

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

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2011
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY	STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206
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F 000	INITIAL COMMENTS A standard survey was conducted 02/01/11 through 02/03/11 and a Life Safety Code survey was conducted 02/01/11. Deficiencies were cited with the highest scope and severity of an "F". This was a Nursing Home Initiative survey beginning at 6:50am. An abbreviated survey was conducted 02/01/11 through 02/03/11 investigating KY00015370, KY00015364 and KY00015550. KY00015370, KY00015264 and KY00015550 were unsubstantiated.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide respect and dignity during meal service for three (3) of twenty-eight (28) sampled residents (Residents #26, #27, and #28). In the Restorative Dining/Activity Room, staff members were observed standing over Residents #26, #27, and #28 while assisting them to eat during morning meal service (#27 and #28) and the noon meal (#26). The findings include: Record review of the facility's policy on Feeding	F 241	<u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Nicole Memara</i>	TITLE Executive Director	(X8) DATE 2/22/2011
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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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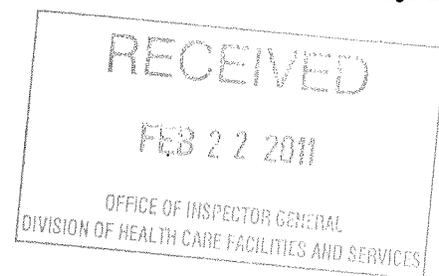
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F 241	Continued From page 1 the Resident (Dependent Eating) states: "Sit at the same level as the resident when possible." Residents #27 and #28 were observed during the morning meal on 02/01/11 at 9:05am being fed by Registered Nurse (RN) #7. During the morning meal, RN #7 was observed standing as she alternated feeding Residents #27 and #28. Resident #26 was observed during the noon meal on 02/01/11 at 1:00pm being fed by the Activity Director, while the director stood over the resident. In an interview with RN #7 on 02/02/11 at 11:15am, she stated she had "not heard anything about whether to stand or sit while feeding." She further stated that she was "cueing and not truly feeding." Interview with the Activity Director, on 02/01/11 at 2:20pm, revealed she was aware staff should sit while feeding residents. She related that she might have received training from the facility on proper feeding techniques. Interview with the Director of Nursing (DON) on 02/03/11 at 8:40am revealed staff should not touch the food with bare hands and should not stand while feeding. The DON stated that staff have been trained and received in-service and know better than to stand while feeding.	F 241	F 241 D 1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? RN #7 and the Activity Assistant (incorrectly identified as the Activity Director) completed training led by DNS on the facility's policy on Feeding the Resident (Dependent Eating) on 2/22/2011. 2) How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? All staff (excluding Housekeeping) completed training led by DNS on the facility policy, Feeding the Resident (Dependent Eating) by 3/8/2011. Additionally all staff (including Housekeeping) completed training, led by DNS on Resident Rights: Maintaining Dignity and Respect in the Nursing Facility by 3/8/2011. 4) How will the facility monitor its performance to ensure that solutions are sustained? Dignity Audits using the Dignity Program Care Audit tool will be conducted by ADNS weekly for 4 weeks, then monthly thereafter. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly thereafter.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		3/16/11



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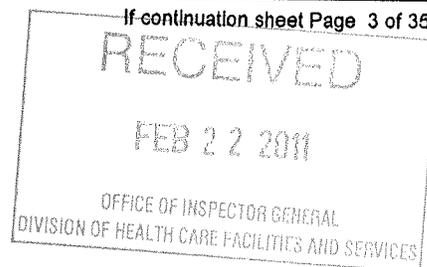
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F 253	<p>Continued From page 2</p> <p>This CONDITION is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide residents with effective housekeeping and maintenance services as evidenced by six (6) wheelchairs with cracked or torn covering on the arm rests and one (1) wheelchair with a cracked and worn seat cushion.</p> <p>The findings include:</p> <p>Record review of the facility's policy for cleaning and disinfecting Non-Critical Resident-Care Items approved by the Medical Director on 01/07/11 revealed that resident-care items should be discarded when damaged or so grossly soiled that a disinfection process is not effective in rendering the item clean.</p> <p>Observation on 02/02/11 at 1:45pm of wheelchairs for the residents in rooms 112, 104, 121-1, and 127-2 revealed that both arm rests were cracked around the edges with foam exposed. The residents in room 105 and 102 had wheelchairs with both arm rests cracked, torn and exposing yellow foam. The resident in room 127-1 had a wheelchair with a seat cushion with two holes which caused the foam to protrude out.</p> <p>Interview with Certified Nursing Assistant (CNA) #3 on 02/03/11 at 8:40am revealed that third shift CNA's are responsible for cleaning and inspecting wheelchairs, although all staff members should be monitoring the condition of the wheelchairs and reporting them to maintenance.</p>	F 253	<p>F 253 D</p> <p>1) <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i> The wheelchairs identified were repaired or replaced by Maintenance on 2/28/2011.</p> <p>2) <i>How will the facility identify other residents having the potential to be affected by the same deficient practice?</i> An audit was conducted by the Interdisciplinary Team for resident equipment to identify housekeeping and maintenance services needed on 3/1/2011. Any repair needs and/or housekeeping needs identified were completed.</p> <p>3) <i>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</i> Staff completed training, led by the DNS, covering recognizing and reporting housekeeping and maintenance needs, including wheelchair repairs by 3/8/2011.</p> <p>4) <i>How will the facility monitor its performance to ensure that solutions are sustained?</i> An audit of resident equipment will be conducted monthly by the central supply manager. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly thereafter.</p>	3/16/11
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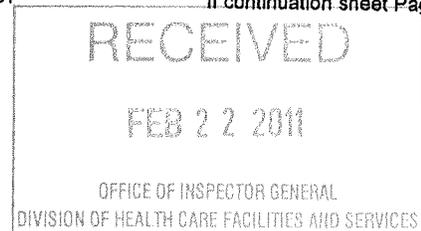
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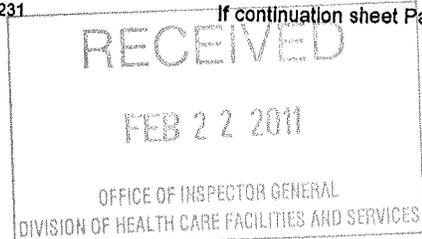
F 253	<p>Continued From page 3</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 02/03/11 at 8:47am revealed that everyone is responsible to report when wheelchairs are in need of repair. All work orders are put in the computer, but she was not sure if a work order had been placed.</p> <p>Interview with the Assistant Director on 02/03/11 at 8:55am revealed that housekeeping started taking responsibility to clean wheelchairs mid January but the CNA cleaning task sheet had not been updated to remove this task from their list. The Assistant Director confirmed that wheelchairs could not be properly cleaned when torn and cracked. She also stated that torn and cracked wheelchairs could potentially place the residents at risk for infection as well as skin integrity.</p> <p>Interview with the Director of Nursing (DON) on 02/03/11 at 9:00am revealed he was not aware the wheelchairs of several residents were in disrepair. The DON admits the current monitoring system for wheelchair cleaning and repair monitoring is not working. He further claims ultimate responsibility for ensuring that the residents' wheelchairs stay in good repair.</p> <p>Interview with the Director of Housekeeping on 02/03/11 at 9:20am revealed that housekeeping started the task of deep cleaning wheelchairs as of 01/14/11. As of 02/03/11 only two (2) of the six (6) hallways had been completed, which is less than half of the facility. Four (4) of the damaged wheelchairs were on the list of those already cleaned, but she was unable to explain why the wheelchairs had not been reported to be repaired. She further states that the current system to report damaged wheelchairs is not working and further in-servicing needs to be completed with</p>	F 253		
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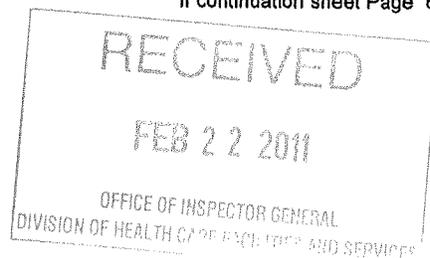
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F 253	Continued From page 4 housekeeping staff. Interview with Maintenance on 02/03/11 at 9:50am revealed he was not aware there were wheelchairs requiring repair and there had not been a work order placed for repair and maintenance of wheelchairs. Interview with Executive Director on 02/03/11 at 11:00am revealed that everyone is responsible to monitor the maintenance of wheelchairs. She further confirmed that she is ultimately responsible for maintenance and housekeeping services provided by the facility.	F 253		
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		



