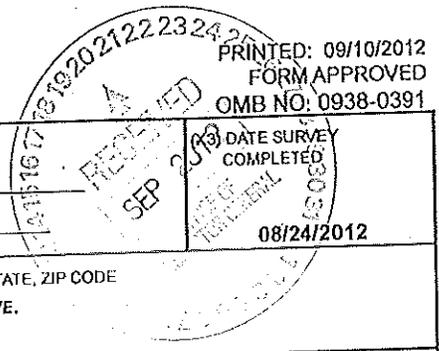


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/24/2012
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NAME OF PROVIDER OR SUPPLIER SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH HAYDEN AVE. SALEM, KY 42078
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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 000	INITIAL COMMENTS	F 000	The statements contained in this plan of corrections are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain compliant with all federal and state regulations the facility has taken or will take the following actions set forth within the following corrections. The following corrections constitute the facility's compliance such that all deficiencies cited will be corrected by 9/21/12.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	1. This resident no longer resides in the facility. 2. All residents have the potential to be affected. 3. Nursing staff will be educated by in-service on policy regarding notification of change. Review of past thirty days of documentation will be done to ensure to identify any other concerns. 4. Nursing documentation will be reviewed by DON or designee daily and any issues will discussed in the daily interdisciplinary meeting. All findings will be reported to the Quarterly Patient Care Committee meeting. 5. Date corrective action will be corrected for F 157	09/21/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sammy Workman TITLE: Administrator (X6) DATE: 9/20/12

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1B5046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/24/2012	
NAME OF PROVIDER OR SUPPLIER SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH HAYDEN AVE. SALEM, KY 42078		
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F 157	<p>Continued From page 1</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, closed record review, review of the facility's policy/procedure, and the hospital's discharge summary, it was determined the facility failed to consult/notify the physician related to a significant change of condition for one resident (#14), in the selected sample of fourteen (14) residents. The facility failed to follow the "Notification of Physicians" policy/procedure. On 05/13/12, the facility failed to notify Resident #14's physician when he/she presented with a decline in appetite, decreased responsiveness and a blood pressure of 80/48 mm/hg (normal for this resident was 130/70 mm/hg range). Resident #14's family member notified the physician, and the physician notified the nurse who was instructed to transfer Resident #14 to the hospital.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Notification of Change," revised 01/11, revealed "the resident's physician must be notified when the resident experiences a change in condition." The physician should be immediately notified when a resident's systolic blood pressure (top number of blood pressure) is less than 90 mm/hg unless the values are consistently this level and the physician is aware.</p> <p>A closed record review revealed the facility</p>	F 157		

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NAME OF PROVIDER OR SUPPLIER SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH HAYDEN AVE. SALEM, KY 42078	
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F 157	<p>Continued From page 2</p> <p>admitted Resident #14 on 04/23/11 with diagnoses to include Hypertension, Dementia, Urinary Tract Infection, and Dementia. A review of the resident's vital signs form revealed blood pressures taken from 04/26/11 through 07/03/12 ranged from 120-140 mm/hg (systolic)/60-80 mm/hg (diastolic). Additionally, a review of Resident #14's intake records, dated 05/2012 revealed the resident usually ate 100 % of breakfast and 75-100 % of lunch and supper.</p> <p>A review of a nurse's note, dated 05/09/12 at 9:00 AM, revealed Resident #14 was up in his/her wheelchair. The resident was on Levaquin and Macrochantin related to UTIs, and the facility was awaiting the results of a urine culture and sensitivity. Further review of a nurse's note, dated 05/09/12 at 12:45 PM, revealed the resident's white blood count was increased, the physician was notified, and an order was received for Rocephin (antibiotic) one gram (gm) intramuscular (IM) times one. On 05/10/12 at 8:30 AM, Resident #14 complained of abdominal cramping, nausea, and loose stools. The physician was notified with an order received for Imodium. On 05/11/12 at 1:00 PM, the nurse practitioner was at the facility and ordered a stool culture and to check stools for occult blood. At 6:00 PM, Resident #14 was propelling self around the facility in his/her wheelchair. Review of a nurse's note, dated 05/12/12 (Saturday) at 5:00 AM, revealed the resident was alert, resting quietly, and continued to have loose stools. The resident's blood pressure was 130/82 mm/hg. Review of the nurse's notes, dated 05/12/12 at 2:15 PM and 2:30 PM, revealed Resident #14 had two episodes of loose stool, was very sluggish, ate no breakfast or lunch, and was</p>	F 157		

