

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

PRINTED: 08/30/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/16/2012
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NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS A standard health survey was initiated on 08/14/12 and concluded on 08/16/12 and a Life Safety Code survey was conducted on 08/14/12 with deficiencies cited at the highest scope and severity of an F. The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	F226 All residents on the A Wing on which Housekeeper #1 worked have been interviewed by the Social Worker to determine if any of them ever attempted to report abuse and were unable to do so due to the Housekeeper's inability to understand them. No residents were found to have been affected by this deficient practice. Housekeeper #1 was terminated due to her inability to report Abuse.	9-30-12 m. Bradford McLaughlin by PB 9-27-12
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 observation, interview, and review of the facility's policy Prevention and Detection of Abuse and Neglect, it was determined the facility failed to ensure employees were trained and understood the state and federal requirements of Abuse/Neglect. One (1) of the five (5) staff failed to verbalize the definition of abuse, the types of abuse, the signs of abuse and neglect, or acknowledge being trained on abuse and neglect. The findings include: Review of the facility's policy regarding Prevention and Detection of Abuse and Neglect, dated 02/16/12, revealed Twinbrook will train employees, through orientation and on-going sessions, on issues related to abuse and neglect.	F 226	All other residents had the potential to be affected. All employees who do not speak English fluently have been questioned to determine their ability to understand and report allegations of Abuse and Neglect. Employees who were unable to verbalize their understanding of Abuse and Neglect and/or the procedure for reporting Abuse and/or Neglect have been terminated Department Heads will be responsible for assessing the English speaking and comprehension skill of all job applicants by having them complete an employment application and by conducting a face to face interview in English prior to employment. No language translators will be permitted during this interview and persons who do not demonstrate English speaking and comprehension skills shall not be	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bradford McLaughlin</i>	TITLE <i>Admin</i>	(X6) DATE <i>9/26/12</i>
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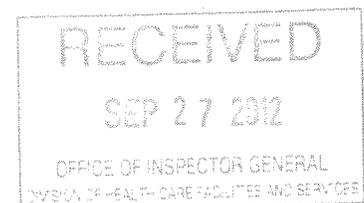
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

OFFICE OF INSPECTOR GENERAL
Division of Health Care Inspection
If continuation sheet Page 1 of 34

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F 226	<p>Continued From page 1</p> <p>This training will include: (1) the treatment of and interventions with residents (particularly those residents with difficult behaviors) 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; (2) prohibition of abuse or neglect and what actions constitute abuse, neglect and misappropriation of residents' property; (3) residents' rights in a long term care facility; (4) reporting of abuse and neglect without fear of reprisal and (5) how to recognize factors (stress, staff knowledge deficits, frustration) that may lead to abuse. It is the responsibility of all staff members to respect residents' rights by not using verbal, mental, physical or sexual abuse, corporal punishment or involuntary seclusion with any resident in the facility. Training will occur both formally during in-services and informally during day-to-day operations and supervision.</p> <p>Interview with Housekeeper #1 in the A hallway, on 08/16/12 at 1:55 PM, revealed she spoke and understood very little English. When the Housekeeper was asked if she had received education and training on abuse and neglect, the Housekeeper smiled but did not respond verbally. Multiple attempts using various types of verbiage was used in an attempt to convey understanding without a response or acknowledgement of understanding from the housekeeper. When asked if she understood, the Housekeeper nodded her head back and forth. Observation during the interview revealed a resident approached the Housekeeper and asked if she was done cleaning the room, and if they could enter safely. The Housekeeper smiled but did not respond or step aside to allow access. When</p>	F 226	<p>hired. All newly hired employees will then be assessed by the Staff Development Coordinator during employment orientation to verify their English speaking and/or English comprehension skills during the orientation process. A note shall be placed in the employee's file indicating that she/he demonstrated her/his ability to comprehend English during the orientation process. Thereafter, the English speaking skills of all employees will be monitored by the supervisors of each department when they interact with the employees on a daily basis. Actions monitored will be comprehension of assignments, the ability to speak and understand instructions when given to them in English, the ability to define Abuse and Neglect and to describe what actions they will take if they need to report Abuse. All employees will have Abuse and Neglect Training upon hire and at least annually thereafter. This training will be conducted by the Staff Development Coordinator for the Nursing and Administrative Staff, the Housekeeping Supervisor for the Housekeeping, Laundry and Maintenance Departments and the Dietary Supervisor for the Dietary Department. All employees will be required to define Abuse and Neglect and describe the process for reporting Abuse and Neglect and this shall be documented on their in-service education record.</p>		