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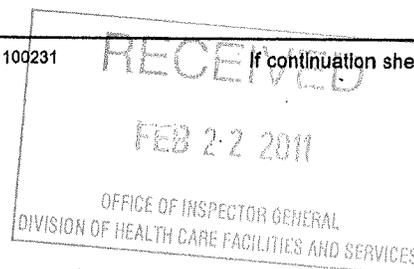
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F 280	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to revise one (1) resident's comprehensive care plan out of a sample of twenty-eight (28) residents (Resident #11) regarding the discontinuation of a restorative program for range of motion (ROM).</p> <p>The findings include:</p> <p>The facility could not provide a policy for periodically reviewing and revising care plans after each assessment.</p> <p>Observations on 02/01/11 at 11:20am and 12:55pm and on 02/02/11 at 08:15am, 9:20am, 10:40am, and 1:15pm revealed Resident #11 did not receive Restorative Care for ROM.</p> <p>Review of the clinical record for Resident #11 revealed there were no orders for a Restorative Program for ROM. A physician order dated 01/08/11 revealed; to discontinue Occupational Therapy (OT) secondary to resident's refusal for intervention. A physician order dated 01/21/11 revealed; to discontinue Physical Therapy (PT) due to the resident repeatedly refusing PT Services despite multiple attempts and encouragement. Review of the facility's Restorative Care Log revealed that Resident #11 was not in a Restorative Program for ROM.</p> <p>Interview with the Restorative RN on 02/03/11 at 1:45pm revealed the Rehab Coordinator was suppose to order Restorative ROM Therapy after doing an evaluation.</p> <p>Interview with the Rehab Coordinator on 02/03/11</p>	F 280	<p>F 280 D</p> <p>1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #11's comprehensive care plan was revised on 2/3/2011 to reflect the discontinuation of the Restorative program for range of motion (ROM).</p> <p>2) How will the facility identify other residents having the potential to be affected by the same deficient practice? An audit was conducted of physician orders and care plans for Restorative services completed by MDS by 3/1/2011 to identify other residents having the potential to be affected. Any discrepancies were clarified as needed and revised.</p> <p>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Training was completed to the Interdisciplinary team on reviewing and revising comprehensive care plans, led by DNS by 2/25/2011.</p> <p>4) How will the facility monitor its performance to ensure that solutions are sustained? Ten active resident care plans will be audited monthly by ADNS to ensure accuracy of care plans. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly thereafter.</p>	3/16/11



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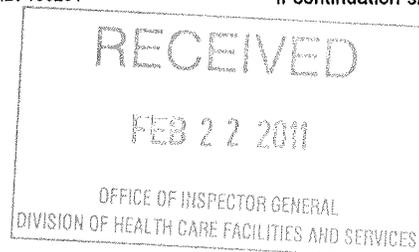
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F 280	Continued From page 6 at 2:00pm revealed that Resident #11 refused PT and OT evaluations and treatments, therefore the Rehab Coordinator did not order Restorative Care for ROM. Interview with the MDS Nurse on 02/03/11 at 1:15pm revealed that a plan initiated on 09/17/10 was revised through 04/07/11 and reflected the need for restorative care to maintain current ROM. According to interventions from the care plan, Resident #11 was to have active ROM, passive ROM, and be rolled side to side times three (3) and repeat seven (7) days a week. The MDS Nurse stated that Restorative Care should be providing ROM therapy to Resident #11. The MDS Nurse thought the resident had been picked up for therapy.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide the necessary care and services for two (2) of the twenty-eight (28) sampled residents (Resident #2 and #16) to maintain the highest practicable physical well-being in accordance with the comprehensive care plan. The facility failed to follow physician orders in a timely manner on	F 309		



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F 309	<p>Continued From page 7</p> <p>Resident #2 regarding a Fast Wrap sling and Resident #16 for removals of staples.</p> <p>The findings include:</p> <p>The facility was not able to provide a policy for following physician orders.</p> <p>Observation of Resident #16 on 02/02/11 and 02/03/11, during the survey, revealed the resident had a left side above knee amputation incision line with approximately thirty-five (35) intact staples.</p> <p>Review of the clinical record for Resident #16 revealed the resident was admitted to the facility with the original admit date of 12/05/10 with diagnoses of, ESRD, CVA, Hypertension and Diabetes. Resident #16 had a hospitalization with a readmission date of 01/24/11 with diagnoses of Convulsions, S/P Lt. AKA (above the knee amputation) on 01/07/11 and Dialysis. The facility's active physician order for Resident #16 on 02/2011 indicated follow up with the physician for staple removal on 02/01/11. Further review of the record revealed an appointment was made for the removal of the staples on 02/01/11 but the resident did not go to the appointment. The updated physician's order for Resident #16 on 02/03/11 indicated staple removal on 02/08/11 at 12:30pm; one week later than the physician indicated date of removal.</p> <p>Interview with Licensed Practical Nurse (LPN #1) on 02/03/11 at 11:00am revealed it is the responsibility of the Unit Manager to enter physician's orders into the computer and to make follow up appointments. She further revealed that she had not communicated with the unit manager</p>	F 309	<p>F 309 D</p> <p>1) <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i> Resident #2 received a Fast wrap sling on 2/1/2011. Resident #16's staples were removed while at a Physician appointment on 2/8/2011.</p> <p>2) <i>How will the facility identify other residents having the potential to be affected by the same deficient practice?</i> Physician orders for active residents were reviewed by unit managers and ADNS by 2/28/2011 to ensure necessary care and services were being provided. Discrepancies were clarified as needed and corrected.</p> <p>3) <i>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</i> Training was completed to the Nurses and Therapists on following physician orders in a timely manner to provide necessary care and services, led by DNS and Rehab Coordinator by 3/8/2011.</p> <p>4) <i>How will the facility monitor its performance to ensure that solutions are sustained?</i> Ten active resident Physician orders will be audited monthly by ADNS to ensure necessary care and services are being provided. Results will be recorded on the Care plan accuracy and MD order tool. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly thereafter.</p>	3/16/11