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F 157	<p>Continued From page 3</p> <p>sitting at the nurse's station asleep with a blood pressure of 128/78 mm/hg. On 05/12/12 at 10:00 PM, Resident #14 was lethargic, speech was clear but very soft, required constant cueing to take fluids, color was pale and blood pressure was 128/74 mm/hg. The resident also had two more loose stools. On 05/13/12 (Sunday-Mother's Day) at 11:30 AM, the resident would not open his/her eyes, but responded with a very low voice. The resident only ate a few bites of breakfast, and had two more loose stools. At that time, the resident's blood pressure was 80/48 mm/hg.</p> <p>An interview with Resident #14's family member, on 08/24/12 at 1:30 PM, revealed he arrived at the facility on 05/13/12 around lunch time. He stated the resident was in his/her room in bed and was unresponsive. The nurse came into the room and stated the resident's blood pressure was "eighty-something over forty-something." He asked the nurse if she had contacted the physician and was told the resident's physician was not on call. He stated he was informed that the resident was in a deep rest and they would contact the physician on Monday. He left the facility and the more he thought about what the nurse said, the more concerned he became, so he decided to contact the physician himself. He revealed that he contacted the physician about the resident's condition and the physician contacted the facility. The resident was then sent out to the hospital.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 08/23/12 at 10:00 AM, revealed the resident's condition had declined and the resident was not the same. The resident was having diarrhea.</p>	F 157			

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F 157	Continued From page 4 The CNA revealed the family had visited Resident #14 and was concerned about the resident's condition. Interview with Registered Nurse (RN) #2, on 08/23/12 at 8:45 AM, revealed she did not see any reason to send the resident out to the hospital or to notify the physician. She revealed she notified the family member and let him know that the resident was having loose stools. She recalled the family did not request to have the resident sent out to the hospital. Interview with the Director of Nursing (DON), on 08/24/12 at 2:00 PM, revealed she relied on her nurses' decisions; however, she probably would have contacted the physician. A review of the hospital's discharge summary, dated 05/16/12, revealed final diagnoses to include Urinary Tract Infection, Clostridium Difficile Colitis, Sepsis, and Acute Renal Failure.	F 157		
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, closed record review, review of the facility's policy/procedure, and the facility's	F 224	1. This resident no longer resides in the facility. 2. All residents have the potential to be affected. 3. Staff education will be completed by 9/20/12 on the policy of abuse and neglect and reporting. Review of past thirty days of documentation will be done to ensure to identify any other concerns. 4. On going daily review of documentation will be completed and discussed at the daily interdisciplinary meeting. Any reportable event will be reported as defined in the CMS operations manual.	

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F 224	Continued From page 5 final Investigation Report, it was determined the facility failed to ensure written policies and procedures were implemented that prohibit neglect of residents for one resident (#14), in the selected sample of fourteen (14) residents. The facility failed to implement the Abuse and Neglect policy/procedure as evidenced by the failure to identify an allegation made by Resident #14's family as neglect, according to the policy's definition of neglect. This failure prevented the facility from notifying the State Agencies about the allegation. Furthermore, the facility failed to conduct a thorough investigation, having only interviewed one staff member regarding the incident. Additionally, due to the failure of identifying the allegation as neglect, this prevented the facility from reporting the investigation results within five (5) days. On 05/30/12, Resident #14's family reported an allegation of neglect to the Director of Nursing (DON), alleging that the facility failed to provide timely care and services to Resident #14 related to notifying the physician when there was a significant change in condition. On 05/13/12, the family member alleged he contacted the physician in order to get Resident #14 transferred to the hospital when the resident was identified as unresponsive, and the resident's blood pressure dropped to 80/48 mm/hg (normal range for this resident was in the 130/70 mm/hg range). The facility failed to identify the allegation as neglect and the investigation failed to determine that neglect occurred. Findings include: A review of the facility's "Abuse and Neglect" policy/procedure, last revised 01/08, revealed the	F 224	All findings will be reported at the Quality Patient Care Committee meetings. 5. Date corrective action will be completed for F 224.	9/21/12

