

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

PRINTED: 01/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185330	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/20/2013
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS An Abbreviated Survey investigating complaint KY00021108 was initiated on 12/17/13 and concluded on 12/20/13. KY00021108 was substantiated with deficiencies identified. Actual harm was determined to exist at 42 CFR 483.20, Resident Assessment, F282; and 42 CFR 483.25, Quality of Care, F309 with the highest Scope and Severity (S/S) of a "G". In addition, non-compliance was determined to exist at 42 CFR 483.20, Resident Assessment, F280 at a S/S of a "D" and F281 at a S/S of an "E"; 42 CFR 483.25, Quality of Care, F315 at a S/S of a "D"; and 42 CFR 483.65, Infection Control, F441 at a S/S of an "E".	F 000	Submission of this Plan of Correction is neither an admission to nor an agreement with the Deficient Practices noted below, but provided as required under the Conditions of Participation.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	1.) R-4 and R-5's care plan have been updated. R-4's has been updated to address the Hemicolectomy as well as interventions to decrease the risk for further bowel obstructions on 12/24/13. R-5's care plan has been updated on 01/06/14 to address specific interventions for prophylactic assessments and monitoring of abdomen and bowels. This resident's care plan has also been		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

U. Edward Foley

TITLE

Intervenor Administrator

(X8) DATE

01/24/14

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

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F 280 Continued From page 2

Congestive Heart Failure (CHF). Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 09/04/13, revealed the facility assessed Resident #4 to have a Brief Interview for Mental Status (BIMS) score of twelve (12) out of fifteen (15). Further review of the MDS revealed the facility assessed the resident as frequently incontinent of bowel and bladder; and, as requiring extensive assistance of two (2) persons for toileting.

Review of the Comprehensive Plan of Care, dated 04/17/13, revealed the resident was at risk for alteration in bowel elimination as evidenced by constipation. Continued review revealed interventions which included to administer medications as ordered; monitor bowel movements; perform bowel assessments, hydration assessments, and pain assessments per the facility protocol.

Review of the SBAR (Situation, Background, Assessment, request) form dated 11/02/13 at 4:30 AM, and the Nursing Home to Hospital Transfer Form dated 11/02/13 at 5:00 PM, completed by Licensed Practical Nurse (LPN) #1, revealed Resident #4 was being transferred to the hospital related to having abdominal pain and vomiting brown emesis.

Review of the Hospital Discharge Summary, dated 11/15/13, revealed Resident #4 was admitted to the hospital 11/02/13. Review of the Summary revealed Resident #4 had a Right Hemicolectomy (surgical procedure in which approximately half of the colon was removed) operation on 11/07/13.

Additional review of the Comprehensive Plan of

F 280 information regarding any procedures completed on the resident completed outside the facility, such as any testing or Physician office visits. Use of 24 hour report as well as Physician telephone orders are being used in an attempt to capture all events occurring for individual residents. BM records are also being reviewed. Information obtained from Department Managers rounds is being considered. A collection of these items are being reviewed and used as part of process to select best course of care for resident. In addition, three random care plans will be reviewed per Director of Nursing or designed weekly to

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F 280 Continued From page 4

three (3) days. The interventions included: hydration and pain assessment as needed, and bowel sounds assessed as needed. Continued review revealed the interventions were revised on 10/28/13 to assess bowel sounds every day until bowel movement and notify the Advanced Registered Nurse Practitioner (ARNP).

Review of the Departmental Notes, which nurses documented on, dated 09/17/13, 10/29/13 and 11/14/13 revealed Resident #5 had required KUB X-rays the results of which indicated the resident had the beginning of an ileus. Review of the Notes revealed nursing staff was to administer soap suds enemas two (2) times and repeat the KUB.

Additional review of the Comprehensive Plan of Care dated 11/04/13, revealed the care plan for Resident #5's risk for alteration in elimination had been revised on 10/28/13, 10/30/13, 11/13/13, 11/15/13 and 11/18/13 with additional interventions. However, there was no documented evidence the care plan was revised to include specific interventions for prophylactic (precautionary) assessments and monitoring of Resident #5's abdomen and bowels, in order to prevent the risk for further ileus. In addition, there was no documented evidence the Comprehensive Plan of Care was revised to indicate Resident #5 was at risk for an ileus even though the resident was repeatedly diagnosed with Colonic ileus, and required repeated soap suds enemas and KUB X-rays.

Interview with the ARNP on 12/20/13 at 2:20 PM, revealed Resident #5 had to have frequent KUB's and enemas, even though the BM record indicated the resident was having regular bowel

F 280 the update and kept for discussion for the QA meeting discussion. Any care plan issues will be discussed and any abnormalities noted will be addressed at time of discovery and the plan revised. Team will consist of Administrator, DON, Medical Director, SW and Activity Director.

5.) Completion Date 01/21/14.

