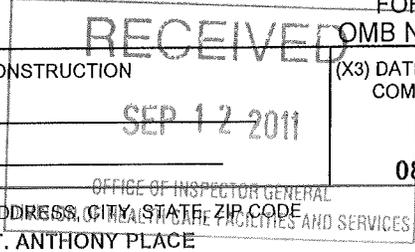


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2011
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185361	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/11/2011
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NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL - LOUISVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205
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F 000	INITIAL COMMENTS A standard recertification survey was conducted on August 9-11, 2011 and found the facility did not meet the minimum requirements with deficiencies cited at a scope and severity of an "E". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition. A Life Safety Code survey was conducted on 08/09/11 with no deficiencies cited.	F 000	This plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Hospital Louisville does not admit that the deficiencies listed in the CMS Form 2567L exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts, and conclusions that form the basis for the deficiencies.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide necessary housekeeping services to maintain a sanitary environment. Observation revealed several resident rooms with dust on ledges and vents. The cabinets containing the tube feedings had a tan colored substance spilled on the bottom of the cabinets, the ice machine had a heavy accumulation of dust on top with dirt and paper debris to the side and the back of the ice machine. The findings include: Observation during the environmental tour, on 08/10/11 at 11:00 AM, revealed Room 324, 332	F 253	483.15 (h) (2) HOUSEKEEPING & MAINTENANCE SERVICES <u>How the corrective action will be accomplished</u> Housekeeping staff completed high and low dusting in room 324, 332, & 336. The top, sides, and back of the ice machine were cleaned. The Unit Secretary cleaned the spillage which was identified in the tube feeding cabinet. <u>How the facility will identify other residents having the potential to be affected by the deficient practice</u> Assigned housekeepers will perform high and low dusting in all resident rooms located on the skilled unit. All ice machines located on the unit were checked and cleaned as needed. <u>What measures will be put into place to ensure no reoccurrence</u> High dusting will be added to the housekeepers weekly cleaning schedule. Ice Machine and surrounding area will be added to the housekeepers daily schedule. Appropriate training or retraining of Housekeeping staff will be conducted to	9/10/11

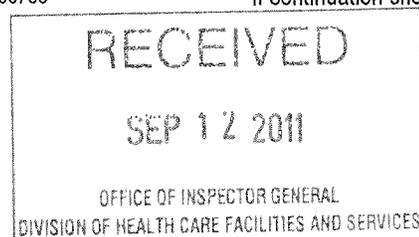
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mike Marshall</i>	TITLE <i>Administrator</i>	(X6) DATE 9/9/11
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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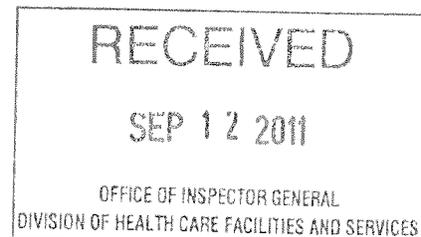
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F 253	Continued From page 1 and 366 had a heavy accumulation of dust on the residents' televisions, and air conditioning units. Dust was observed to be on top of the ice machine on the Central Unit. A can, paper cup, paper towels, and dirt was observed to be beside and behind the ice machine. Observation of the cabinets that contained bottles of tube feeding revealed spillage on the outside of the cabinets. In addition, spillage was observed to be on the bottom of the tube feeding cabinets. On 08/11/11 at 10:00 AM, an interview with a Housekeeper revealed residents' rooms are cleaned daily but once a month the resident is taken out of the isolation room and the room is thoroughly cleaned. Dusting should be occurring daily. Interview with the Housekeeping Supervisor and the Director of Nursing, on 08/11/11 at 11:00 AM, revealed the housekeepers are suppose to dust daily. The refrigerator on the unit was to be cleaned by the unit secretary weekly and the tube feeding cabinets are to be cleaned by nursing as needed.	F 253	ensure unit is cleaned to maintain a sanitary and orderly environment. This includes high & low dusting, ice machine and surrounding area. Training was conducted on August 30 th & 31 st by the Infection Control Preventionist and the Clorox Healthcare Area Sales Representative. The tube feeding bottle cabinet has been added to the Unit Secretary daily "to do" task list. <u>How effectiveness of change will be monitored to ensure that solutions are sustained</u> Housekeeping Supervisor will perform audit of unit cleanliness including resident rooms at least weekly for 1 month, then bi-weekly for 2 months. The results will be reviewed and discussed by the Administrator and Director of Plant Operations. Results will be presented at the monthly Skilled Unit Performance Improvement Committee Meeting. The Skilled Unit Administrator is responsible for overall compliance.	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	483.20 (d), 483.20 (k) (1) DEVELOP COMPREHENSIVE CARE PLANS <u>How the corrective action will be accomplished</u> Care plans for residents' #1, #2, #3, #4, #5, #6, #7, #8, #9, & 11 were updated by adding comments to identify organism, site, and type of infection control precaution.	9/10/11