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F 224	<p>Continued From page 6</p> <p>facility's definition of neglect was "the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness". The Administrator and DON should coordinate completion of a full investigation to include summary of the incident and witness statements. The State Agency should be notified about allegations of neglect within 24 hours of the allegation and in accordance with state law, and within five days of initiating the investigation, the Administrator will fax the results of the investigation and investigation data to the State Agency.</p> <p>A closed record review revealed the facility admitted Resident #14 on 04/23/11 with diagnoses to include Hypertension, Dementia, Urinary Tract Infection, and Dementia. A record review revealed no evidence the physician was notified about Resident #14's change in condition.</p> <p>An interview with Resident #14's family member, on 08/24/12 at 1:30 PM, revealed he arrived at the facility on 05/13/12 (Sunday-Mother's Day) around lunch time. He stated the resident was in his/her room in bed and was unresponsive. The nurse came into the room and stated the resident's blood pressure was "eighty-something over forty-something." He asked the nurse if she had contacted the physician and was told the resident's physician was not on call. He stated he was informed that the resident was in a deep rest and they would contact the physician on Monday. He left the facility and the more he thought about what the nurse said, the more concerned he became, so he decided to contact the physician himself. He revealed that he contacted the physician about the resident's condition and the</p>	F 224		

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F 224	<p>Continued From page 7</p> <p>physician contacted the facility. The resident was then sent out to the hospital.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 08/23/12 at 10:00 AM, revealed the resident's condition had declined and the resident was not the same. The resident was having diarrhea. The CNA revealed the family had visited Resident #14 and was concerned about the resident's condition.</p> <p>Interview with Registered Nurse (RN) #2, on 08/23/12 at 8:45 AM, revealed she did not see any reason to send the resident out to the hospital or to notify the physician. She revealed she notified the family member and let him know that the resident was having loose stools. She recalled the family did not request to have the resident sent out to the hospital.</p> <p>A review of the DON's note, dated 05/30/12, revealed Resident #14's family member came to her with a concern that he had to contact the physician in order to get Resident #14 transferred to the hospital. The note revealed the DON assured Resident #14's family member that she would "look into things." Further review of the note revealed the DON discussed the situation with RN #2, who told her the resident was assessed and that the family member contacted the physician before she had the chance to do so.</p> <p>A review of the facility's Investigation Report, completed 08/14/12, after a State Agency reported the allegation of neglect to the facility on 08/09/12, revealed the DON reviewed the medical record and determined that "care and services were rendered accurately, appropriately</p>	F 224			

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F 224	Continued From page 8 and in a timely manner." Further review of the Investigation Report revealed the DON interviewed RN #2; however, she did not interview the other staff who provided care for Resident #14 that weekend. Additionally, the DON did not identify that the resident's appetite decreased and the resident's systolic blood pressure dropped below 90 mm/hg, which required notification of the physician according to the facility's policy and procedure. Interview with the DON, on 08/24/12 at 2:00 PM, revealed she did not complete a thorough investigation of the incident back in May 2012 because she did not feel that this was an allegation of neglect. The DON stated her definition of neglect was when staff did not take care of the resident or meet their basic needs. She revealed the physician should have been notified.	F 224		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, closed record review, review of the facility's policy/procedure, and the facility's final Investigation Report, it was determined the facility failed to ensure written policies and procedures were implemented that prohibit	F 226	1. This resident no longer resides in the facility. 2. All residents have the potential to be affected. 3. Staff education on the policy of abuse and neglect and reporting will be completed by 9/20/12. Review of past thirty days of documentation will be done to ensure to identify any other concerns. 4. All documentation will be reviewed daily and discussed in the daily interdisciplinary meeting to ensure compliance to the facility policy and to CMS operations manual. All findings will be reported to the Quality	