F 281

- 1.) Physicians for R- C on 12/20/13, R- E on 12/20/13 and R- F on 12/18/13 were notified, any new orders obtained were followed. LPN 1 and LPN 4 were counseled on 12/18/13 per ADON.
- 2.) All residents who were receiving antibiotic

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F 281	<p>Continued From page 6</p> <p>resident. However, review of the Medication Administration Record (MAR), revealed the medication had been signed out as administered for two (2) consecutive days.</p> <p>In addition, observation of the medication cart for Unsampled F on 12/18/13, revealed there was no Ciprofloxacin as ordered in the cart; however, review of the 12/13 MAR revealed the resident had been receiving the medication daily since 12/01/13. Interview with the Pharmacist revealed, a total of ten (10) tablets had been since the day of the original order 11/19/13. Although the resident should have been administered a total of thirty (30) tablets since 11/19/13, only ten (10) tablets had been sent from pharmacy and none had been removed from the emergency box.</p> <p>Additionally, although Resident E's, Augmentin (antibiotic medication) 875 milligrams was not issued and sent to the facility from pharmacy until 12/12/13 and there was no documented evidence the medication was taken from the E-box, the medication was signed out as administered on 12/10/13 at 8 PM, and 12/11/13 at 8 AM and 8 PM. Also, although there should have been four (4) doses left to administer, there was ten (10) doses left to administer.</p> <p>In addition, seven (7) of twenty-one (21) doses of the antibiotic Ampicillin 500 mg, ordered for Unsampled Resident C, were returned to the Pharmacy without being administered.</p> <p>The findings include:</p> <p>Review of the policy titled "Physician Medication Orders", revised April 2010, revealed medications were to be administered in accordance with the</p>	F 281	<p>compare to count sheet to ensure totals both match. In addition, Licensed Nurses are to review the MAR to ensure the off going shift has signed out the antibiotic. All licensed Nurses were in serviced on this topic on January 10, 2014. This in-service was conducted per Education Training Registered Nurse. In addition, these flow sheets will be reviewed five times per week per Director of Nursing or designee. Any abnormalities noted will be addressed at time of discovery. In addition, 100 % MARS/TARS will be reviewed three times per week per Director of Nursing or designee to review entire</p>		

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F 281	<p>Continued From page 8</p> <p>nurses at the time of this observation revealed if they had "pulled" the Macrobid medication from the E-box, there would be two (2) doses of the medication missing from it.</p> <p>Interview, on 12/20/13 at 9:45 AM, with the facility's Pharmacist revealed the pharmacy had sent a full box of the Macrobid 100 mg on 12/18/13, and there had been no charges for the medication indicating it's removal from the E-box.</p> <p>2. Further review of Unsampled Resident F's medical record, revealed Physician's Orders dated 11/19/13 for Ciprofloxacin (an antibiotic) 250 mgs every day prophylactically (for prevention).</p> <p>Additional observation of the medication cart on 12/18/13 at 10:30 AM, revealed there was no evidence of Ciprofloxacin in the cart. Interview, at the time of this observation with LPN#1, who administered medications to the resident at 8:00 AM, revealed the Ciprofloxacin was not in the medication drawer. However, she stated she must have pulled the medication from the E-box earlier that morning because she had signed it as administered on the MAR at 8:00 AM.</p> <p>Interview with LPN #4 on 12/18/13 at 11:00 AM, revealed she had administered and signed the Ciprofloxacin as administered on the MAR for the dates of 12/16/13 and 12/17/13; and, had re-ordered the medication on 12/17/13.</p> <p>Additional observation of the E-box on 12/18/13 at 11:00 with LPN #1 and LPN #4, revealed the amount of Ciprofloxacin in the E-box indicated there was none missing from it. Observation of the PAR level revealed no missing doses of the</p>	F 281	<p>returned to the pharmacy will be reviewed and compared three times per week to Physician orders and MARS for four weeks, then five medications in the return bin monthly/PRN thereafter. This review will be done per Director of Nursing or designee.</p> <p>4.) Quality Assurance Team to meet weekly times four weeks starting week of January 12, 2014, then monthly and PRN thereafter. Medication Administration audits as well as Antibiotic flow sheet to be reviewed and any abnormalities noted will be addressed and the plan</p>		

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F 281

Continued From page 10

Continued observation of the medication cart on 12/18/13 at 10:30 AM, revealed the Augmentin medication box showed an issue date of 12/12/13, and there to be ten (10) doses of medication left to be administered.

Interview with the facility Pharmacist on 12/20/13 at 9:45 AM, revealed the Augmentin was issued and sent the same day, 12/12/13. He stated there was no E-box charges to indicate the medication had been obtained from it for this resident.

Although the medication was not issued and sent to the facility from pharmacy until 12/12/13, and there was no documented evidence the medication was taken from the E-box; the medication was signed out as administered on 12/10/13 at 8:00 PM, and 12/11/13 at 8:00 AM and 8:00 PM. In addition, there should have been only four (4) doses left to be administered; however, there were ten (10) doses left in the box sent from pharmacy on 12/12/13.

4. Review of the clinical record revealed Unsamped Resident C was admitted by the facility on 07/26/12 with diagnoses which included Hypertension and Status Post Cerebrovascular Accident (Stroke).