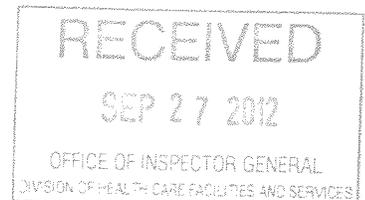
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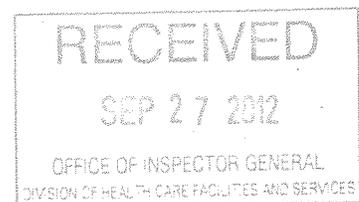
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F 226	<p>Continued From page 2</p> <p>asked if she understood the resident, the Housekeeper smiled and shrugged her shoulders. Again, multiple attempts were made to complete the staff abuse interview, but was unable to convey understanding to the housekeeper.</p> <p>Interview with the Housekeeping Supervisor, on 8/16/12 at 3:00 PM, revealed Housekeeper #1 was from Turkey, but did understand some English. The Housekeeping Supervisor revealed he utilized one of the other housekeepers to translate. However, the Housekeeping Supervisor revealed the translator was not readily accessible nor worked the same schedule as Housekeeper #1. After being informed of the observation and interview with the Housekeeper, the Housekeeping Supervisor revealed housekeeper #1's understanding sometimes depends on the wording being used. The Housekeeping Supervisor did not respond when asked how the facility ensured staff understood the facility's policy on abuse and neglect, or a resident if they were to report an allegation, or incident of abuse.</p> <p>Interview with the Staff Development Coordinator, on 8/16/12 at 3:10 PM, revealed she provided education and training to the facility staff on abuse and neglect upon hire in orientation and periodically throughout the year. The Staff Development Coordinator revealed she utilized employee's friends or family to translate information if necessary to convey understanding, and provided a handout to each employee. However, the Staff Development Coordinator revealed she did not conduct a test herself to ensure knowledge and understanding, but did</p>	F 226	<p>A report shall be made to the Quality Assurance Committee by the Staffing Coordinator on a quarterly basis beginning at the quarterly meeting on 10-30-2012 verifying that all new hires are able to communicate and comprehend English and that they have received in-service training on Abuse and Neglect and are able to explain the procedure to report Abuse and Neglect.</p>	



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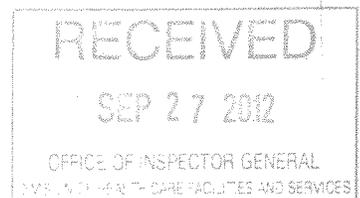
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F 226	Continued From page 3 give an abuse test to the Housekeeping Supervisor to handout and turn back in once completed. The Staff Development Coordinator revealed handout material and in-services are only provided in English. Interview with the Director of Nursing (DON), on 8/16/12 at 4:40 PM, revealed she had not actually observed the orientation process and was not aware of how abuse testing was being completed. The DON revealed Staff Development was responsible for the abuse in-service upon hire, and was responsible to ensure all employees understood the information. Interview with the Administrator, on 8/16/12 at 4:40 PM, revealed they relied on other housekeepers to help translate amongst the staff, and if a housekeeper did not understand something, they should go get help. The Administrator revealed the facility should not rely on one person to translate to the housekeeping staff.	F 226	F253 A physical exam and chart review were conducted of Resident #4 and no ill effects were noted as a result of this deficient practice. All nursing and housekeeping staff who provide services to Resident #4 were shown how to properly wash their hands. Housekeeping staff were shown how to clean the room and the bathroom, bedroom and all furniture, fixtures and floors were cleaned using bleach solution to kill the C-Diff organism. The facility will identify all residents who have isolation precautions and perform a room inspection, chart review and interview the resident or perform a physical exam to determine if they had an adverse effect as a result of using improper cleaning chemicals or procedures. For residents in a semi-private room, we will also review the chart of the roommate and either interview the roommate or perform a physical exam to ensure that he/she did not have any adverse effects. If adverse effects are discovered, we will notify the resident, physician and family members and will take corrective action as prescribed by the physician. All rooms wherein a resident has a C-Diff infection shall be thoroughly cleaned with a bleach solution to ensure that the C-Diff organism has been killed. All housekeeping staff received in-service training from the Housekeeping Supervisor on 9-14-2012 and 9-17-2012	
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to maintain a sanitary environment to prevent infection for one (1) of twenty-one (21) sampled residents, Resident #4. Housekeeping	F 253		9/30/12