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F 226	Continued From page 9 neglect of residents for one resident (#14), in the selected sample of fourteen (14) residents. The facility failed to implement the Abuse and Neglect policy/procedure as evidenced by failure to identify an allegation of neglect according to their policy's definition of neglect. This failure prevented the facility from notifying the State Agencies about the allegation. Furthermore, the facility failed to conduct a thorough investigation, having only interviewed one staff member regarding the incident. Additionally, the facility failed to identify the allegation as neglect, which prevented the facility from reporting the investigation results within five (5) days. On 05/30/12, Resident #14's family reported an allegation of neglect to the Director of Nursing (DON), alleging that the facility failed to provide timely care and services for Resident #14 related to the failure to notify the physician when the resident had a significant change in condition. On 05/13/12, the family member alleged he contacted the physician in order to get Resident #14 transferred to the emergency room when the resident had a significant change in condition. The facility failed to identify the allegation as neglect and their investigation failed to determine neglect occurred. Refer to F224 Findings include: A review of the facility's "Abuse and Neglect" policy/procedure, last revised 01/08, revealed the facility's definition of neglect was "the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness". The Administrator and DON will coordinate	F 226	Patient Care committee quarterly. 5. Date corrective action will be completed for F 226	9/21/12	

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F 226	<p>Continued From page 10</p> <p>completion of a full investigation to include a summary of the incident and witness statements. The State Agency will be notified about allegations of neglect within 24 hours of the allegation and in accordance with state law, and within five days of initiating the investigation, the Administrator will fax to the State Agency the results of the investigation and investigation data.</p> <p>A closed record review revealed the facility admitted Resident #14 on 04/23/11 with diagnoses to include Hypertension, Dementia, Urinary Tract Infection, and Dementia. Further review revealed no evidence the physician was notified regarding Resident #14's change in condition.</p> <p>An interview with Resident #14's family member, on 08/24/12 at 1:30 PM, revealed he arrived at the facility on 05/13/12 (Sunday-Mother's Day) around lunch time. He stated the resident was in his/her room in bed and was unresponsive. The nurse came into the room and stated the resident's blood pressure was "eighty-something over forty-something." He asked the nurse if she had contacted the physician and was told the resident's physician was not on call. He stated he was informed that the resident was in a deep rest and they would contact the physician on Monday. He left the facility and the more he thought about what the nurse said, the more concerned he became, so he decided to contact the physician himself. He revealed that he contacted the physician about the resident's condition and the physician contacted the facility. The resident was then sent out to the hospital.</p> <p>A review of the DON's note, dated 05/30/12,</p>	F 226		

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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	PROMOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 11</p> <p>revealed Resident #14's family member came to her with a concern that he had to contact the physician in order to get Resident #14 transferred to the hospital. The note revealed the DON assured Resident #14's family member that she would "look into things." Further review of the note revealed the DON discussed the situation with RN #2, who told her the resident was assessed and that the family member contacted the physician before she had the chance to do so. No further investigation or action was taken at that time.</p> <p>A review of the facility's Investigation Report, completed 08/14/12, after a State Agency reported the allegation of neglect to the facility on 08/09/12, revealed the DON reviewed the medical record and determined that "care and services were rendered accurately, appropriately and in a timely manner." Further review of the Investigation Report revealed the DON interviewed RN #2; however, she did not interview the other staff who provided care for Resident #14 that weekend. Additionally, the DON did not identify that the resident's appetite decreased and the resident's systolic blood pressure dropped below 90 mm/hg, which required notification of the physician according to the facility's policy and procedure.</p> <p>Interview with the DON, on 08/24/12 at 2:00 PM, revealed she did not complete a thorough investigation of the incident back in May 2012 because she did not feel that this was an allegation of neglect. The DON stated her definition of neglect was when staff did not take care of the resident or meet their basic needs. She revealed the physician should have been</p>	F 226			