Review of the Physician Order dated 11/29/13, revealed Unsamped Resident C was to receive Ampicillin (an antibiotic) 500 mg three (3) times daily for seven (7) days, for a total of twenty-one (21) doses. Continued review revealed the antibiotic was prescribed for a diagnosis of Urinary Tract Infection.

Review of the MAR for the period including

F 281

determination of which residents may have been affected. All resident care plans were reviewed for any needed updates on 01/20/14. This review was done per DON, ADON, SW and a Registered Nurse.

3.) Director of Nursing or designee will review resident bowel movement records for an expanded period of time, increased from three day review time frame to seven day time frame. This review will be conducted per Director of Nursing or designee five days per week and the staff Nurses will conduct on the weekends. Facility will utilize the B.M flow sheet that

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F 281	Continued From page 12 transcribed incorrectly. In addition, she indicated all doses of the medication were not administered as evidenced by the surplus capsules. Additionally, the interview with the Assistant Director of Nursing (ADON) on 12/20/13 at 4:35 PM, revealed she was not aware of a problem regarding the failure of nursing staff to administer the complete Physician ordered course of antibiotics for residents. She stated, prior to the survey, the facility was not auditing the medication carts or conducting pill counts to ensure medications were being administered as ordered. The ADON stated the Staff Development Nurse observed medication pass randomly, and, Pharmacy also observed medication pass for one (1) nurse a month. Interview with the Staff Development Nurse on 12/20/13 at 6:19 PM, revealed she observed medication pass randomly, especially when the facility was in the standard survey time frame. The Staff Development Nurse stated she was unaware of any concerns recently in regards to the pharmacy medication pass observation or with her observations of medication pass.	F 281	reviewed/updated five times per week in the morning interdisciplinary team meetings. This process has been expanded to include obtaining further information regarding any procedures completed outside the facility, such as testing and Physician office visits. Use of 24 hour report as well as Physician telephone orders are being used in an attempt to capture all events occurring for individual residents. BM records are also reviewed. Information obtained from Department Managers rounds is being considered, such as any	
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of	F 282		

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F 282 Continued From page 14

functional levels; it was to enhance optimal functioning of the resident; and, reflect currently recognized standards of practice for problem areas and conditions.

1. Review of Resident #4's clinical record revealed diagnoses which included Paranoid Schizophrenia, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD), and Congestive Heart Failure (CHF).

Review of the Quarterly Minimum Data Set (MDS) Assessment dated 09/04/13, revealed the facility assessed Resident #4 as having a Brief Interview for Mental Status (BIMS) score of twelve (12) which indicated the resident was not cognitively impaired. Further review of the MDS revealed the facility assessed the resident as being frequently incontinent of bowel and bladder and to require extensive assistance of two (2) persons for toileting.

Review of the Comprehensive Plan of Care dated 04/17/13, revealed a care plan which indicated the resident was at risk for alteration in bowel elimination as evidenced by constipation. Review of this care plan revealed the goal stated the resident would have a normal bowel movement (BM) at least every three (3) days. Further review revealed the care plan interventions included to administer medications as ordered, monitor bowel movements, perform bowel, hydration and pain assessments per protocol.

Review of the Physician's Orders dated October 2013 and November 2013, revealed orders for laxatives which included two (2) scheduled, as well as, two (2) prn (as needed) laxatives.

F 282

plans have been reviewed for any needed updates on 01/20/14 per DON, ADON, SW and a Registered Nurse.

4.) Quality Assurance Team to meet weekly times four weeks starting the week of January 12, 2014, then monthly, PRN thereafter. BM flow sheets as well as care plans to be discussed and any abnormalities noted will be discussed and the plan revised. A sample of five BM records with the care plan will be reviewed to ensure that interventions were implemented. Team will consist of Administrator, DON, ADON, Medical Director, SW.

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F 282	<p>Continued From page 16</p> <p>of residents who had not had a BM in three (3) days. She stated nurses were then to follow through with administering a laxative. LPN #2 stated nurses were to check the "BM Report" themselves on weekends. Continued interview with LPN #2 revealed on 11/01/13 she would have received the list of residents who had not had BMs for three (3) days. She stated she did not recall Resident #4 being on the list that day; and, did not remember having been instructed to assess the resident or administer a laxative. In addition, LPN #2 stated nurses were to check Certified Nursing Assistants (CNAs) documentation; but, did not do this daily. She indicated she was unaware the CNAs were not documenting if residents' had BMs each shift or not.</p> <p>Interview, on 12/20/13 at 10:40 AM, with CNA #1, who was assigned to Resident #4 on 11/01/13 on the day shift, revealed CNAs documented BMs in the computer; however, could not look to see how many days residents had gone without a BM. She indicated this was because CNAs could not look at more than one (1) day of documentation in the computer.</p> <p>Interview, on 12/19/13 at 3:30 PM with LPN #3, who was assigned to Resident #4 on 11/01/13 from 3:00 PM until 3:00 AM on 11/02/13, revealed nurses were to administer a laxative if a resident had not had a bowel movement in three (3) days. LPN #3 stated if the laxative was ineffective the nurse was to notify the Physician. She stated nurses received a list of who required a prn laxative each day. However, she indicated she did not recall receiving a list with Resident #4's name on 11/01/13. Further interview revealed she did not remember anything unusual about</p>	F 282	<p>may have been affected.</p> <p>3.) Director of Nursing or designee will review resident bowel movement records for an expanded period of time, increased from a three day review to a seven day review, five days per week with staff nurses completing on the weekends. Facility will utilize BM flow sheet that includes as an a component the action that is taken for every resident that has went three days without a bowel movement. All licensed Nurses</p>		