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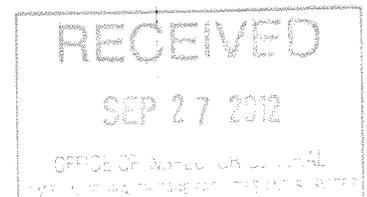
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F 253	<p>Continued From page 4</p> <p>failed to use the appropriate disinfectant to clean a bedside commode for Resident #4 who had Clostridium Difficile (C-Diff) infection. In addition, the facility failed to provide evidence of training on the use of the correct disinfectant.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Cleaning and Disinfection of Environmental Surfaces, revised 08/09, revealed Disinfecting Clostridium Difficile 1:10 dilution of household bleach will be used for routine environmental disinfection.</p> <p>Record review of the Virucide, H2 Orange2 Concentrate 117 Manual and Dispenser Dilution, revealed when used as directed as a virucide, H2 Orange Concentrate 117 manual and Dispenser Dilution, kills the following viruses in five (5) minutes at room temperature ; herpes simplex virus Type 2, Influenza A2/Japan, HBV (Hepatitis B Virus) and HIV-1 (Human Immunodeficiency Virus).</p> <p>Record review of the Clorox Solution label, revealed organisms killed included all the above including Clostridium Difficile spores and more.</p> <p>Observation of Housekeeper #1 cleaning Resident #4's bathroom, on 08/16/12 at 11:13 PM, revealed Housekeeper #1 using a Virucide Solution to clean a bedside commode with a brown substance noted to the top of the commode.</p> <p>Interview with Housekeeper #1, on 08/16/12 on 11:35 PM, revealed she had not been trained on what to use when cleaning C-Diff.</p>	F 253	<p>regarding Infection Control and, in particular, the appropriate use of disinfectants and procedures to utilize when disinfecting specific types of organisms, including C-Diff. A brown dot will be placed on the isolation sign at the door to all rooms wherein a resident resides with contact precautions for C-Diff to notify staff members to utilize bleach when cleaning and appropriate precautions for C-Diff.</p> <p>The Housekeeping Supervisor has developed an Infection Control Cleaning Monitoring checklist to ensure the compliance of the housekeepers with C-Diff and other disinfecting procedures and shall conduct skills competency testing on 100% of his staff members monthly to ensure that they are knowledgeable in the procedures to properly disinfect surfaces contaminated with C-Diff and other infectious organisms. This checklist includes cleaning toilets, sinks, showers, resident rooms, furniture, fixtures, floors as well as handwashing and use of gloves. The Housekeeping Supervisor shall make a report to the Quality Assurance Committee monthly detailing who he has performed skills testing on during the month and the results of the testing. If any housekeeper needs additional training the Housekeeping Supervisor shall conduct the training immediately and document the training on the skills assessment</p>	