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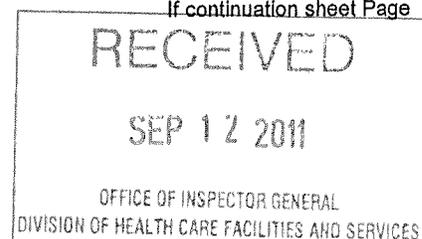
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F 279	<p>Continued From page 2</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and review of the Infection Control Sheet, Isolation Signs and the Infection Control Policy it was determined the facility failed to develop a comprehensive plan of care regarding isolation, for ten (10) out of twelve (12) sampled residents. The comprehensive care plans for Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, and #11, did not include a care plan which identified the type of organism and the required isolation.</p> <p>The findings include:</p> <p>Review of the Contact Isolation sign revealed the staff was required to use a gown, gloves and mask when in contact with body fluids. Review of the Infection Control policy and procedure manual revealed a care plan should be developed for required isolation with the type of organisms and and PPE- Personal Protective Equipment to be used.</p> <p>Interview with the Director of Nursing (DON), on</p>	F 279	<p>The Infection Preventionist updated the daily log of residents with infections to more clearly delineate the organism, site, and type of infection.</p> <p><u>How the facility will identify other residents having the potential to be affected by the deficient practice</u></p> <p>All residents were reviewed and care plans updated to reflect the organism, site, and type of infection.</p> <p><u>What measures will be put into place to ensure no reoccurrence</u></p> <p>Current Infection Control log is maintained and kept at the nurses station. Infection Control information is also available via computer.</p> <p>The organism, site and type of infection will be added to the resident care plan during the admission process. In addition, care plans will be reviewed during the weekly IDT meetings and be updated with the identification of any new organism. Post IDT meetings, the RAI Coordinator will update care plans as needed.</p> <p>The DNS or Registered Nurse will perform care plan reviews of all residents with identified organisms monthly to ensure compliance has been met.</p>	



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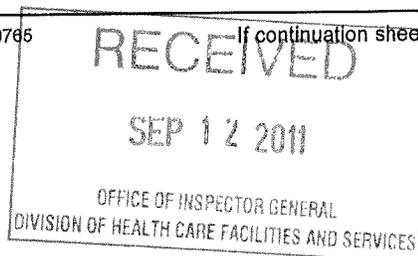
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F 279	<p>Continued From page 3</p> <p>08/11/11 at 10:45 AM, revealed the comprehensive plan of care should address the type of infectious organism and the type of isolation required by each organism.</p> <p>1. Review of the infection control sheet and the clinical record for Resident #4 revealed the facility admitted the resident on 11/02/07 with a diagnosis of Respiratory Failure. The resident was in Contact Isolation for Vancomycin Resistant Enterococci (VRE) , Clostridium Difficile (C-Diff) and a history of Methicillin Resistant Staphylococcus Aureus (MRSA). The comprehensive care plan did not include a care plan which addressed isolation and the three (3) types of infectious organisms.</p> <p>Observation of Resident #4, on 08/09/11 at 3:15 PM, revealed the resident was in Contact Isolation. A Contact Isolation sign was posted outside the door to the resident's room.</p> <p>2. Review of the infection control sheet and the clinical record for Resident #6 revealed the facility admitted the resident on 06/01/11 with a diagnosis of Respiratory Failure. The resident was in Contact Isolation for VRE, MRSA, Mufti-Drug Resistant Pseudomonas (MDR Ps), Multi-Drug Resistant Acinetobacter (MDRA), and Extended Spectrum Beta Lactamase Klebsiella (ESBL Kleb). The comprehensive care plan did not include a plan of care which addressed the five (5) types of infectious organisms and contact isolation.</p> <p>Observation of Resident #6, on 08/09/11 at 2:00 PM, revealed the resident was in Contact Isolation. A Contact Isolation sign was posted</p>	F 279	<p><u>How effectiveness of change will be monitored to ensure that solutions are sustained</u></p> <p>Results of care plan audits will be presented by the DNS monthly at the Skilled Unit Performance Improvement Committee Meeting for 3 months or until 100% compliance has been achieved.</p>	