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F 282	<p>Continued From page 18</p> <p>bowel sounds, abdominal distention and abdominal pain. Further interview with the ADON revealed the care plan should have been followed for this resident.</p> <p>2. Review of Resident #3's clinical record revealed diagnoses which included Asthma, Dysphagia, and Diabetes Mellitus. Review of the Annual MDS Assessment dated 09/20/13, revealed the facility assessed Resident #3 as having a Brief Interview for Mental Status (BIMS) score of fourteen (14) which indicated the resident had no cognitive deficits. Further review revealed the facility assessed Resident #3 as requiring extensive assist of two (2) persons for toileting and as frequently incontinent of urine and occasionally incontinent of bowel.</p> <p>Review of the Comprehensive Plan of Care dated 04/22/13, revealed a bowel care plan related to Resident #3 being occasionally incontinent of bowel and had a history of constipation. Review of this care plan revealed the goal stated the resident would have a normal bowel movement (BM) at least every three (3) days for ninety (90) days. Further review of this care plan revealed interventions which included the following: medications as ordered, monitor BMs, perform bowel, hydration and pain assessments per protocol and notify the Physician as needed.</p> <p>Review of the Physician's Orders dated December 2013 revealed orders for laxatives which included the following: Senna 8.6 mg-50 mg, two (2) tablets at night; Miralax 17 GM prn; MOM 30 ml daily prn; and, Bisac-Evac 10 mg suppositories one (1) daily prn.</p> <p>Review of the "BM Report", revealed the resident</p>	F 282	<p>completion of any assessments assigned.</p> <p>Certified Nursing Assistants have been in serviced per Education Training Registered Nurse regarding the importance of asking residents who independently use the restroom if they have had an a bowel movement every shift on January 13, 2014.</p> <p>4.) Quality Assurance Team to meet weekly times four weeks starting the week of January 12, 2014 then monthly and PRN thereafter. Bowel</p>	

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Review of Resident #7's Comprehensive Plan of Care related to bowel elimination revealed it was initiated 08/20/13 with goals which included normal BMs at least every three (3) days. Further review revealed interventions included the monitoring of bowel movements and the administration of medications as ordered by the Physician.

Review of the "BM Report" revealed no documented evidence Resident #7 had a bowel movement between 09/18/13 and 09/25/13; and, between 10/29/13 and 11/03/13.

Review of the MAR for the months of September, October and November 2013 revealed no documented evidence the prn stool softener was administered as ordered between 09/18/13 and 09/25/13, or between 10/29/13 and 11/03/13, as per the Comprehensive Plan of Care.

Review of the IDT notes revealed no documented evidence of discussion or further monitoring related to Resident #7's lack of bowel movements between 09/18/13 and 09/25/13, or between 10/29/13 and 11/03/13.

Interview with the ADON on 12/20/13 at 4:36 PM, revealed Resident #7 toileted independently. The ADON stated the aides were supposed to ask the resident every shift whether he/she had a bowel movement. Continued interview revealed the ADON could not explain why the lack of documented bowel movements for Resident #7 was not discussed by the IDT on the specified dates, in order to ensure monitoring and implementation of appropriate interventions. She indicated the interventions in the Comprehensive

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- 1.) C.N.A -4 and C.N.A -5 have been in serviced on 12/20/13 regarding the proper procedure for perineal incontinence care as well as infection control standards. This in-servicing was conducted per Education Training Registered Nurse.
- 2.) All residents have the potential to be affected.
- 3.) All Certified Nursing Assistants have been in serviced regarding the proper procedure for perineal/inconti

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This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of facility policies, it was determined the facility failed to ensure necessary care and services were provided for residents' physical well-beings for three (3) of eleven (11) sampled residents (Residents #4, #3, and #7). The facility failed to follow the bowel protocol for Resident #4 who did not have bowel elimination for four (4) days, from 10/29/13 through 11/01/13. On 11/01/13, Resident #4 was noted to have a distended firm abdomen and complained of abdominal pain. As a result, Resident #4 was admitted to the hospital on 11/01/13 and subsequently underwent a Hemicolectomy (surgical procedure to remove approximately half of the colon), on 11/07/13 for Colonic Volvulus (a twisting of a segment of colon resulting in obstruction). The resident was readmitted to the facility on 11/10/13.