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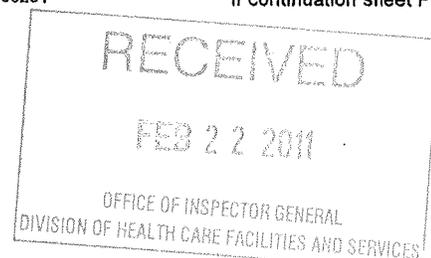
F 309	<p>Continued From page 8</p> <p>regarding Resident #16's staples remaining in after the follow up date of 02/01/11. Additionally she stated it could increase discomfort to remove staples greater than thirty (30) days.</p> <p>Interview with the Unit Manager (RN #1) on 02/03/11 at 11:15am revealed it is her responsibility to enter physician orders into the computer and make the follow up appointments. She further revealed that by not making the appointment and following the physician's order dated 01/24/11, it could cause the resident discomfort when the staples are removed on 02/08/11.</p> <p>Interview with the Director of Nursing (DON) on 02/03/11 at 11:30am revealed it is the responsibility of the Unit Manager to enter physician's orders into the computer and schedule appointments. He further revealed that it is the responsibility of all the nurses caring for the resident to assess physician orders. The DON further stated that Resident #16 could have an increase in discomfort by having staples removed after thirty (30) days.</p> <p>Observation on 02/01/11 at 7:30am during the initial tour revealed Resident #2 sitting up while in bed with the head of the bed elevated. A blue sling on the right side of the resident was up around his/her back neck area and not on the arm. Resident #2 complained of pain in the right arm.</p> <p>Record review of Nursing Notes dated 01/31/11 at 11:51 revealed resident " removes sling or wears it incorrectly, staff attempts to educate resident, but unsuccessful secondary to short term memory loss." Further review revealed a</p>	F 309		
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PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

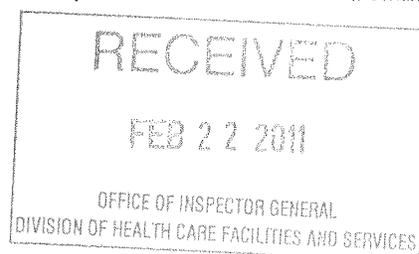
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/03/2011
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY			STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206		
(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 309	<p>Continued From page 9</p> <p>physician order dated 01/26/11 that documented "Pt is to have fast wrap shoulder immobilizer to prevent movement of right upper extremity (RUE) and promote healing of humerus fx."</p> <p>Observation on 02/01/11 at 11:05am revealed Resident #2 sitting in a chair in physical therapy with the Fast Wrap (sling and swath) on the right arm.</p> <p>Interview on 02/01/11 at 1:45pm with Resident #2 revealed the Fast Wrap was just put on this morning and he/she thinks it will help with the pain.</p> <p>Record review on 02/02/11 of Orthotics/Prosthetics Order Form revealed a Fast Wrap Shoulder Immobilizer was ordered on 01/26/11, delivered to the facility on 01/28/11 and placed on resident on 02/01/11. There was a delay of four days from the time of receipt of the sling and the time it was put on the resident.</p> <p>Interview with Occupational Therapist (OT) on 02/02/11 at 1:45pm revealed the ordered sling was ordered on Wednesday 01/26/11 and came in the late afternoon on the 01/28/11 at approximately 5:30pm. She stated she had been sick on Monday 01/31/11 but when she returned on 02/01/11 she did place the Fast Wrap sling on the resident. When asked if Resident #2 was more comfortable with the Fast Wrap on the OT replied that yes the resident was more comfortable since application of Fast Wrap sling. She revealed that prior to applying the Fast Wrap sling Resident #2 kept trying to move his/her right arm which caused increased pain and increased anxiety due to staff reminding the resident not to use the right arm. The OT stated Resident #2 is</p>	F 309			



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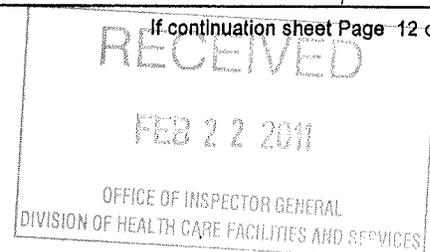
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F 309	<p>Continued From page 10</p> <p>a lot more comfortable since the application of the Fast Wrap sling. The OT stated that someone else could have applied the sling but she was unclear if they could educate the resident. When asked if another therapist could have applied the sling on Monday 01/31/11 she replied they could have but she was not sure which therapist worked with Resident #2 in the OT's absence?</p> <p>Interview with RN #4 on 02/02/11 at 5:00pm revealed that usually someone in therapy puts on the sling but if not then sometimes the nurses will put on the sling when the resident comes back from ER. RN #4 reported that Resident #2 has been much more comfortable since application of Fast Wrap sling and has not had any pain medication since the Fast Wrap sling was applied.</p> <p>Record review on 02/03/11 of the Nurse's Notes dated 02/02/11 at 8:26pm revealed, "Resident voices that their arm is feeling better and that the new sling works better."</p> <p>Interview with the Unit Manager on 02/03/11 at 9:20am revealed that nurses can put on Fast Wrap slings if they have them for the residents, but they do not keep them on the floor, therapy orders the slings. She stated she was unaware that the ordered sling was in the building from 1/28-02/01/11. She stated she guessed it was back in therapy. She stated if the nurses had known the sling was in therapy, they could have applied the sling. When asked if she could see a difference in Resident #2 since the application of the correct sling, she responded, "I don't know, not really."</p> <p>Interview with the Occupational Therapist (OT) on</p>	F 309		



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F 309	Continued From page 11 02/03/11 at 11:15am revealed there are no policies that prohibit nurses from putting slings on residents. The OT stated a therapist usually does not put slings on another therapist's residents because they have not worked with them before. The OT revealed they do not put on braces or slings unless they can observe the resident for effectiveness and comfort. When asked if a nurse could observe residents, the OT responded by saying they could. Interview with the Rehab Coordinator, on 02/03/11 at 11:40am, revealed that if staff let her know a task needs to be completed, she has that task done. When asked if a therapist is available on Saturdays, she replied not every Saturday, and sometimes the staff on Saturdays are PRN, so she would not feel comfortable having a PRN person put a sling on someone who is anxious. There would need to be a period of time for observations of the resident and education of staff. She reported that had the Occupational Therapist, who called in sick on 01/03/11, let her know of the need, the brace would have been put on Resident #2 and monitored. She reported that nurses could have put on the sling and made observations but not pick up on gait abnormalities that a therapist would. The Rehab coordinator reported that with the Fast Wrap sling there is decreased movement at the fracture site and that movement at the fracture site causes pain and delays healing.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		



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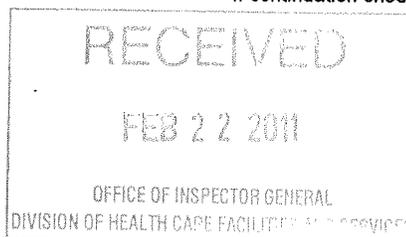
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F 323	<p>Continued From page 12 prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the residents' environment remained as free from accident hazards as possible. Observation during the morning meal pass revealed the facility failed to ensure scissors were secured and not accessible to residents. The findings include:</p> <p>Observation on 02/02/11 at 8:40am revealed a pair of scissors was left unsecured on top of the medication cart on the West Hall and accessible to residents.</p> <p>Interview on 02/02/11 at 2:00pm with Registered Nurse (RN) #8 revealed she did leave scissors on top of the medication cart while passing breakfast trays and came back later to put them in a caddy she keeps stored unsecured on the side of her medication cart. It was further revealed when she enters a room while passing medications, the scissors are not secured and remain in a caddy placed on the side of the medication cart, accessible to residents.</p> <p>Interview on 02/02/11 at 3:30pm with the Director of Nursing revealed staff are in-serviced on the types of scissors to be used and scissor safety within the facility.</p> <p>Interview on 02/02/11 at 4:33pm with the Director of Clinical Education revealed there was no</p>	F 323	<p>F 323 D</p> <p>1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? RN #8 completed training led by DCE on 2/2/2011 on proper storage of scissors and sharps.</p> <p>2) How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected.</p> <p>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Nursing staff completed training, led by the DNS on potential environmental hazards by 3/8/2011.</p> <p>4) How will the facility monitor its performance to ensure that solutions are sustained? Safety audits will be conducted weekly by DNS for 4 weeks, then monthly thereafter. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly thereafter.</p>	3/16/11
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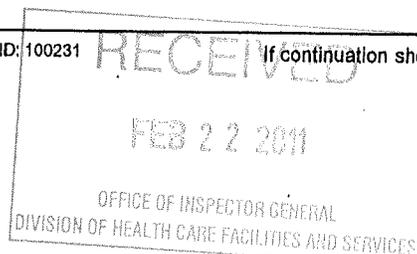
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F 323	Continued From page 13 record to review as "there is no in-service on that", and there is not an orientation on either the types of scissors to use or the safe storage when scissors are not in use.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure proper storage and labeling of food items as evidenced by multiple food items found uncovered and not dated in the refrigerator and walk-in freezer. Also, the facility failed to clean equipment and contact surfaces in the kitchen as evidenced by dirty carts in the food preparation area, dirty plate warmer containing clean dishes, and dirty racks in refrigerator. The findings include: Review of the policy on the Storage of Frozen Foods dated 2002 revealed that all items must be properly resealed, labeled and dated. Review of the policy on Cold Food Storage dated 12/15/09 revealed that all opened containers should have a date when opened to assure correct rotation.	F 371		