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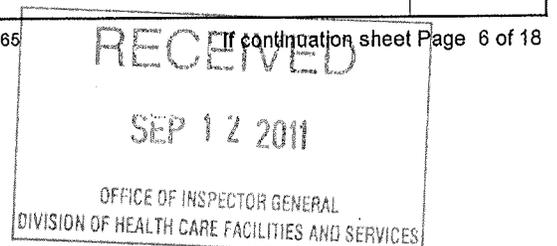
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F 279	<p>Continued From page 4 outside the resident's door.</p> <p>3. Review of the infection control sheet and the clinical record for Resident #9 revealed the facility admitted the resident on 08/04/11 with a diagnosis of Respiratory Failure. The resident was in Contact Isolation for ESBL Klebsiella. The comprehensive care plan did not address isolation and the type of infectious organism.</p> <p>Observation of Resident #9, on 08/10/11 at 4:55 PM, revealed the resident was in Contact Isolation. A Contact Isolation sign was posted outside the resident's door.</p> <p>4. Review of the infection control sheet and the clinical record for Resident #11 revealed the facility admitted the resident on 04/02/10 with a diagnosis of Respiratory Failure. The resident was in Contact Isolation for VRE.</p> <p>Observation of Resident #11, on 08/11/11 at 4:40 PM, revealed the resident was in Contact Isolation. A Contact Isolation sign was posted outside the resident's room.</p> <p>Interview with Registered Nurse #1, on 08/09/11 at 2:00 PM, during the initial tour of the facility, revealed she was unable to explain why residents were in Contact Isolation.</p> <p>Continued interview with the Director of Nursing (DON), on 08/11/11 at 10:45 AM, revealed the DON was unaware Nurse #1 could not identify why residents were in isolation. The DON stated this information was included on the nursing report sheet.</p>	F 279		



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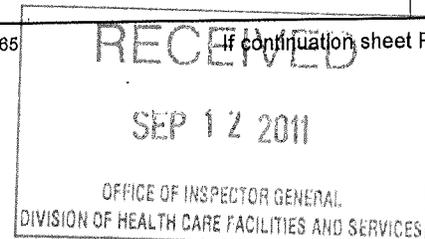
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F 279	<p>Continued From page 5</p> <p>Interview with the DON, on 08/11/11 at 1:00 PM, revealed the nursing worksheet was missing information explaining the reason the resident was in isolation.</p> <p>5. Review of the infection control sheet and the clinical record for Resident #1 revealed the facility admitted the resident on 11/18/10 with diagnoses of Respiratory Failure and Ventilator Dependence. The resident was in Contact Isolation for Vancomycin Resistant Enterococci (VRE) and Methicillin Resistant Staphylococcus Aureus (MRSA). The comprehensive care plan did not include a care plan which addressed isolation for the two (2) infectious organisms.</p> <p>Observation of Resident #1, on 08/09/11 at 3:55 PM, revealed the resident was in Contact Isolation. A Contact Isolation sign was posted outside the door to the resident's room. The infection control sheet indicated the organisms were acquired after admission to the nursing facility.</p> <p>6. Review of the infection control sheet and the clinical record for Resident #5 revealed the facility admitted the resident on 05/23/11 with diagnoses of Respiratory Failure and Ventilator Dependent. The resident was in Contact Isolation for MRSA, Mufti-Drug Resistant (MDR), and C-diff. The comprehensive care plan did not include a plan of care which addressed these infectious organisms and contact isolation.</p> <p>Observation of Resident #5, on 08/09/11 at 3:40 PM, revealed the resident was in Contact Isolation. A Contact Isolation sign was posted outside the door to the resident's room. The</p>	F 279		