In addition, the facility failed to provide documented evidence Resident #3 and #7 experienced bowel movements for periods ranging from five (5) to eight (8) days.

Additionally, for these residents there was no documented evidence the facility followed its "Bowel Policy", regarding the administration of laxatives as ordered by the Physician and checking for bowel sounds daily until resolved for residents who had not had regular bowel movements.

The findings include:
Review of the facility policy titled, "Bowel Policy",

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at least the Administrator, DON, ADON, Housekeeping Supervisor, a housekeeper or laundry worker, dietary worker, C.N.A and Licensed Nurse. This committee will discuss the current isolations, reasons for, proper procedures for such and ways to prevent infections. Round table discussion held regarding any questions / concerns brought forth from meeting. This meeting will be held weekly times four weeks then monthly/PRN

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F 309 Continued From page 24

Self assessment form dated 09/28/13, revealed under the Gastrointestinal (GI) section the nurse assessed Resident #4 to be incontinent of bowel and have a history of constipation.

Review of the Comprehensive Care Plan for Resident #4, dated 04/17/13 revealed revealed a care plan for the resident being at risk of alteration in bowel elimination as evidenced by constipation. The goal stated the resident would have a normal bowel movement at least every three (3) days. Interventions included to administer medications as ordered, monitor bowel movements, perform bowel, hydration and pain assessments per protocol.

Review of the Physician's Orders for October 2013 and November 2013, revealed the following orders: Senokot-S (a laxative medication) 8.6-50 milligram (mg) tablets, one tablet twice a day scheduled; Miralax (a laxative medication) 17 GM's (grams) daily scheduled; Dulcolax (a laxative medication) 10 mg's by mouth twice a day prn (as needed); and Milk of Magnesia (a laxative medication) 400 mg/5 milliliters (ml) suspension, give 30 ml by mouth twice a day prn for constipation.

Review of the computerized "BM Report", revealed Resident #4 had a large BM on 10/28/13 which was documented at 1:15 PM. Continued review of the "BM Report" revealed no documented evidence the resident had BMs from 10/29/13 through 11/01/13 (4 days). Further review revealed staff had not documented each shift per the facility's policy.

Interview, on 12/20/13 at 10:40 AM with Certified Nursing Assistant (CNA) #1, revealed CNAs were

F 309 expanded Infection Control Committee will be included in the QA process by having one member attend the QA process by having one member attend to discuss any concerns of the committee. Any abnormalities noted will be addressed and the plan revised at that time. Team will consist of Administrator, DON, ADON, Medical Director, and SW.

5.) Completion Date 01/24/14.

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F 309	<p>Continued From page 26</p> <p>abdominal assessment which included bowel sounds; and, no reference to Resident #4 having no bowel movement during this time frame.</p> <p>Interview with LPN #2 on 12/19/13 at 3:00 PM, revealed she was assigned to Resident #4's care on 11/01/13 on the day shift. She stated on week days, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were to check the "BM Report" each morning and give nurses the list of residents who had not had a BM in three (3) days. According to LPN #2, nurses were to follow through with administering a laxative. She further stated on weekends nurses were responsible for checking the "BM Report". LPN #2 confirmed 11/01/13 was a Friday, and she would have received the list of residents' who had not had a BM from management. She indicated she did not remember Resident #4 being on the list she received; and, did not remember anyone instructing her to assess the resident or administer a laxative. The LPN stated she did remember giving Resident #4 his/her scheduled Miralax the morning of 11/01/13 which the resident consumed. She stated Resident #4 drank some Sprite (a soft drink) later that day and vomited at approximately 2:30 PM. She indicated the vomitus was clear like the Sprite she/he had been drinking. LPN #2 stated after Resident #4 vomited she completed an abdominal assessment which revealed the resident's abdomen was not firm or distended, and there were positive bowel sounds. According to LPN #2, she notified the Advanced Registered Nurse Practitioner (ARNP) of Resident #4's vomiting, which she thought was the result of allergies and mucous and did not check the resident's "BM Report". LPN #2 stated she did not receive any new orders from the ARNP. Continued interview</p>	F 309	

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F 309	<p>Continued From page 28</p> <p>ever remember the resident having any abdominal distention or vomiting.</p> <p>Interview, on 12/20/13 at 5:00 PM with CNA #3, revealed she was assigned to Resident #4 from 11:00 PM on 11/01/13, through the morning of 11/02/13. She stated the resident had no complaints throughout the night; and, she was unaware of the resident having any abdominal distention, pain, or vomiting.</p> <p>Review of the SBAR (situation, background, assessment, request) form dated 11/02/13 and timed 4:30 AM, completed by LPN #1, revealed Resident #4 was experiencing abdominal pain and had vomiting with brown emesis. Review of the "Nursing Home to Hospital Transfer Form" dated 11/02/13 at 5:00 PM, completed by LPN #1, revealed Resident #4 was being transferred to the hospital related to the abdominal pain and vomiting.</p> <p>Interview, on 12/19/13 at 2:30 PM with LPN #1, revealed she normally worked day shift and part of the daily process was for nurses to check the AccuNurse computer program to review the "BM Report". She stated if nurses noted residents who had not had a BM in three (3) days the nurse was to administer a laxative or notify the Physician if a laxative was not ordered. She stated sometimes the IDT Notes related to the BMs were given to the second shift nurse to administer the laxative and follow up. LPN #1 further stated she arrived at work the morning of 11/02/13 at 3:00 AM, and was told by the CNA caring for Resident #4, she could not remember who this was, the resident was complaining of his/her "belly hurting". She stated she checked the resident's vital signs, completed a pain</p>	F 309			