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F 226	Continued From page 12 notified. She was unable to give an explanation as to why she did not identify the resident's systolic blood pressure was below 90 mm/hg, which required physician notification per the facility's policy and procedures.	F 226		
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to ensure food preferences were honored for three residents (#4, #5 and #7), in the selected sample of fourteen (14) residents, and for one resident (#16), not in the selected sample. Findings include: 1. A record review revealed the facility admitted Resident #5 on 07/23/09 and was re-admitted on 05/20/10 with diagnoses to include Intracranial Hemorrhage, Hypertension, Closed Fracture Lumbar Vertebra, Psychosis, Anemia, Pain, and Dysphagia. Observation during the lunch meal, on 08/21/12 at 12:45 PM, revealed documentation on Resident #5's dietary slip that the resident disliked carrots. Further observation revealed he/she was served mixed vegetables containing carrots. The resident refused to eat the mixed vegetables after two small bites.	F 366	1. Residents #4, #5, #7 and #16 were interviewed for likes and dislikes by the dietary manager and their tray card was updated to reflect likes/dislikes. All dislikes entered into the tray card system. 2. All residents have the potential to be affected. 3. Dietary staff educated on tray card system and on not serving residents what is on their dislike section of their tray card. All residents will be interviewed and their tray card system updated 4. The dietary manager or designee will interview all residents and update all likes/ dislikes in the tray card system. The dietary manager will monitor for compliance 5 days a week for 2 weeks then 3 days a week for 2 weeks then monthly for 3 months to ensure compliance. All findings will be reported quarterly to the Quality Patient Care committee meetings. 5. Date corrective action will be corrected for F 366.	9/21/12

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F 366	<p>Continued From page 13</p> <p>2. A record review revealed the facility admitted Resident #16 on 08/04/09 with diagnoses to include Anemia, Esophageal Stricture, Malnutrition, Dementia, Diabetes Type II, and Alzheimer's Disease.</p> <p>Observation during the lunch meal, on 08/21/12 at 12:47 PM, revealed documentation on Resident #16's dietary slip that the resident disliked corn and beans. Further observation revealed he/she was served mixed vegetables which contained corn and lima beans. Resident #16 refused to eat the mixed vegetables.</p> <p>3. A record review revealed the facility admitted Resident #7 on 03/17/08 and was re-admitted on 06/25/10 with diagnoses to include Diabetes, Dementia, Heart Failure, and Epilepsy.</p> <p>Observation during the lunch meal, on 08/21/12 at 12:49 PM, revealed documentation on Resident #7's dietary slip that the resident disliked carrots. Further observation revealed the resident was served mixed vegetables which contained carrots. Resident #7 refused to eat the carrots on his/her plate.</p> <p>4. A record review revealed the facility admitted Resident #4 on 07/13/11 and was re-admitted on 02/09/12 with diagnoses to include Diverticulitis and Intestinal Obstruction.</p> <p>Further review revealed Resident #4 was assessed by the facility's Registered Dietician, on 07/13/11, for a "regular diet, no nuts, seeds, corn or peas," and noted the resident had a diagnosis of Diverticulitis.</p>	F 366		