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F 279	<p>Continued From page 6</p> <p>infection control sheet indicated the MDR and C-diff organisms were acquired after admission to the nursing facility.</p> <p>7. Review of the infection control sheet and the clinical record for Resident #7 revealed the facility admitted the resident on 06/24/11 with diagnoses of Respiratory Failure and Ventilator Dependence. The resident was in Contact Isolation for MRSA, MDRA, and C-diff. The comprehensive care plan did not include a care plan which addressed isolation of the these infectious organisms.</p> <p>Observation of Resident #7, on 08/10/11 at 4:30 PM, revealed the resident was in Contact Isolation. A Contact Isolation sign was posted outside the door to the resident's room. The infection control sheet indicated the C-diff infection was acquired after admission to the nursing facility.</p> <p>8. Review of the infection control sheet and the clinical record for Resident #2 revealed the facility admitted the resident on 02/08/11 with a diagnosis of Respiratory Failure. The resident was in Contact Isolation for MRSA, VRE, MDRA, and MDRP. The comprehensive care plan did not include a care plan which addressed isolation of the these four (4) infectious organisms.</p> <p>Observation of Resident #2, on 08/09/11 at 3:45 PM, revealed the resident was in Contact Isolation. A Contact Isolation sign was posted outside the door to the resident's room. The infection control sheet indicated the Multiple Resistant Drug organisms were acquired after admission to the nursing facility.</p>	F 279		



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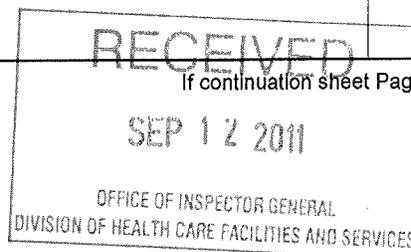
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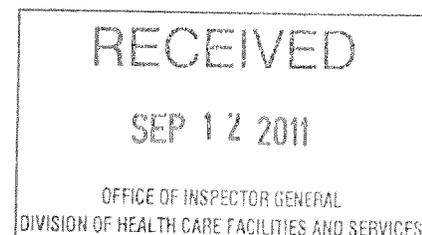
F 279	<p>Continued From page 7.</p> <p>9. Review of the infection control sheet and the clinical record for Resident #3 revealed the facility admitted the resident on 07/27/10 with a diagnosis of Respiratory Failure. The resident was in Contact Isolation for MRSA, VRE, MDR-A, MDR-P and Klebsiella. Review of the comprehensive care plan revealed no care plan developed to addressed isolation of the these infectious organisms.</p> <p>Observation of Resident #3, on 08/09/11 at 3:55 PM, revealed the resident was in Contact Isolation. A Contact Isolation sign was posted outside the door to the resident's room. The infection control sheet indicated the Multiple Resistant Drug (MRD-P) organism was acquired after admission to the nursing facility.</p> <p>10. Review of the infection control sheet and the clinical record for Resident #8 revealed the facility admitted the resident on 10/26/10 with a diagnosis of Respiratory Failure. The resident was in Contact Isolation for MRSA and MDR-P. The comprehensive care plan did not include a care plan which addressed isolation for these infectious organisms.</p> <p>Observation of Resident #8, on 08/10/11 at 5:05 PM, revealed the resident was in Contact Isolation. A Contact Isolation sign was posted outside the door to the resident's room. The infection control sheet indicated the Multiple Resistant Drug (MRD-P) organism was acquired after admission to the nursing facility.</p> <p>Interview with the nurse responsible for Infection Control/Prevention, on 08/11/11 at 1:00 PM,</p>	F 279		
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F 279	Continued From page 8 revealed she was new to this position but had identified the Skilled Nursing Unit had a large number of infections requiring isolation. She stated she had begun to track and trend the infectious organisms by each unit through a monthly review.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and clinical record review it was determined the facility failed to provide services in accordance with the plan of care for one (1) of twelve (12) sampled residents. The facility care planned Resident #7 to not use incontinent products (Depends) until the wound healed on the resident's sacrum and the dermatitis cleared; however, observation on 08/11/11, revealed the resident was wearing a depend brief. The findings include: Review of Resident #7's clinical record revealed the facility admitted the resident on 06/24/11 with diagnoses of Respiratory Failure and Ventilator Dependence. The facility assessed the resident to be high risk for skin breakdown; however, the resident's skin was intact upon admission. On 06/28/11, the facility documented in the clinical record (weekly wound assessment) that the	F 282	483.20 (k) (3) (11) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN <u>How the corrective action will be accomplished</u> The CNA on the Skilled Unit was immediately instructed to remove resident's briefs. Education was provided by the DNS on the importance of reviewing resident work lists prior to documentation and delivery of care, as well as communication of resident specific information during change of shift reports. <u>How the facility will identify other residents having the potential to be affected by the deficient practice</u> All residents were checked for appropriate use of incontinent briefs and no deficiencies were found. <u>What measures will be put into place to ensure no reoccurrence</u> The "DO's & DON'Ts" of wound management are routinely discussed in the monthly staff meetings by the Director of Nursing Services.	9/10/11