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F 309	Continued From page 30 extensive Right Hemicolectomy (surgical procedure in which approximately half the colon is removed) was performed. The discharge diagnoses included Colon Volvulus, Ileus and Intestinal Obstruction. Interview with Resident #4's ARNP on 12/20/13 at 2:20 PM, revealed it would be hard to say if a Volvulus could occur from not having a BM for five (5) days. She stated her expectation was residents would have a BM at least every three (3) days; however, that would also depend on what was normal for each resident. Further interview revealed the facility's bowel policy should have "caught" this resident not having had a bowel movement with follow through for laxatives as needed. 2. Review of Resident #3's medical record revealed the facility admitted the resident on 07/01/12, with diagnoses which included Asthma, Dysphagia, Diabetes Mellitus and history of Constipation. Review of the Annual MDS Assessment dated 09/20/13, revealed the facility assessed the resident to have a Brief Interview for Mental Status of a fourteen (14) which indicated the resident had no cognitive impairment. Further review of the MDS revealed the facility assessed Resident #3 to require extensive assist of two (2) persons for toileting; and, as frequently incontinent of urine and occasionally incontinent of bowel. Review of the Comprehensive Plan of Care for Resident #3, dated 04/22/13 revealed a bowel care plan related to resident being occasionally incontinent of bowel and a history of constipation. The goal stated the resident was to have a normal bowel movement at least every three (3)	F 309			

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F 309 Continued From page 32
12/09/13, seven (7) days after the last recorded BM. Review revealed the resident received MOM 400 mg/5 ml suspension, 30 ml's on that date. Continued review of the MAR revealed pain assessments were completed on all three (3) shifts from 12/03/13 to 12/06/13; and, hydration assessments were completed on three (3) shifts on 12/03/13, on two (2) shifts on 12/04/13, three (3) shifts on 12/06/13 and two (2) shifts on 12/07/13. Further review of the MAR revealed bowel sounds were to be assessed every shift starting on 12/06/13; however, Resident #3's bowel sounds were only monitored on two (2) shifts on 12/07/13, 12/08/13 and 12/10/13 and on only one (1) shift on 12/09/13.

Review of the "Departmental Notes", which nurses documented on, dated 12/02/13 through 12/10/13 revealed no documented evidence Resident #3 had not had a BM during this time frame.

Further interview on 12/20/13 at 6:00 PM with the ADON revealed if a resident did not have a BM in three (3) days, the bowel policy was to be followed.

3. Review of Resident #7's clinical record revealed the facility admitted the resident on 01/22/13, and readmitted on 07/17/13, with diagnoses which included COPD, Chronic Lymphocytic Leukemia and Constipation. Review of the Quarterly MDS assessment dated 10/23/13 revealed the facility assessed Resident #7 to have a BIMS score of six (6) which indicated the resident was cognitively impaired. Further review of the MDS revealed the facility assessed Resident #7 to require supervision of one (1) staff for toileting; and, to always be continent with

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F 309	<p>Continued From page 34</p> <p>bathroom and toilet independently. Continued interview revealed staff was not usually present when the resident toileted. Resident #7 stated staff "sometimes" asked if the resident had a bowel movement.</p> <p>Interview with the ADON, on 12/20/13 at 4:35 PM, revealed she acknowledged the IDT did not address Resident #7's lack of a bowel movement from 09/18/13 through 09/25/13; and, 10/29/13 through 11/03/13. She stated each instance should have been discussed and she was not sure why it had not been. She further stated Resident #7 was able to toilet independently. Continued interview revealed the aides were to ask each independent resident, every shift, if they had a bowel movement so it could be documented. Review of the MAR with the ADON revealed there was no documented evidence the PRN (as needed) medications were given as ordered by the physician and as directed by the bowel protocol.</p> <p>Interview regarding the facility's policy and procedures, on 12/20/13 at 2:30 PM with the ADON, in the absence of the DON, revealed CNAs inputted residents' BMs in the computer; the DON "pulled" the "BM Report" Monday through Friday; and on weekends the shift nurse "pulled" the "BM Report". She stated the DON monitored to ensure residents did not go over three (3) days without a BM; and, also monitored to ensure the documentation was complete. Continued interview with the ADON, revealed the DON was to give the list of residents, who had not had a BM in three (3) days, to the nurse after the IDT meetings. According to the ADON, the Staff Development Nurse was in charge of ensuring nurses followed through with</p>	F 309			

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assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent Urinary Tract Infections (UTIs) for one (1) of eleven (11) sampled residents (Resident #8).