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F 366	Continued From page 14 A review of Resident #4's nutritional care plan, dated 07/13/11, and last reviewed 08/07/12, revealed an intervention of "no seeds, corn, peas or nuts." Observation during the lunch meal, on 08/21/12 at 12:47 PM, revealed documentation on Resident #4's dietary slip that the resident disliked corn. Further observation revealed the resident was served mixed vegetables which contained corn and peas. Resident #4 refused to eat the mixed vegetables. Interview with the facility's Dietary Manager, on 08/24/12 at 2:20 PM, revealed the tray card showed the food likes and dislikes, and any food allergy was indicated by an "A" circled beside the food listed. The kitchen staff were responsible for reviewing the tray card on the tray line to ensure the resident was served the appropriate foods. If a resident expressed a dislike for certain food, then information was to be documented on the dietary card at that time. Interview with the Dietician, on 08/23/12 at 2:30 PM, revealed the staff were suppose to go by the tray cards related to likes/dislikes. She stated the staff should not serve mixed vegetables to residents if the mixed vegetables contained a resident's dislike.	F 366		
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	F 371	1. Dietary Manager discarded all identified items. Can opener was washed. 2. All residents have the potential to be affected. 3. Education on how to properly store/prepare/ and serve food provided for all dietary staff by 9/20/12.	

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F 371	<p>Continued From page 15</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies and procedures, it was determined the facility failed to store and prepare food under sanitary conditions related to the lack of labeling of opened food items, boxes of vegetables in the freezer open to air, the use of a soiled can opener, and putting away dishes which were not dry.</p> <p>A review of the facility's Census and Condition, dated 08/21/12, revealed there were 53 residents in the building and two residents received tube feedings.</p> <p>Findings include:</p> <p>A review of the facility's "Storage" policy/procedure, last revised 12/09, revealed food in the refrigerator should be covered, dated and stored loosely. All foods in the freezer should be wrapped in moisture proof wrapping or placed in suitable containers to prevent freezer burn. They are to be labeled and dated. A review of the facility's policy/procedure for sanitizing the bench can opener, no date, revealed the bench can opener will be cleaned and sanitized after each use.</p> <p>1. Observations during the initial tour, on</p>	F 371	<p>4. The dietary manager or designee will monitor for compliance 5 days a week for 1 month then 3 days a week for 3 months.</p> <p>All findings will be reported to the Quality Patient Care committee quarterly.</p> <p>5. Date corrective action will be corrected for F 371.</p>	9/21/12	

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F 371	<p>Continued From page 16 08/21/12 at 11:00 AM, revealed:</p> <p>A. A package of sliced cheese stored in the walk-in refrigerator that was opened and in a sealed plastic bag that was not dated or labeled.</p> <p>B. Two (2) boxes of frozen green peas and two (2) boxes of frozen carrots in opened plastic bags in the walk-in freezer that were not sealed and were open to air.</p> <p>C. A box with a plastic bag containing liquid thickener powder that was open to air in the dry storage area.</p> <p>D. A can opener with a black sticky substance noted on the blade and small pieces of plastic paper noted below the blade.</p> <p>An interview with the Dietician and Dietary Manager, on 08/23/12 at 2:45 PM and on 08/24/12 at 2:30 PM, respectively, revealed the open items of food should be stored in the original container, freezer bag or plastic container. The items should be dated when opened and should have the expiration date on them. They revealed all food should be sealed and not open to air, and the can opener should be cleaned every day.</p> <p>2. Observation of the dishwasher area, on 08/24/12 at 9:05 AM, revealed the dishwasher removed coffee cups and plate holders from the dish rack and stacked them without letting them completely dry. Further observation of the stacks of plate holders and coffee cups revealed the inverted coffee cups stacked on the shelf unit, and a stack of plate holders next to the steam</p>	F 371		

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F 371	Continued From page 17 table had water on the inside of them.	F 371		
F 441 SS=D	An interview with the Dietician and Dietary Manager, on 08/23/12 at 2:45 PM and on 08/24/12 at 2:30 PM, respectively, revealed the dishes should be allowed to air dry completely before stacking them and putting them away. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if 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	F 441	1. Residents #5, and # 11 were not negatively affected by the deficient practice. 2. All residents have the potential to be affected. 3. Education on Infection Control policy, Standard Precautions, and proper handling of linens will be completed by 9/20/12. 4. A random audit will be completed by DON or designee for 5 days a week for 2 weeks then 3 days a week for a month to ensure compliance. 5. All findings will be reported to the Quality Patient Care committee quarterly. Date corrective action will be corrected for F 441.	9/21/12