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F 282	<p>Continued From page 9</p> <p>resident now had a "Stage II" pressure ulcer on the sacrum that measured 0.8 cm x 0.8 cm, with no depth. The nurse documented perineal dermatitis was present on the resident's perineum and buttocks. The physician ordered the open area to be cleansed with soap and water, pat dry, then apply trypsin/balsam cream. In addition, the physician ordered, "Do not use Depends until wound healed to help clear dermatitis."</p> <p>Review of the most current impaired skin integrity care plan dated 08/10/11 revealed depends were not to be used on the resident to help clear dermatitis and wound healing.</p> <p>Observation of incontinent care, on 08/11/11 at 9:10 AM, revealed CNA #1 removed a brief (Depend) from the resident, cleaned the perineum with disposable wipe, applied barrier cream, and then applied a clean (Depend) incontinent brief. Observation of the sacrum revealed a very small superficial open area.</p> <p>Interview with CNA #1, on 08/11/11 at 2:40 PM after the above observation, revealed she was unaware the resident was not suppose to wear an incontinent brief. She stated the night shift CNA had not provided that information. She stated specific instructions on how to care for each resident was included on the flowsheet that was computer generated. Computer review of the flowsheet for Resident #7 revealed the CNA had already signed off on the instructions that stated not to use depends. Review of the flowsheet for the next shift revealed information was included on the flowsheet that the CNAs utilized to care for each resident. Continued interview with CNA #1 revealed she had checked off on the instructions</p>	F 282	<p>Skilled Nursing Staff will be reminded of importance of reading the worklist before providing care via an in service presented by the DNS by 9/10/11.</p> <p>The Wound Care Nurse will conduct an audit of products being used on 100% all residents seen during the weekly wound reassessments for 2 months. Any disparities with care plan interventions will be reported to the Director of Nursing.</p> <p>The Director of Nursing will address any variances found during audit with the appropriate care-giver and provide staff education and/or counseling as necessary.</p> <p><u>How effectiveness of changes will be monitored to ensure that solutions are sustained</u></p> <p>DNS will present results of care plan intervention audits to the monthly Skilled Unit Performance Improvement Committee Meeting for at least 2 months or until compliance is sustained.</p>	