Observation revealed staff performed poor infection control technique in performing perineal care/incontinence care for Resident #8 who had a history of Urinary Tract Infections (UTIs). This included the failure to provide hygienic care when removing a soiled brief and applying a new one, and failure to wash hands after perineal/incontinence prior to touching objects in the room and prior to exiting the room.

The findings include:

Review of the facility's "Guidelines for Providing Pericare", inservice dated 08/08/13, revealed; cleanse a woman's vulva or the man's penis before the peri-rectal area is cleansed, washing front to back, rinse the skin thoroughly to remove soap, pat the skin dry, remove your gloves and

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F 315 Continued From page 38

to the resident without performing perineal care or incontinence care. With the same soiled gloves, CNA #4 placed a mechanical lift pad under Resident #8, moved the mechanical lift to the bed, attached the lift pad to the mechanical lift and assisted the resident to the wheelchair. CNA #4, with the same soiled gloves, straightened and pulled the bed linens back up on the bed, opened the resident's door and exited the room with the bag of soiled attends without washing her hands. Further observation revealed CNA #4 disposed of the plastic bag in a trash cart in the hall, and then re-entered Resident #8's room to wash her hands. During the procedure CNA #5 assisted with mobility of the resident in the bed and transferring the resident to the wheelchair.

Interview, on 12/18/13 at 4:50 PM, with CNA #4 and CNA #5, revealed Resident #8's brief was "barely wet"; however, if the resident had been very wet, they would have cleansed the vagina front to back with peri-wash. CNA #5 stated if a resident was just wet with urine, she would normally place a new attends without washing the resident. CNA #4 stated she should have provided perineal care, washing the perineal area and vagina prior to placing a new brief for Resident #8. CNA #4 further stated, she should have washed her hands after performing incontinence care for the resident and before touching objects such as the mechanical lift, the bed linens, and other objects in the room, and should have washed her hands prior to exiting the rooms. CNA #4 stated she had training on perineal care on hire in October 2013; however, was never observed by a facility nurse for competency.

Interview, on 12/20/13 at 8:40 AM, with the

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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40089
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policies and guidelines, it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for five (5) of eleven (11) sampled residents (Resident #8, #10, #6, #7 and #9).

Observation of staff during the provision of perineal care/incontinence care for Residents #8 and #10, revealed staff failed to cleanse the residents' perineal area after removal of a wet, soiled briefs and before applying new briefs. Staff failed to wash hands after perineal/incontinence prior to touching objects in the residents' rooms and prior to exiting the rooms.

Observation revealed a Respiratory Therapist

F 441 01/13/14 have been in-service as well. This in-service was conducted per Education Training Registered Nurse. Random observations highlighting the infection control practices, such as hand washing, per-care observations, donning and taking off PPE equipment will be observed per Education Training Registered Nurse or designee times four weeks then monthly and PRN thereafter. Any abnormalities noted during these observations will be addressed at time of discovery. Upon hire, all new employees will review the hand washing/isolation precautions with the Education Training Registered Nurse. Proper cleaning procedures for personal equipment to be monitored per nursing management, which consists of DON, ADON, Education Training

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CNA #4 then applied a new brief without performing perineal care or incontinence care. Continued observation revealed CNA #4, without removing her soiled gloves, placed a mechanical lift pad under Resident #8; moved the mechanical lift to the bed; attached the lift pad to the mechanical lift, and, assisted the resident to his/her wheelchair. Observation revealed CNA #4, with the same contaminated gloves, pulled the bed linens back up on the bed; opened the resident's door and exited the room with the bag containing the soiled brief. Further observation revealed upon entering the hall, CNA #4 disposed of the plastic bag with the soiled brief in a trash cart located there; and, then re-entered Resident #8's room to remove her gloves and wash her hands.

2. Observation of perineal/incontinence care for Resident #10 on 12/18/13 at 4:40 PM, revealed CNA #4 removed the soiled brief, and placed it in a plastic bag. She was observed to apply periwash (a cleansing agent) to wet wash cloths, and cleansed stool from the resident's buttocks and anal area; however, she did not perform perineal care (cleansing the vulva area). Continued observation revealed, without removing her gloves or washing her hands, CNA #4 applied a clean brief to Resident #10; assisted the resident up in the bed by touching the resident's shoulders; placed a cushion under the resident's legs and pulled the covers up. Observation revealed CNA #4, with the same contaminated gloves, used the bed control to lower the bed; opened the resident's door; and exited the room carrying the bag with the soiled brief. She was observed to discard the bag in the trash cart located in the hall, and re-entered Resident #10's room to wash her hands.

F 441 for, proper procedures for such and ways to prevent infections. Round table discussion held regarding any questions/ concerns brought forth from meeting. This meeting will be held weekly times four weeks then monthly/ PRN thereafter.