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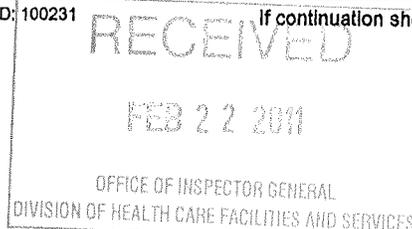
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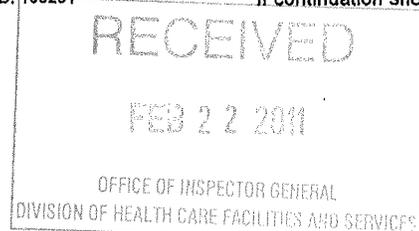
F 371	<p>Continued From page 14</p> <p>Review of the policy on Storage of Refrigerated Foods dated 2002 revealed that all items not stored in original container must be labeled and dated and used or discarded within three days, and date all bulk condiment items with the date opened.</p> <p>Observation during the initial tour of the kitchen on 02/01/11 at 6:30am revealed a plate warmer, filled with clean plates that had white spots, a sticky clear residue, and white colored crumbs and particles on the top of the warmer. There was a gray colored cart in front of steam table with brown and red colored spots and splatters on both shelves and a sticky residue on the top of cart. A cart parked between the reach-in refrigerator and the chopping station was covered with brown splatters and caked on black/brown residue on the edges and hinges of the cart.</p> <p>Observation of the reach-in refrigerator on 02/01/11 at 6:55am revealed the following items had been opened but not dated: one package of Monterey jack cheese, one large bag of pre-made salad, one bag of pepperoni slices, a stack of sliced American cheese, one jar of maraschino cherries, one jar of mayonnaise, one jar of mustard, one jar of dill pickle slices, and a container of sour cream. Also found in the reach-in refrigerator were two (2) sterlites pitchers containing a brown colored liquid without a lid and no date? A clear plastic pitcher containing a brown colored liquid with an expired use by date of 01/27/10 was found on the shelf in the back of the refrigerator. A large container of peaches with the lid half open was found on the bottom of the reach-in refrigerator.</p> <p>Observation of the walk-in freezer on 02/01/11 at</p>	F 371	<p>F 371 E</p> <p>1) <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>The identified plate warmer , refrigerator racks, ledge above the stove and utility carts in use in the kitchen area were deep cleaned by the dining staff on 2/18/2011. The improperly labeled/dated identified food items in the reach in and walk in freezer were discarded on 2/1/2011.</p> <p>2) <i>How will the facility identify other residents having the potential to be affected by the same deficient practice?</i></p> <p>All residents have the potential to be affected</p> <p>3) <i>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</i></p> <p>Daily cleaning of the plate warmer, shelf above stove and utility carts was added to the opening and closing checklists on 2/22/2011. Deep cleaning schedule was revised by the DSM on 2/22/2011. Kitchen staff in-service completed by DSM and RD by 2/24/2011 for the topic of how to store, prepare, distribute and serve food under sanitary conditions .</p> <p>4) <i>How will the facility monitor its performance to ensure that solutions are sustained?</i></p> <p>Sanitation checklist audit will be conducted twice a week, once by the DSM and once by the RD x 4 weeks, then by the RD once a week x 4 weeks, then monthly. Finding from this audit will be presented to the QAA committee monthly x 3 months, then quarterly thereafter.</p>	3/16/11
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F 371	<p>Continued From page 15</p> <p>7:30am revealed the following items had been opened but not dated: one box of pork chops, a box of glazed chicken breast, a box of chopped ham, a box of breaded chicken tenders, a box of beef patty crumbles, and a box of Black Angus patties.</p> <p>Interview on 02/01/11 at 9:00am with the Dietary Manager revealed she was not aware that there were food items in the reach-in refrigerator and walk-in freezer that were not properly sealed or dated. She stated everyone is responsible for ensuring all items are properly sealed and dated after opening.</p> <p>Observation on 02/02/11 at 4:06pm revealed the plate warmer parked in the dish washing area containing two stacks of clean plates. The plate warmer's top surface had white particles, small pieces of a blue metallic paper, large yellow particles, and white spots.</p> <p>Interview with the Dietary manager on 02/02/11 at 4:06pm confirmed that the plate warmer was not clean and the plates should not have been stacked in the warmer until the surface had been wiped down. She stated that storing clean plates in a dirty plate warmer could potentially place the residents at risk for infection. She also stated there was a new cleaning schedule. The staff had been in-serviced on the new schedule on 01/06/11, but she confirmed the current system of ensuring the new cleaning schedule was being followed was not working.</p> <p>Observation on 02/02/11 at 4:20pm revealed a cart parked between the reach-in refrigerator and chopping station with black and brown buildup on hinges and edges of cart, and orange/brown</p>	F 371		



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F 371	Continued From page 16 splatters on each shelf. The upper ledge of the stove was covered with white particles and a greasy film residue. When the ledge was touched by the chef a visible streaky handprint was noted in the residue. The refrigerator racks were covered with yellow and black residue and multi colored particles were noted on the bottom shelf of the reach-in refrigerator. Interview with the Dietary Manager on 02/02/11 at 4:30pm revealed that all carts are supposed to be cleaned by the chef at the end of each shift. The refrigerator bottom is cleaned at the end of each shift by the dietary aide, and the racks were cleaned by the evening shift. Again, she stated there was a new cleaning assignment but currently no system or record keeping was in place to ensure the tasks were being completed. The Dietary Manager stated she is ultimately responsible for the cleanliness of the kitchen. She has a checklist that she completes every morning. The checklist does include an area to ensure cleanliness of the refrigerator and to check that all items are sealed and dated. The checklist did not include an area to ensure the cleanliness of the stove and carts used in the kitchen area. The Dietary Manager admitted she did not complete this checklist on 02/01/11 and 02/02/11.	F 371			
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	F 441			