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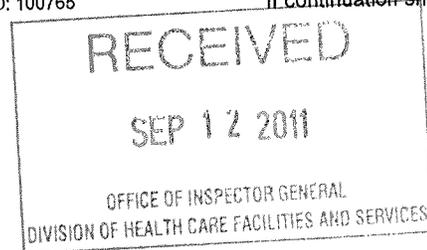
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185361	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/11/2011
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NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL - LOUISVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205
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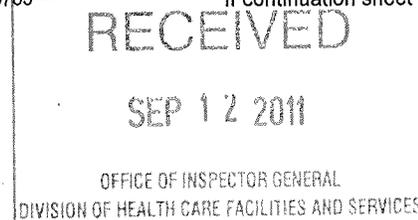
F 282	Continued From page 10 to not use depends; however, she had put a depend brief on the resident that morning. Interview with the Director of Nursing for the Skilled Nursing Facility, on 08/11/11 at 3:00 PM, revealed all nursing assistants have access to the flowsheet information in the computer. She stated the expectation would be all CNAs would review those flowsheets prior to providing care to the residents. She stated it was clearly stated not to put depends on the resident but the CNA did not review.	F 282		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS. The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431	483.60 (b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS <u>How the corrective action will be accomplished</u> The expired vial of Insulin was immediately discarded. The Nurse performing the audit a few days earlier who failed to identify the expired insulin was coached and educated by the DNS on Aug. 17, 2011 about expected performance of identification and removal of expired drugs. <u>How the facility will identify other residents having the potential to be affected by the deficient practice</u> All resident medications cabinets were rechecked and no other expired medications were found.	9/10/11



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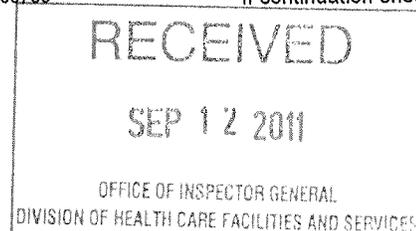
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F 431	<p>Continued From page 11</p> <p>permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review it was determined the facility failed to remove from the medicine cabinet one (1) opened vial of insulin on the discard date for one (1) of two (2) units observed.</p> <p>The findings include:</p> <p>Review of the facility's policy for Storage of Medications PRO 62000-06 revealed insulin vials should be stored in the refrigerator until opened and dated when first opened.</p> <p>Observation of the medicine cabinet in Room 368 on the East Unit, on 08/11/11 at 09:30 AM, revealed one (1) vial of insulin labeled with a discard date of 07/28/11. The insulin was available for staff to use.</p> <p>Interview, on 08/11/11 at 09:30 AM, with Licensed Practical Nurse (LPN) #1 revealed the nursing staff was instructed to label and date insulin when opening a new vial and to label the vial with a discard date of twenty eight (28) days after opening.</p>	F 431	<p><u>What measures will be put into place to ensure no reoccurrence</u></p> <p>The responsibility of checking the resident medication cabinets for expired medications is assigned to the night shift nurses on a weekly basis every Sunday. Expired medications will be discarded and any discrepancies will be reported to the DNS at end of shift.</p> <p>Skilled Licensed Nurses will be in serviced on the requirement to check medication expiration dates daily. DNS will complete in-services by 9/10/11.</p> <p><u>How effectiveness of change will be monitored to ensure that solutions are sustained</u></p> <p>In addition to the weekly checks of the resident medication cabinets for expired medications, the Director of Nursing Services and/or the Consultant Pharmacist, will conduct monthly random spot checks to verify that no expired medications are present.</p> <p>DNS or Consultant Pharmacist will present results of expired medication audits monthly to the Skilled Unit Performance Improvement Committee Meeting for at least 3 months or until compliance is sustained.</p>	



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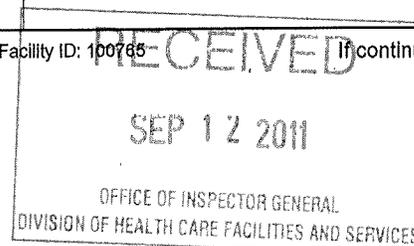
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F 431	Continued From page 12	F 431		
F 441 SS=E	<p>Interview, on 08/11/11 at 10:05 AM, with the Director of Nursing (DON) revealed the nursing staff were instructed to label and date vials of insulin when opened with a discard date of twenty eight (28) days after opening.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p>	F 441	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p><u>How the corrective action will be accomplished</u></p> <p>All glucometer units, the top of the medication carts, and the glucometer holder were cleaned by the nursing staff with Clorox wipes, a 10% bleach solution on the both wings of the Skilled Nursing Units</p> <p><u>How the facility will identify other residents having the potential to be affected by the deficient practice</u></p> <p>All glucometer units, the top of the medication carts, and the glucometer holder were cleaned by the nursing staff with Clorox wipes a 10% bleach solution on both wings of the Skilled Nursing Units.</p> <p><u>What measures will be put into place to ensure no reoccurrence</u></p> <p>The Director of Nursing Services developed a "DO's & DON'Ts" education related specifically to glucometer cleaning focusing on clean and dirty and will</p>	9/10/11