4.) Quality Assurance Team to meet weekly times four weeks starting the week of January 12, 2014, then monthly and PRN thereafter. Information such as numbers of infections will be discussed to ensure safe infection control practices are being utilized. Any isolation procedure issues identified to be discussed and any abnormalities noted will be addressed and the plan revised at that time. The expanded Infection Control Committee will be included in the QA process by having one member attend the QA meeting to discuss any concerns of that

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guidelines related to perineal care.

3. Review of the facility's "Contact Precaution Policy", undated, revealed Contact Precautions were to be implemented for residents known or suspected to be infected with microorganisms that could be transmitted by direct contact with the resident; or indirect contact with environmental surfaces; or resident care items in the resident's environment. Review of the section related to gloves and handwashing revealed staff were to remove gloves and perform hand hygiene prior to leaving a resident's room. After removing gloves and washing hands, the policy prohibited the touching of potentially contaminated environmental surfaces or items in the resident's room.

Review of the Hospital Discharge Summary for Resident #8, revealed the resident was discharged on 12/09/13, with diagnoses which included Pneumonia with Klebsiella (a form of bacterial pneumonia), Pneumonia with Carbapenem-Resistant Enterobacteriaceae (CRE) positive (bacteria that are difficult to treat because they have high levels of resistance to antibiotics), and Urinary Tract Infection (UTI) with Klebsiella Pneumonia and Morganella Morganii (a gram negative bacteria)-CRE positive.

Review of the Physician's Orders dated December 2013, revealed orders for contact precautions. Further review revealed an order dated 12/10/13 for Tygacil (an antibiotic medication) 30 milligrams (mg) IV (intravenous) every twelve (12) hours for seven (7) days.

Observation, on 12/19/13 at 10:06 AM, revealed CNA #6, CNA #7, and Respiratory Therapist (RT)

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 donned PPE appropriately. She indicated she had performed inservices on 12/09/13, 12/10/13, and 12/18/13 related to PPE and handwashing. She stated in addition on 12/04/13, she did an inservice on contact, droplet, and handwashing for all staff including maintenance and housekeeping. The Staff Development Nurse stated she did not do the inservice with RT #1.

4. During an interview with Housekeeper #1, on 12/19/13 at 8:30 AM, related to infection control within the facility, Housekeeper #1 stated housekeeping staff transported the red biohazard waste bags out of isolation rooms, through the laundry area and out the door to the courtyard where the biohazard bin was located.

Observation, on 12/19/13 at 8:45 AM, revealed the biohazard waste bin was outside in the courtyard; and the only door to the biohazard bin was on the clean side of the laundry area which contained the dryer and the folding table for the clean clothes.

Interview, on 12/19/13 at 8:45 AM, with the Housekeeping Supervisor, revealed housekeeping staff removed the red biohazard bags from the isolation rooms; and took them from the hall through the laundry area to the biohazard bin located outside the laundry door in the courtyard. The Housekeeping Supervisor stated housekeeping staff had to carry the biohazard waste bags past the clean side of the laundry which housed the dryer and the folding tables in order to get to the biohazard bins. She stated it was not the best situation and thought the biohazard bins could be moved.

Interview, on 12/20/13 at 8:40 AM, with the

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F 441	<p>Continued From page 48</p> <p>without any PPE in use. LPN #1 stated Volunteer #1 should not have entered the room without donning a mask, gown and gloves.</p> <p>Interview with the ADON/Infection Control Nurse, on 12/19/13 at 11:02 AM, revealed volunteers should not enter any resident isolation rooms without using the proper PPE.</p> <p>Interview with the Staff Development Coordinator, on 12/20/13 at 6:20 PM, revealed she ensured every staff member, from every department, received education on isolation procedures, including droplet precautions. Continued interview revealed she had been made aware of the incident involving Volunteer #1 and Resident #7; and had subsequently provided education to Volunteer #1. She stated, prior to this incident, outside volunteers had not been included in training sessions related to isolation procedures. However, she indicated they should have been.</p> <p>6. Review of the facility's policy titled, "Clostridium Difficile", revised August 2012, revealed resident items with fecal soiling, including bedpans, should be disinfected with an agent recommended for Clostridium Difficile, such as, a bleach and water solution.</p> <p>Review of Resident #9's clinical record revealed the facility admitted the resident on 08/25/13, with diagnoses which included Status Post Open Reduction and Internal Fixation of a Left Femoral Head Fracture. Continued review revealed Resident #9 had also been diagnosed with Clostridium Difficile infection, and treated with antibiotic therapy, on four occasions since admission. Clostridium Difficile is a bacterial infection of the colon manifested by frequent</p>	F 441		

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F 441	<p>Continued From page 50 environmental surfaces and personal equipment, including bedpans. Continued interview revealed the failure to disinfect and/or replace Resident #9's bedpan after use, could have been a factor in the resident's recurrent infections.</p> <p>Interview with the Staff Development Coordinator, on 12/20/13 at 6:20 PM, revealed all staff was trained on contact precautions and isolation procedures for residents with Clostridium Difficile infection. She stated each infected resident was to have a designated (not shared) commode or bedpan; however, she did not train specifically regarding disinfection of bedpans.</p>	F 441		