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F 441	<p>Continued From page 18 professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy and procedure review, it was determined the facility failed to ensure staff changed gloves and/or washed hands to ensure a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for two residents (#5 and #11), in the selected sample of fourteen (14) residents.</p> <p>Findings include:</p> <p>A review of the facility's policy and procedure for "Standard Precautions", undated, revealed gloves were to be worn "when touching body fluids... and contaminated items." Gloves were to be changed "between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms." Additionally, staff was to "wash hands immediately after gloves were removed... to avoid transfer of microorganisms to other residents or environments." Staff was also to "wash hands between tasks and procedures on the same resident to prevent cross contamination of different body sites."</p>	F 441			

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F 441	<p>Continued From page 19</p> <p>1. A record review revealed the facility admitted Resident #5 on 09/07/10 and was re-admitted on 06/08/12 with diagnoses to include Muscle Weakness, Dysphagia, Neuropathy, Congestive Heart Failure, Depressive Disorder, and Chronic Airway Obstruction.</p> <p>An observation of a skin assessment, on 08/22/12 at 2:55 PM, revealed Resident #5 was assessed to have a three inch by four inch area of red skin around the coccyx. Registered Nurse (RN) #4 used her gloved hand to determine blanchability of the skin and proceeded with the skin assessment without changing gloves. After blanching the perimeter of the reddened skin, RN #4 used the same glove to reset the tag alarm when it sounded, reposition the resident with the resident's personal body pillow, and remove and re-attach the tag alarm clip to the resident's clothing. With gloves still on, RN #4 covered and smoothed the resident's sheet and blanket at the conclusion of the skin assessment.</p> <p>Interview with RN #4, on 08/24/12 at 11:10 AM, revealed precautions should be used that were appropriate for the task being completed. The precautions included gloves, gowns, and masks.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 08/24/12 at 11:25 AM, revealed gloves should be changed after touching any area of the body with fluids, such as the sacral area.</p> <p>Interview with the Director of Nursing (DON), on 08/24/12 at 5:30 PM, revealed she expected her staff to change gloves during a skin assessment if they touched any body fluids.</p>	F 441		

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F 441	<p>Continued From page 20</p> <p>2. A record review revealed the facility admitted Resident #11 on 07/03/08 and was re-admitted on 12/11/11 with diagnoses to include Depression, Anemia, Kidney Disease, Diabetes Type II, and Parkinson's disease.</p> <p>A review of the facility's policy and procedure for "Laundry/ Linen", undated, revealed "all soiled linen should be considered potentially infectious" and "must be placed directly into a covered laundry hamper which is adequate to contain moisture."</p> <p>An observation, on 08/24/12 at 9:00 AM, revealed a strong odor of urine prior to entering the room of Resident #11. An open plastic bag was on the floor in the room approximately three feet from the doorway. The open bag contained white bed linens and a blue and white bed pad.</p> <p>Interview with Certified Nurse Aide (CNA) #5, on 08/24/12 at 9:05 AM, revealed the bags were not suppose to be stored on the floor after the bed was changed. She stated the dirty linen bags should have been placed in the dirty linen cart that was kept in the hallway.</p> <p>Interview with LPN #1, on 08/24/12 at 11:25 AM, revealed dirty linen bags should not be left on the floor in a resident's room. She stated the linens should have be placed in the dirty linen cart immediately.</p> <p>Interview with other facility staff #10, on 08/24/12 at 3:25 PM, revealed she removed the soiled linens from Resident #11's bed, placed the soiled linens in the clear plastic bag, and placed the bag on the floor next to the trash can in the room. She</p>	F 441		

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F 441	Continued From page 21 stated an unknown CNA entered the room while she assisted Resident #11 with ambulation. She stated she asked the CNA to take care of the dirty linens and the CNA did so.	F 441			