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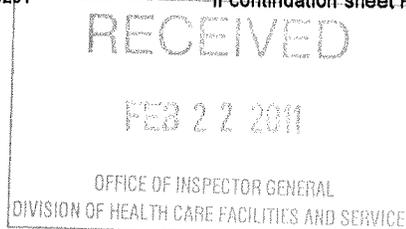
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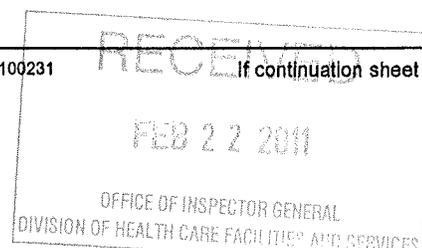
F 441	<p>Continued From page 17</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</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</p> <p>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 maintain a sanitary environment to prevent the development and transmission of disease for eight (8) of twenty-eight (28) sampled residents (Residents #5, #16, #17, #21, #22, #23, #24, and</p>	F 441	<p>F 441 F</p> <p>1) <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>Identified staff (CNA #1, CNA #2, RN #4, SLP#1) observed during meal service on 2/1/2011 have completed training led by ADNS on infection control related to Dining Services and Universal Precautions on 2/25/2011. RN #5 completed training led by DNS on sanitizing hands between wound care and glove changes on 2/2/2011. Respiratory tubing for residents #17, #21, #22, and #23 were discarded and replaced by RN Supervisor on 2/2/2011. The treatment cart on the annex unit was taken out of service on 2/2/2011 by the DNS. The treatment cart on the main unit was cleaned by the RN treatment nurse and the top replaced by the Pharmacy Repair tech on 2/2/2011. Wheelchairs in rooms 104, 112, 121-1, 127-1, 127-2 and 206-2 were repaired by Maintenance by 2/28/2011 and then cleaned by Housekeeping by 2/28/2011.</p> <p>2) <i>How will the facility identify other residents having the potential to be affected by the same deficient practice?</i></p> <p>All residents have the potential to be affected. An audit was conducted by Central Supply to ensure all respiratory tubing was labeled, dated, clean, and stored correctly completed by 2/28/2011. An audit of the wheelchairs was conducted for repair needs and cleanliness by Central Supply by 3/9/2011.</p>	
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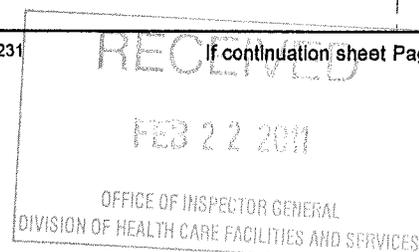
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F 441	<p>Continued From page 18</p> <p>#25). Staff handled three (3) sampled residents' (Residents #16, #24, and #25) food with bare hands during meal service. Staff failed to sanitize hands between wound care for Resident #5. The facility failed to maintain clean respiratory equipment for Residents' #17, #21, #22, and #23. Additionally, the facility failed to maintain clean treatment carts and wheelchairs.</p> <p>The findings include:</p> <p>1. Review of the facility's Infection Control Policy approved by the Medical Director states associates will observe universal precautions at all times.</p> <p>Observation of the breakfast meal service in the Restorative Dining/Activity Room on 02/01/11 at 8:40am revealed Certified Nursing Assistant (CNA) #1 removed one piece of bread from a wax paper wrapper with his bare hand for Resident #24. Using his bare hand CNA #1 placed the bread in Resident #24's right hand.</p> <p>Observation of the breakfast meal service in the Restorative Dining/Activity Room on 02/01/11 at 8:55am revealed CNA #2 touched bread with his bare hands and buttered it for Resident #25.</p> <p>Interview with CNA #1 on 02/01/11 at 2:15pm revealed he received in-service training and was taught not to touch food with bare hands because "you might transfer something." He related that he realized he touched the bread with his bare hands for Resident #24. He further stated he was not thinking at the time, and was trying to get the resident to eat.</p> <p>Interview with CNA #2 on 02/01/11 at 2:00pm</p>	F 441	<p>F441 F cont.</p> <p>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Infection control training was conducted by DNS to the facility staff to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection, completed by 3/8/2011.</p> <p>4) How will the facility monitor its performance to ensure that solutions are sustained? An audit of infection control practices will be documented using the Monitoring Compliance with Infection Control Checklist completed by ADNS weekly for 4 weeks, then monthly thereafter. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly thereafter.</p>	3/16/11



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F 441	<p>Continued From page 19</p> <p>revealed acknowledgment of touching the food of Resident #25 with bare hands. During the interview, CNA #2 stated staff should not touch food with their bare hands, and should use a fork or knife to hold the bread down while spreading butter. According to CNA #2, he attended in-service education for Infection Control and Dining Room Services.</p> <p>Observations on 02/01/11 at 8:45am during the breakfast meal revealed RN #4 in room 325 using their bare hands to butter the resident's toast.</p> <p>Observation on 02/01/11 at 8:50am during the breakfast meal revealed Speech Language Pathologist (SLP) #1 assisting Resident #1 with the meal tray and adjusted his/her wheelchair, then proceed back to clean the dining cart without sanitizing their hands, then served a breakfast tray to Resident #16. Further observation of SLP #1 in Resident #16's room revealed she took the breakfast tray and placed it on the bedside table and raised the head of the bed. SLP #1 then gave the resident a damp wash cloth to wipe his/her face and hands, then placed the soiled wash cloth in bathroom. SLP#1 picked up the fall mat from the floor and placed it near the window, then proceeded to assist feeding Resident #16, without sanitizing or washing her hands.</p> <p>Interview with RN #4 on 02/03/11 at 4:00pm revealed she had received training in infection control. She further revealed that staff should not touch food with bare hands because of cross-contamination.</p> <p>Interview with SLP #1 on 02/03/11 at 4:15pm revealed she had received training in infection control. She further revealed that hand washing</p>	F 441			



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

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FORM APPROVED
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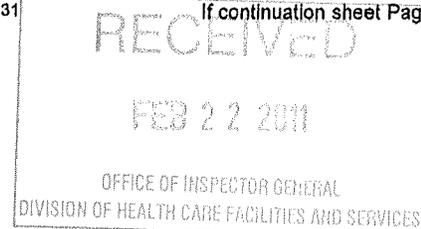
F 441	<p>Continued From page 20 and hand sanitizing is very important to prevent the spread of germs.</p> <p>Interview with the Director of Clinical Education on 02/03/11 at 1:35pm revealed the facility has in place an Infection Control Policy/Program, and staff receive in-service on proper food handling techniques. She conducted an in-service on Infection Control on 10/27/10, and provided the attendance sign-in sheet, which showed the signatures of CNA #1 and CNA #2 indicating their attendance. Avoiding bare-hand contact was covered during the in-service.</p> <p>Interview with the Director of Nursing (DON) on 02/03/11 at 8:40am revealed staff should not touch food with bare hands. The DON stated that staff have been trained and received in-service and know better than to touch food with bare hands.</p> <p>2. Record review of the policy Infection Control Policy and Procedure Manual revealed; Use an alcohol-based hand rub containing 60-95% ethanol or isopropanol after the removal of gloves.</p> <p>Observation of Resident #5 on 02/01/11 at 2:15pm revealed Registered Nurse (RN) #5 performed wound care on Resident #5's right lower extremity, removed gloves, put on another pair of clean gloves, proceeded to perform wound care to the left lower leg then removed the dirty gloves and applied another pair of clean gloves, and repeated the same procedure on the left lower arm. RN #5 did not sanitize hands during Resident #5's treatments or when applying new gloves.</p>	F 441		
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If continuation sheet Page 21 of 35
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PRINTED: 02/17/2011
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F 441	<p>Continued From page 21</p> <p>Interview with RN #5 on 02/03/11 at 12:30pm revealed she had been trained in infection control. She further revealed that hand sanitation should be used between glove changes to prevent cross contamination.</p> <p>Interview with RN #6 on 02/03/11 at 2:30pm revealed that all staff are trained in infection control. She further stated that hand sanitation should be used between glove changes to prevent cross contamination.</p> <p>3. Review of the facility policy on Departmental (Respiratory Therapy) - Prevention of Infection (Revised April 2007) revealed oxygen cannula and tubing are to be changed every seven (7) days and oxygen cannula and tubing are to be in plastic bags when not in use.</p> <p>Review of the TEACHING GUIDE COMPRESSOR DRIVEN NEBULIZER revealed nebulizers should be stored in a clean dry plastic bag.</p> <p>Observation during the facility tour on 02/01/11 at 7:05am until 8:30am on the West Hall revealed Resident #23 in room 101 had no date label on the oxygen tubing and a nebulizer was uncovered and not labeled. Resident #22 in room 109 had no date label on the oxygen tubing and a nebulizer was uncovered and not labeled. Resident #17 in room 110 had oxygen tubing touching the floor with no date label. The roommate of Resident #21 in room 112 had no date label on the oxygen tubing and a nebulizer was uncovered and not labeled.</p> <p>Interview on 02/03/11 at 8:10am with LPN #2 revealed staff are in-serviced on the storage of</p>	F 441		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