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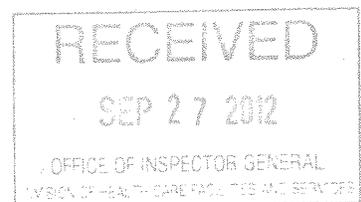
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F 253	Continued From page 5 Interview with the Housekeeping Manager, on 08/16/12 on 2:17 PM, revealed Viralcide did not kill C-Diff. The Housekeeping Manager stated staff were encouraged to use Bleach because the organisms can live on the surface of objects for a long period of time. The Manager stated housekeepers were to use bleach because it was recommended by the Board of Health. Interview with the Director of Nursing (DON), on 08/16/12 at 4:20 PM, revealed she expected housekeeping to use Clorox bleach when cleaning the commodes. The DON further stated she expected housekeeping to wear a gown if they were cleaning feces in a bathroom. The DON stated it was the Housekeeping Manager's responsibility to ensure housekeeping staff cleaned rooms appropriately.	F 253	form. The Housekeeping Supervisor shall also make a report to the quarterly Quality Assurance Committee. The Administrator shall attend the weekly, monthly and quarterly Q.A. meetings and shall sign his name on the attendance sheet to verify his attendance. If the Housekeeping Supervisor does not perform the testing as prescribed, the Administrator shall counsel him to ensure that the required testing is performed and, if necessary, assign another staff person to perform the testing to ensure that it is accomplished.	
F 279 SS=D	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. 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	F 279		9/30/12



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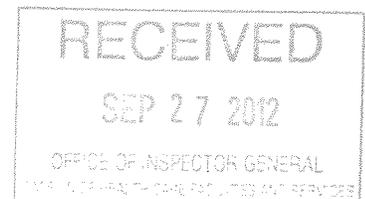
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F 279	<p>Continued From page 6</p> <p>be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy Isolation - Categories of Transmission-Based Precautions, it was determined the facility failed to develop a comprehensive plan of care for three (3) of the twenty-one (21) sampled residents (#4, #13 and #17) regarding contact isolation precautions to prevent the spread of infection.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Isolation - Categories of Transmission-Based Precautions revealed (2) the facility will ensure that the resident's care plan and care specialist communication system indicates the type of precautions implemented for the resident.</p> <p>Interview with the Licensed Practical Nurse (LPN) #1, on 08/16/12 at 3:57 PM, revealed the initial care plans were completed by the charge nurse upon admission.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator, on 08/16/12 at 4:53 PM, revealed the admitting nurse was responsible for completing the admission care plan. The MDS Coordinator stated she was involved with the care plan once the fourteen (14) day assessment was completed.</p>	F 279	<p>F279</p> <p>A chart review was performed for the charts of Residents #4, #13 and #17 and no infections or other adverse conditions were found to have occurred as a result of this deficient practice. A comprehensive care plan was developed for each of these residents specifically identifying their infections and the appropriate isolation procedures and interventions.</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>An Infection Control Care Plan has been developed (copy attached) to be utilized with residents requiring isolation upon which the appropriate items can be checked which are relevant to treating the particular type of infection warranting isolation. This care plan has focus columns to designate the type of infection, location of infection and types of precautions warranted. There are also columns for goals and interventions. This care plan will be kept in the same care plan book as the interdisciplinary care plan. Isolation signs shall be placed at the door to the resident's room signifying the resident has an infection which warrants special precautions. The front of the sign by the door contains specific precautions to be taken by anybody who enters the room based upon the type of infection identified. The back of the card has a</p>	8/30/12



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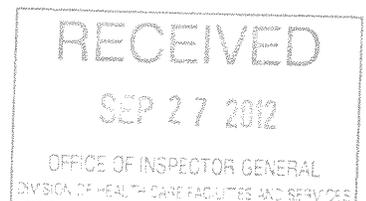
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F 279	Continued From page 7 1. Observation of Resident #17, on 08/15/16 at 3:45 PM, revealed signage on the resident's room door stating standard precautions and contact precautions. Review of the Resident's clinical record revealed a Wound Culture report, dated 07/27/12, identifying an infection of a left toe wound with Methicillin Resistant Staphylococcus Aureus (MRSA). A Physician's order, dated 07/30/12, revealed an order to start Contact Precautions. Review of the resident's comprehensive plan of care revealed there was no care plan for infection control relating to contact precautions. Interview with Registered Nurse (RN) #1, on 08/16/12 at 3:45 PM, revealed Resident #17 was positive for MRSA of a wound and was in contact isolation. The RN revealed specifics as to the individualized care needs for infection control should be found on the residents care plan. The RN revealed a care plan is used to make sure care needs are being met and that each resident and circumstance is different. After reviewing the resident's plan of care, the RN confirmed there was not a plan of care regarding contact precautions and what specifically should be done to prevent the spread of infection. Interview with the Unit Manager, on 08/16/12 at 4:00 PM, revealed the care plan directs the care for each resident and how it applies to each resident. After reviewing the resident's care plan the Unit Manager revealed that there was an intervention for contact precautions in the focus of activities of daily living, however location of infection, type of infection, treatment of infection, and how to prevent the spread of the	F 279	list of organisms requiring this type of isolation precautions. This care plan will be initiated for all residents for whom the physician or Nurse Practitioner orders contact or droplet precautions. The Infection Control Care Plan will be placed in the care plan book with the rest of the comprehensive care plans. Nursing staff will receive in-service training on the new care plan which will specify the types of precautions which are appropriate for the condition diagnosed. All R.N.'s and L.P.N.'s including the MDS nurses will receive training on the new Infection Control Plan on 9-24-2012, 9-25-2012 and 9-28-2012. Training will be conducted by the Infection Control Nurse. The Infection Control Nurse will be responsible for monitoring the initiation of the infection control care plans. She maintains a list of all infections in the building and will verify that Infection Control Care Plans are initiated for all residents requiring isolation by going to the care plan book for the resident and verifying that the Infection Control Care Plan has been completed. She will do this for all residents who have isolation precautions on all wings of the facility. If she discovers that an Infection Control Care Plan has not been completed when one was warranted, she will complete an incident report and	