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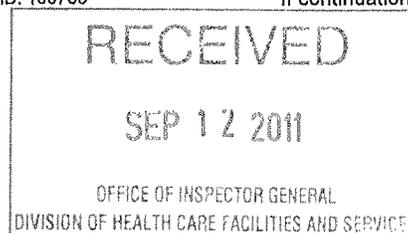
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F 441	Continued From page 13 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and review of the infection control sheet it was determined the facility failed to ensure their Infection Control Program was consistently implemented to prevent the development and transmission of infection for three (3) out of twelve (12) sampled residents. The facility staff failed to follow Cleaning and Disinfecting of diagnostic equipment (glucometer) for Residents #9, #11, and #12. The findings include: 1. Review of the facility's policy for cleaning and disinfecting diagnostic equipment (glucometer) dated 10/31/10, revealed the equipment was to be disinfected with 10% bleach solution moistened wipes in-between each patient and as needed. Allow contact with bleach solution for one minute. In addition, the facility provided a blood glucose cleaning protocol that instructed the staff to clean the glucometer after every patient use with a dampened cloth with a 10% bleach solution. The protocol states to allow contact with the bleach solution for two (2) minutes.	F 441	provide this education to Skilled Licensed Nurses by 9/10/11. The education will include a review of the Infection Control policy on Multi Drug Resistant Organisms (MDROs) as well as a review of "Cleaning Equipment In and Out of the Resident Rooms." <u>How effectiveness of change will be monitored to ensure that solutions are sustained</u> The Director of Nursing Services and/or Infection Control Preventionist will conduct spot checks weekly for 1 month, then bi-weekly for 2 months. This will be accomplished by direct observation. Additionally, peer review by staff members of each others' techniques will be conducted. DNS or Infection Control Preventionist will present results of the audits to the monthly Skilled Unit Performance Committee Improvement Meeting for at least 3 months or until 100% compliance is obtained.	



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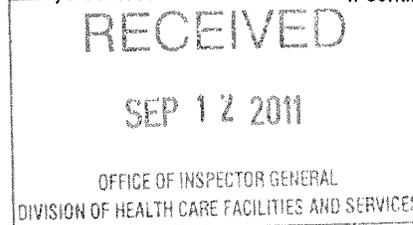
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F 441	<p>Continued From page 14</p> <p>Observation of RN #2, on 08/10/11 at approximately 4:55 PM, revealed she went into Resident #12's room to obtain a blood glucose reading. The resident was in contact isolation. The Nurse gowned and donned clean gloves after washing her hands with soap and water because the resident was in isolation for C-Diff. The nurse identified the resident via name bracelet and then proceeded to prick the resident's right thumb to obtain blood for the test. The nurse then placed the blood onto the test strip and into the glucometer. The blood sugar reading was 136. The nurse removed the test strip and placed into the trash. The nurse then removed the protective gown and gloves, touched the glucometer with her naked hands and brought the glucometer out of the isolation room and placed on top of the medication cart. The nurse picked the glucometer up and cleaned the machine with a bleach wipe, placing the glucometer immediately back on top of the medication cart where she had laid the glucometer prior to cleaning.</p> <p>Interview with RN #2, at the time of the observation, revealed she didn't realize she had placed the glucometer back onto the medication cart where the glucometer had been prior to cleaning. In addition, the nurse did not allow contact with the bleach solution one (1) or two (2) minutes according to the facility's policy and protocol.</p> <p>Review of the infection control log revealed Resident #12 was in isolation for Vancomycin Resistant Enterococci (VRE), Clostridium Difficile (C-Diff), Multi-Drug Resistant Acinetobacter (MDR-A) and Multi-Drug Resistant</p>	F 441		