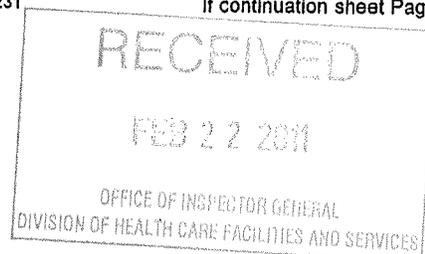
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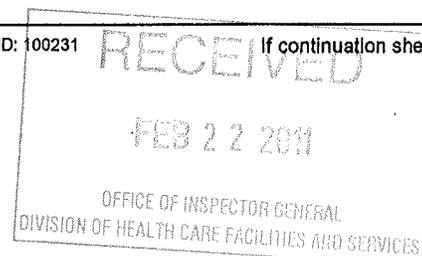
F 441	<p>Continued From page 22</p> <p>oxygen equipment when not in use. It was further revealed that staff should make sure the tubing is dated and changed as required.</p> <p>Interview on 02/03/11 at 8:30am with the Director of Nursing (DON) revealed the oxygen tubing should be changed every Tuesday night by the Supervisor. In addition, the DON stated there was no check off sheet or documentation involved, because it is a task that they should do.</p> <p>Interview on 02/03/11 at 4:00pm with the Director of Clinical Education revealed documentation of changing the oxygen equipment should be on the medication administration record (MAR). Review of the Clinical Monitoring For Oxygen on the MAR showed no area to document the changing of equipment.</p> <p>4. Record review of the facility's policy for cleaning and disinfecting Non-Critical Resident-Care Items approved by the Medical Director on 01/07/11 revealed that resident-care items should be discarded when damaged or so grossly soiled that a disinfection process is not effective in rendering the item clean.</p> <p>Record review of the facility's policy on Cleaning and Disinfection of Resident-Care items and Equipment approved by the medical Director on 01/07/11 revealed that resident-care equipment including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard.</p> <p>Review of the facility's night nurse assignment task sheet did not include cleaning of the</p>	F 441		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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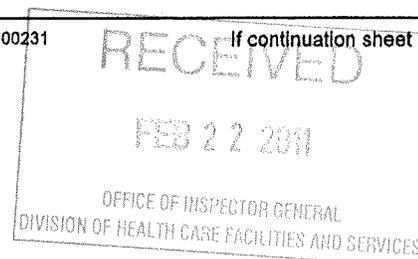
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F 441	<p>Continued From page 23 treatment carts.</p> <p>Observation of the treatment cart for the main nursing station on 02/02/11 at 10:25am revealed the treatment cart was parked in the hallway and had a brown/black sticky substance on the top of the cart. There was also brown discolored tape on the top and the edges of the cart. The lip at the base of cart had a brown caked on substance all the way around the cart and brown fuzzy particles on the sides of cart. The top edges of the cart were cracked with holes.</p> <p>Interview with Registered Nurse (RN) #5 on 02/02/11 at 10:25am revealed she was not sure when the treatment cart was last cleaned or if there was a cleaning schedule for it to be cleaned. She stated it "looks like it has not been done in awhile". She was not aware if there was a policy on when or how to clean the treatment cart. She stated that she will wipe it down if it looks dirty, but admitted that she did not wipe it down before starting treatments.</p> <p>Observation of the treatment cart on the annex side on 02/02/11 at 11:00am revealed a treatment cart in the medication room with yellow charge stickers around the edges on top of the cart. There was brown stained tape on the top and around the edges of the cart. There was an orange/yellow sticky substance next to a greasy film on top of the treatment cart. The front drawer facing was missing from all three drawers leaving two inch gaps between each drawer and exposing items inside the drawer to the air. The treatment cart was sitting directly beneath a window air conditioning unit which was covered with brown fuzzy particles. The bottom of the last drawer was covered with an orange sticky</p>	F 441		



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

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FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 24 substance.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 02/02/11 at 11:03am revealed the air conditioner appeared to have "dirt, grime, and dust bunnies". She stated housekeeping was responsible for cleaning the air conditioner. She also stated that having the treatment cart parked under an air conditioner could cause potential infection to residents. She revealed that night shift was responsible for cleaning the treatment carts and everyone was responsible for reporting disrepair of the treatment cart. In addition, she further stated that she was not aware if the treatment cart had been reported for the missing drawer facings.</p> <p>Interview with RN #1 on 02/02/11 at 11:15am revealed a broken treatment cart parked under a dirty air conditioner could blow dirt down on both medication and treatment carts which could potentially cause problems with infection to the residents. She admitted that she was responsible for making sure medication rooms were clean and she would have to allow access to housekeeping since the room was kept locked. She admitted to not having allowed them access to the room for a couple of days. She confirmed that the treatment cart was not clean and could harbor bacteria. She also stated that pharmacy was responsible for the maintenance of the treatment carts but did not think it had been reported as broken.</p> <p>Interview with LPN #3 on 02/02/11 at 1:15pm revealed the night shift supervisor should make sure the treatment cart was being cleaned. Every nurse was responsible for making sure the treatment carts are sanitary. She also confirmed</p>	F 441			



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

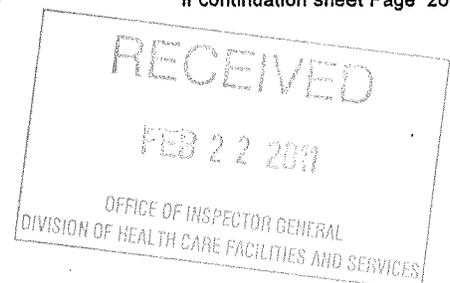
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F 441	<p>Continued From page 25</p> <p>that she does not ensure that the treatment nurse is cleaning the cart. She confirmed that the cart cannot be properly cleaned with cracked edges and tape on the top and sides of the cart.</p> <p>Interview with the Assistant Director on 02/02/11 at 1:20pm revealed that treatment carts cannot be effectively cleaned with cracked and broken edges. She confirmed there was no monitoring system in place to ensure the carts were being cleaned. She confirmed she was responsible for ensuring the night shift supervisor was making sure the carts were being cleaned, but she was not aware that the night nurse assignment sheet did not have cleaning of the treatment carts on the task list.</p> <p>Interview with the Director of Nursing (DON) on 02/02/11 at 1:30pm revealed he was not aware of the condition of the treatment carts until it was brought to his attention by staff members during the survey. The DON did confirm that the treatment carts were unsanitary and in disrepair. He was also not aware that the task of cleaning the carts was not on the night nurse assignment list or that there was currently no system in place to ensure treatment carts were being cleaned. He did confirm that he was ultimately responsible for ensuring the sanitization and condition of the treatment carts.</p> <p>Observations on 02/02/11 at 1:45pm revealed the wheelchairs in rooms 112, 104, 121-1, and 127-2 had both arm rests that were cracked around the edges with exposed foam. The residents in room 105 and 102 had wheelchairs with both arm rests cracked and torn with exposed yellow foam. The resident's wheelchair in room 127-1 had a seat cushion with two holes causing the foam to</p>	F 441		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

