an indicator will be</p>	
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F 514	<p>Continued From page 65</p> <p>10/22/10, 10/23/10 and 10/24/10 were located in Resident #11's medical record.</p> <p>Interview with the Director of Nursing (DON) on 04/20/11 at 10:00 AM revealed she would hope this would not be a concern. She further stated it could possibly be a concern.</p> <p>Interview with Registered Nurse (RN) #2 on 04/21/11 at 6:15 PM revealed Nurses Notes are kept in a separate binder for one (1) month and carried over to the medical record when the Medication Administration Record (MAR) and Treatment Administration Record (TAR) are changed with the next months and then carried over to the medical record. She further indicated night shift Nurses are responsible for changing the Nurses Notes, MAR's, and TAR's over at the end of the month. She stated this was an error on night shift's part made when filling the Nurses Notes in the records at the end of the month.</p>	F 514	<p>incorporated into the facility's existing QA program to verify that clinical records are being maintained according to the facility's policy. This indicator will be done quarterly for 12 months.</p> <p>4) The DON will provide a report to the QA committee quarterly on the results of the quarterly clinical record audits.</p> <p>Compliance Date – June 6, 2011</p>	

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 820 SOUTH FOURTH STREET LOUISVILLE, KY 40203
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K 000	INITIAL COMMENTS	K 000		
K 045 SS=D	<p>A Life Safety Code survey was initiated and concluded on 04/20/2011. The facility was found to not meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide illumination of the means of egress at the exit discharges as required per NFPA Standards. This condition has the potential to affect one (1) of three (3) basement smoke compartments, all residents and staff using the Adult Daycare area where the exit discharge stair is located in the basement. The facility has the capacity for one hundred and twenty-two (122) beds; the census was one hundred and eight (108) on the day of the survey.</p> <p>Findings Include:</p> <p>Observation on 04/20/2011 at 11:40 AM, with the Maintenance Director, revealed the exit discharge from the stairs located within the Adult Daycare area of the basement, was observed and questioned about the level of illumination required for exit discharge. There was a light fixture</p>	K 045	<p>The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because of federal and state law.</p> <p style="text-align: center;">RECEIVED MAY 16 2011</p> <p>1) The light fixture was wired to the generator on May 3, 2011. 2) There are no other exit discharges from the basement that would be affected. 3) The Maintenance Director will conduct a monthly audit of this light fixture to ensure proper illumination. 4) The Maintenance Director will report the audit findings to the Quality Assurance (QA) Committee monthly or as directed.</p> <p>Compliance Date June 6, 2011</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ronald A. [Signature]</i>	TITLE Executive Director	(X6) DATE 5/16/11
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203	
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K 045	Continued From page 1 Installed on the exterior of the building, but could not be confirmed that it was connected to the emergency power requirements for egress. Interview on 04/20/2011 at 11:40 AM, with the Maintenance Director, revealed he was not aware if the light fixture was connected to the emergency powere source. Actual NFPA Standard: The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor per NFPA 101, 7.8.1.3. Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area per NFPA 101, 7.8.1.4. An example of the failure of any single lighting unit is the burning out of an electric bulb per NFPA 101, A.7.8.1.4.	K 045		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure proper signage was maintained for fire extinguishers according to National Fire Protection Association (NFPA) standards. This condition has the potential to affect one (1) of three (3) basement smoke compartments, all residents and staff using the Basement Dining area. The facility has	K 069	1) The signage was placed over the fire extinguisher in the kitchen on April 28, 2011. 2) An audit was completed of all fire extinguishers in the facility to ensure all have proper signage. 3) The Maintenance Director or designee will conduct an audit monthly of all fire extinguishers to ensure the required signage continues to be in place. 4) The Maintenance Director will report the audit findings to the Quality Assurance (QA) Committee monthly or as directed. Compliance Date June 6, 2011	

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K 069	Continued From page 2 the capacity for one hundred and twenty-two (122) beds; the census was one hundred and eight (108) on the day of the survey. The findings include: Observation on 04/20/2011 at 11:30 AM, with the Maintenance Director, revealed a K type extinguisher located in the kitchen area did not have the required signage. Interview on 04/20/2011 at 11:30 AM, with the Maintenance Director, revealed they were not aware of the requirement for signage. Reference: NFPA 96 (1998 edition) 7-2.1.1 A placard identifying the use of the extinguisher as a secondary backup means to the automatic fire suppression system shall be conspicuously placed near each portable fire extinguisher in the cooking area.	K 069			
K 073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency has the potential to affect all six (6) smoke	K 073	1) As noted in the surveyor's report, the facility had properly treated decorations and stuffed animals with fire-retardant spray. 2) The Environmental Services Director will conduct an audit of the facility to verify treatment of fire-retardant spray to any applicable items. Results of this audit will be documented. In addition, a revised policy was completed addressing the requirements for documentation of this activity (EXHIBIT #1).		

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K 073	Continued From page 3 compartments on the First and Second floors, all one-hundred and eight (108) residents, staff and visitors. The facility is licensed for one-hundred and twenty-two (122) beds and the census on the day of the survey was one-hundred and eight (108). The findings include: Observation on 04/20/2011 between 10:30 AM and 12:30 AM, with the Maintenance Director, revealed hanging decorations were on the residents' doors in various locations throughout the facility. The Maintenance Director indicated the facility has been treating the decorations with a fire-retardant spray, but has no written policy for documenting treatment with a fire retardant spray. Interview on 04/20/2011 at 10:30 AM, with the Maintenance Director on, confirmed that hanging decorations, as well as stuffed animals belonging to residents, have been treated with a fire retardant spray but have no written policy for documentation. He indicated that a written policy would be implemented.	K 073	3) The Environmental Services Director will ensure fire-retardant treatments are documented as they occur. In addition, the Environmental Services Director will conduct a quarterly audit of the facility to identify any items in need of fire-retardant spray and ensure the fire-retardant treatment is completed. (EXHIBIT #2). 4) The Environmental Services Director will provide a report to the QA Committee monthly or as directed. Compliance Date June 6, 2011	
K 130 SS=F	Reference : NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130		

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K 130	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress. They shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. This deficiency has the potential to affect four (4) of six (6) smoke compartments located on the First and Second floors, all one hundred and eight (108) residents, staff and visitors. The facility is licensed for one hundred and twenty-two beds; the census on the day of the survey was one hundred and eight (108). The findings include: Observation on 04/20/2011 at 10:30 AM, with the Maintenance Director, revealed that an unapproved lock (slide bolt type) was installed on the egress side of the door to the electrical room. Further observation on 04/20/2011, revealed dead bolt locks installed on the egress side on the doors to the linen rooms, utility rooms, and the whirlpool rooms, located in both wings of the First and Second Floors. Interview, with the Maintenance Director, on 04/20/2011 at 10:30 AM, indicated that he was unaware of the requirements and would remove the slide bolt locks. NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130	1) All of the slide bolt locking mechanisms were removed on April 20, 2011. 2) The Maintenance Director completed an audit of all facility doors to ensure no other slide bolt locking mechanisms were present. No other locks of this type were in the facility. 3) The Maintenance Director will conduct an audit quarterly of all facility doors to ensure no slide bolt locking mechanisms are present. 4) The Maintenance Director will provide a report to the QA Committee quarterly or as directed. Compliance Date June 6, 2011	