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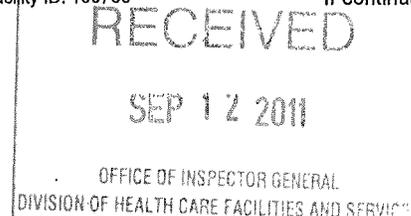
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F 441	<p>Continued From page 15 Pseudomonas (MDR Ps).</p> <p>2. Record review for Resident #9 revealed the facility admitted the resident on 08/04/11, with diagnoses of Respiratory Failure and Diabetes Mellitus. The infection control log revealed the resident was in Contact Isolation for Extended Spectrum Beta Lactamase Klebsiella.</p> <p>Observation of LPN #2, on 08/11/11 at 4:50 PM, revealed she entered the room of Resident #9 after donning a gown and gloves. She took the glucometer into the room and scanned the resident's identification bracelet. LPN #1 placed the glucometer on top of a counter in the resident's room. She wiped the resident's finger with alcohol and proceeded to stick the finger with a lancet. A drop of blood was placed on a test strip and inserted into the glucometer. The blood glucose reading was eighty (80). LPN #1 removed her gown and gloves and sanitized her hands. She exited the room and placed the glucometer on top of the medication cart. The glucometer was cleaned with a bleach wipe and returned to the top of the medication cart which had not been cleaned.</p> <p>3. Review of the infection control sheet and the clinical record for Resident #11 revealed the facility admitted the resident on 04/02/10 with diagnoses of Respiratory Failure and Diabetes Mellitus. The resident was in Contact Isolation for Vancomycin Resistant Enterococci.</p> <p>Observation of a blood glucose check for Resident #11 revealed Licensed Practical Nurse (LPN) #2, on 08/11/11 at 4:40 PM, donned a gown and gloves and entered the room of</p>	F 441		



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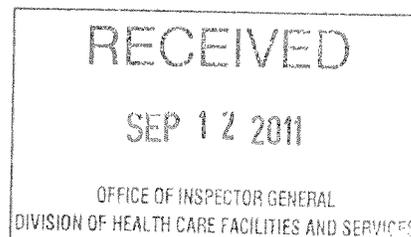
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F 441	<p>Continued From page 16</p> <p>Resident #11. The nurse took the glucometer into the room, scanned the identification bracelet of the resident and wiped the finger with an alcohol wipe. The nurse dropped the strip used to collect the blood. She stepped outside the resident's room and opened the strip container to retrieve a new strip. She re-entered the resident's room and stuck the finger with a lancet to obtain a drop of blood. The drop of blood was placed on the strip and the strip was placed in the glucometer. The blood glucose was one hundred eighty three (183). LPN #1 removed her gown and gloves and placed the glucometer on top of the medication cart. She then took a bleach wipe and cleaned the glucometer. However, she placed the cleaned glucometer on top of the medication cart that had not been sanitized.</p> <p>Interview with LPN #2, on 08/11/11 at 5:00 PM, revealed she should have removed her gloves and sanitized her hands prior to touching the bottle containing the strips for the glucometer. She stated she had placed the glucometer on top of the medication cart before wiping it with a bleach wipe and she should not have done that.</p> <p>Interview with the Director of Nursing (DON), on 08/11/11 at 10:45 AM, revealed the glucometer should not be placed on top of the medication cart prior to being cleaned. The glucometer should have been placed on top of a paper towel before cleaning it with the bleach wipe.</p> <p>Interview with the Infection Control/Prevention nurse, on 08/11/11 at 1:00 PM, revealed all equipment should be cleaned after being removed from an isolation room, including the glucometer, which should not have been placed</p>	F 441		



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F 441	Continued From page 17 on top of the medication cart prior to being cleaned.	F 441		



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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Plan Approval: 1992</p> <p>Survey under: 2000 existing</p> <p>Facility type: SNF/NF on the third floor of a Hospital</p> <p>Type of structure: Six (6) stories with Basement, Type II unprotected.</p> <p>Smoke Compartment: Five (5) smoke compartments</p> <p>Fire Alarm: Full fire alarm system installed in 1992.</p> <p>Sprinkler System: Automatic (wet and dry) sprinkler system installed in 1992.</p> <p>Generator: Type I generator, fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 08/09/11. The skilled nursing facility located on the third floor of Kindred Hospital was found to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for forty-seven (47) beds and the census was thirty-nine (39) on the day of the survey.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Mike Maxwell

TITLE
Administrator

(X8) DATE
8/31/11

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her 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.