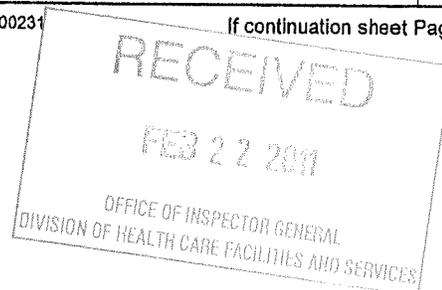
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F 441	<p>Continued From page 26</p> <p>protrude out, and the resident's wheelchair in room 206-2 had multiple strips of dark dingy tape on both arm rests.</p> <p>Interview with Certified Nursing Assistant (CNA) #3 on 02/03/11 at 8:40am revealed the third shift CNA's are responsible for deep cleaning and inspecting wheelchairs, although all staff members should monitor the condition of the wheelchairs and report them to maintenance. She stated that wheelchair arms cannot be effectively cleaned and sanitized when torn and cracked.</p> <p>Interview with LPN #3 on 02/03/11 at 8:47am revealed the night shift was responsible for the cleaning of wheelchairs. The night shift supervisor should be checking to ensure the wheelchairs were cleaned and in good repair. She stated that wheelchairs cannot be properly cleaned when they are cracked and torn due to the risk of infection to the residents. She further revealed that everyone was responsible to report when wheelchairs were in need of repair. All work orders are put into the computer, but she was not sure if a work order had been placed.</p> <p>Interview with the Assistant Director on 02/03/11 at 8:55am revealed she confirmed the fact that wheelchairs cannot be properly sanitized and cleaned when they are in disrepair. She further revealed that housekeeping recently started taking the responsibility to clean the wheelchairs in mid January, but the CNA cleaning task sheet had not been updated to remove this task from their list. The Assistant Director confirmed that wheelchairs could not be properly cleaned when torn and cracked. She also stated that torn and cracked wheelchairs could potentially place the</p>	F 441		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

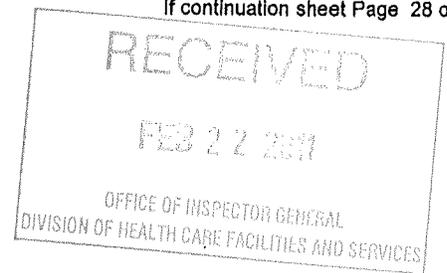
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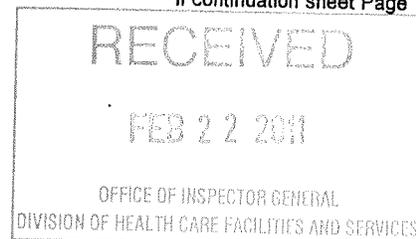
F 441	<p>Continued From page 27</p> <p>residents at risk for infection as well as skin integrity. She admitted responsibility for ensuring the night shift supervisor was monitoring the cleaning and maintenance of the wheelchairs.</p> <p>Interview with the DON on 02/03/11 at 9:00am revealed he was not aware the wheelchairs of several residents were in disrepair. The DON admitted the current monitoring system for wheelchair cleaning and repair monitoring was not working. He further claimed ultimate responsibility for ensuring that the resident wheelchairs stayed in good repair.</p> <p>Interview with the Director of Housekeeping on 02/03/11 at 9:20am revealed housekeeping started the task of deep cleaning wheelchairs as of 01/14/11. As of 02/03/11 only two (2) of the six (6) hallways had been completed, which was less than half of the facility. Four (4) of the damaged wheelchairs were on the list of those already cleaned, but she was unable to explain why the wheelchairs had not been reported to be repaired. She further stated that the current system to report damaged wheelchairs was not working and further in-servicing needed to be completed with housekeeping staff. She stated that no in-servicing had been completed with housekeeping staff on infection control and the importance of keeping wheelchairs in good repair. She stated that she was responsible for ensuring the housekeeping staff were effectively deep cleaning the wheelchairs.</p> <p>Interview with Maintenance on 02/03/11 at 9:50am revealed he was not aware there were wheelchairs requiring repair and there had not been a work order placed for repair and maintenance of wheelchairs.</p>	F 441		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

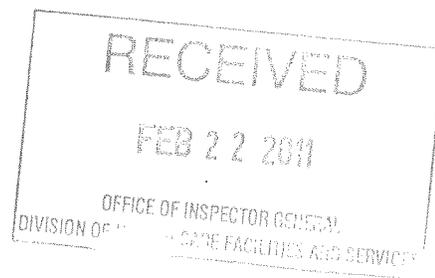
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 28 Interview with the Executive Director on 02/03/11 at 11:00am revealed that everyone was responsible for monitoring the maintenance of wheelchairs. She further acknowledged that she was ultimately responsible for maintenance and housekeeping services provided by the facility. Interview with Registered Nurse #6 on 02/03/11 at 2:55pm revealed that she was responsible for infection control in the facility. She was not aware of the sanitary conditions of the treatment carts. She stated that treatment carts are stored in the medication rooms when not in use and are left in the hallways during treatment times. She stated the treatment carts should be cleaned, although she could not specify how often they should be cleaned and when they were last cleaned. She stated dirty treatment carts could potentially place the residents at risk for infection due to the storage of medication, and the potential for them to be touched by residents in the hallway. She also stated that wheelchairs with cracked and torn arm rests with exposed foam could not be thoroughly cleaned and could potentially place the resident at risk for infection. There had been no in-service for employees on the importance of ensuring the residents' wheelchairs were cleaned and in good repair.	F 441			
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced	F 465			



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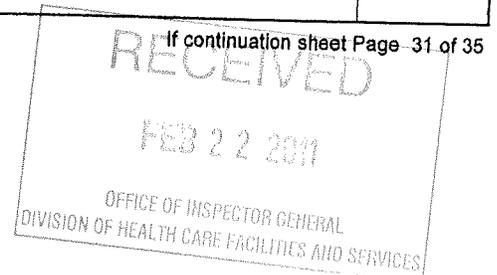
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F 465	<p>Continued From page 29</p> <p>by: Based on observation, interview and record review it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for the residents, staff, and the public. Observations during the standard survey revealed two (2) out of the two (2) treatment carts for the facility were found unsanitary in condition and in disrepair.</p> <p>The findings include:</p> <p>The facility failed to produce a policy on maintenance of the treatment cart.</p> <p>Review of the facility's night nurse assignment task sheet did not include cleaning of the treatment carts.</p> <p>Observation of the treatment cart for the main nursing station on 02/02/11 at 10:25am revealed the treatment cart parked in the hallway with a brown/black sticky substance on the top of the cart. There was also brown discolored tape on the top and the edges of the cart. The lip at the base of cart had a brown caked on substance all the way around the cart and brown fuzzy particles on the sides of cart. In addition, the top edges of the cart were cracked with holes.</p> <p>Interview with Registered Nurse (RN) #5 on 02/02/11 at 10:25am revealed she was not sure when the treatment cart was last cleaned or if there was a cleaning schedule for it to be cleaned. She stated that it "looks like it has not been done in awhile". She was not aware if there was a policy on when or how to clean the treatment cart. She stated that she will wipe it down if it looks dirty, but admits she did not wipe it</p>	F 465	<p>F 465 D</p> <p>1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The treatment cart on the annex unit was removed from use on 2/2/2011. The treatment cart on the main unit was cleaned and the top was replaced on 2/2/2011.</p> <p>2) How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected.</p> <p>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The treatment Nurse completed training led by the DNS on 2/2/2011 on infection control and cleaning the treatment cart. The treatment cart will be cleaned weekly by the treatment Nurse. An audit of medication carts and treatment carts was completed by the ADNS by 2/25/2011. Licensed nursing staff will be educated by the DNS on Infection Control in a Safe, Sanitary and Comfortable Environment by 3/8/2011.</p> <p>4) How will the facility monitor its performance to ensure that solutions are sustained? Treatment cart and medication cart audits will be conducted by the DNS weekly for 4 weeks, then monthly thereafter. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly thereafter.</p>	3/16/11



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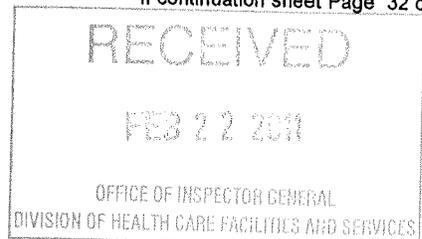
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F 465	<p>Continued From page 30 down before starting treatments.</p> <p>Observation of the treatment cart on the annex side on 02/02/11 at 11:00am revealed a treatment cart in the medication room with yellow charge stickers around the edges on top of the cart. There was brown stained tape on the top and around edges of the cart. There was an orange/yellow sticky substance next to a greasy film on top of the treatment cart. The front drawer facing was missing from all three drawers leaving two inch gaps between each drawer and exposing items inside the drawer to the air. The treatment cart was sitting directly beneath a window air conditioning unit which was covered with brown fuzzy particles and the bottom of the last drawer was covered with an orange sticky substance.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 02/02/11 at 11:03am revealed the air conditioner appeared to have "dirt, grime, and dust bunnies". She stated housekeeping was responsible for cleaning the air conditioner. She also stated that having the treatment cart parked under the air conditioner could cause potential infection to residents. She stated that night shift was responsible for cleaning the treatment carts and everyone was responsible for reporting disrepair of treatment carts. In addition, she stated she was not aware if the treatment cart had been reported as missing the drawer facing.</p> <p>Interview with RN #1 on 02/02/11 at 11:15am revealed the broken treatment cart parked under the dirty air conditioner could blow dirt down on both medication and treatment carts which could potentially cause problems with infection to the residents. She confirmed that the treatment cart</p>	F 465			



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F 465	<p>Continued From page 31</p> <p>was not clean and could harbor bacteria. She also acknowledged that treatment carts cannot be properly cleaned with the door facing missing from the cart. She stated that pharmacy was responsible for the maintenance of the treatment carts, but did not think it had been reported as broken.</p> <p>Interview with LPN #3 on 02/02/11 at 1:15pm revealed the night shift supervisor was to make sure the treatment carts were being cleaned. In addition, she stated that every nurse was responsible for making sure the treatment carts were sanitary. She also confirmed that she did not ensure the treatment nurse was cleaning the carts. She acknowledged the carts could not be properly cleaned with cracked edges and tape on the top and sides of the cart.</p> <p>Interview with the Assistant Director on 02/02/11 at 1:20pm revealed that treatment carts cannot be effectively cleaned with cracked and broken edges. She confirmed that there is no monitoring system in place to ensure the carts are being cleaned and monitored for repair. She confirmed that she was responsible for ensuring the night shift supervisor was making sure the carts were being cleaned, but she was not aware that the night nurse assignment sheet did not have cleaning of the treatment carts on the task list.</p> <p>Interview with the Director of Nursing (DON) on 02/02/11 at 1:30pm revealed he was not aware of the condition of the treatment carts until it was brought to his attention by staff members during the survey. The DON did confirm that the treatment carts were unsanitary and in disrepair. He was also not aware that the task of cleaning the carts was not on the night nurse assignment</p>	F 465			



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F 465	Continued From page 32 list or that there was currently no system in place to ensure treatment carts were being cleaned. He did confirm that he is ultimately responsible for ensuring the sanitization and condition of the treatment carts.	F 465		
F 514 SS=B	Interview with Executive Director on 02/03/11 at 11:00am revealed everyone was responsible to monitor the maintenance of wheelchairs. She further acknowledged that she was ultimately responsible for the maintenance and housekeeping services provided by the facility. 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to maintain a clinical record that was complete and accurately documented for one (1) of twenty-eight (28) sampled residents (Resident #2). The findings include:	F 514		

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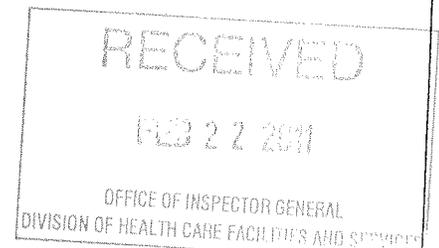
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F 514	Continued From page 33 The facility was unable to produce a policy on documentation and approved abbreviations. Record review on 02/02/11 of Resident #2's clinical record revealed the following entry made on 01/20/11 by LPN #2, "Res lim assist with UE dressing, lim assist with Ledressing supervision with toileting and grooming, lim assist with bathing, ST communication, res oriented to person, time, adequate hearing, usually understood, and aud comp usually understood, speech gd progress." Record review on 02/02/11 of Resident #2's clinical record revealed a progress note from Dr. Joseph Werner indicating Resident #2 was seen in his office on 01/21/11. In reviewing the resident's clinical record for that date there was no mention that the resident was out of the facility on that date. Record review on 02/02/11 of Resident #2's clinical record revealed the dates and times of administering Hydrocodone-APAP 5-500mg recorded on the pain rating and follow up sheet, the Medication Administration Record (MAR) and the Individual Patient's Narcotic Record did not match. The pain rating and follow up sheet lists the hydrocodone as being given 1/23 at 9:00pm, 1/24 at 5:00pm and 10:00pm, 1/25 at 9:00pm and 1/31 at 9:00am. The MAR lists the hydrocodone as being given on 1/24 at 5:00pm, 1/29 at 10:00p and 11:00pm, 1/30 at 11:00pm and 1/31 at 9:00am. The Individual Patient's Narcotic Record lists the hydrocodone as being signed out on 1/21 at 8:00am, 1/22 at 4:00am, 1/23 at 8:30pm, 1/24 at 5:00pm and 9:00pm, 1/27 at 8:00pm, 1/28 at 12:00am, 1/29 at 9:00pm, 1/30 at 10:00pm and	F 514	F 514 B 1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? LPN #2 completed training on making entries in the Medical Record led by DNS on 2/4/2011 . 2) How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Licensed Nurses, Social Service staff, Activity staff, Dining Services Manager, RD, and Therapists were trained using the Making entries in the Medical Record guideline, led by DNS by 3/8/2011. 4) How will the facility monitor its performance to ensure that solutions are sustained? An audit of 10 active resident records of entries made in the medical record will be completed by ADNS monthly. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly thereafter.	3/16/11



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F 514	<p>Continued From page 34 1/31 at 8:45am and 8:45pm.</p> <p>Interview with Director of Nursing (DON) on 02/03/11 at 2:30pm revealed he was aware of LPN #2's use of unapproved abbreviations and had spoken to her about that. He stated the facility did not have a list of approved abbreviations. He stated that LPN #2's documentation was confusing with her use of unapproved abbreviations. He stated the MAR, Individual Patient's Narcotic Record and Pain Rating, and Follow up Sheet should match and could cause confusion when they do not. The DON stated nurses should chart when a resident leaves the facility and did not know why it was not done for Resident #2 on 01/21/11.</p> <p>Interview with LPN #2 on 02/03/11 at 3:25pm revealed she was aware that she had used unapproved abbreviations in the clinical record of Resident #2. She stated the DON had discussed documentation with her and had given her a list of approved abbreviations to use when entering information in the clinical record. She stated that she now understands that information in the clinical record could be misunderstood if she did not spell out her words or use approved abbreviations.</p>
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F 514	
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