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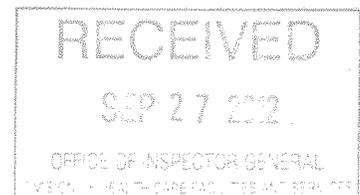
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F 279	<p>Continued From page 8</p> <p>infection was not listed. The Unit Manager revealed the Minimum Data Set (MDS) Coordinators created the care plans and nurses are responsible to update the care plan. The Unit Manager acknowledged the physician's order for contact precaution, but did not think to put all of the information on the care plan.</p> <p>Interview with the MDS Coordinator, on 08/16/12 at 4:05 PM, revealed she was responsible to develop and initiate a plan of care if the problem was during an assessment period, otherwise the floor nurses should update as needed. The MDS Coordinator revealed Resident #17 was not in an assessment period when the order for contact precautions was obtained.</p> <p>Interview with the Director of Nursing (DON), on 08/16/12 at 4:15 PM, revealed the desk nurse receiving the order should add the precautions to the care plan. The DON revealed all the interventions relating to the care of the infection specific to that resident should be added to the care plan. The DON revealed she received a copy of the physicians orders and reviewed them every morning. The DON revealed at the bottom of each order was a place for the desk nurse to check when the care plan was updated, and she trusted that it was done when it was marked. The DON revealed she called the affected unit to see what interventions were in place and periodically did a visual checks. The DON revealed she did not check Resident #17's plan of care.</p> <p>2. Review of Resident #13's record revealed the</p>	F 279	<p>will provide additional in-service training to the nurse who failed to complete the care plan appropriately. She will also assess the resident to ensure that she/he did not have any adverse consequences as a result of the care plan not being completed and will take appropriate measures to remedy any adverse consequences which may be discovered. The Infection Control Nurse will report her results to the Q.A. Committee on a weekly and quarterly basis. This weekly reporting will begin on 9-26-2012 and will continue for one year at which time the Q.A. Committee will discuss whether monthly monitoring is sufficient. Quarterly monitoring shall begin at the next quarterly Q.A. meeting scheduled for October 30, 2012. If the Infection Control Nurse is not completing these duties, the Administrator shall counsel her to correct the problem or shall assign another person to complete the monitoring to ensure that it is done. The Administrator shall attend the weekly and quarterly Quality Assurance Committee meeting and shall document his presence by signing the attendance form.</p>	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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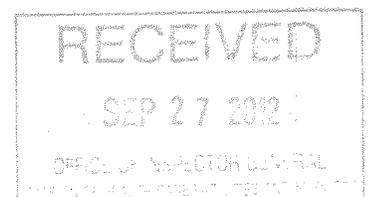
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/16/2012
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F 279	<p>Continued From page 9</p> <p>resident had positive test results for Clostridium Difficile (an infection requiring Contact Precautions) of the stool on 07/03/12. Resident #13 was placed on Contact Precautions Isolation at that time. Review of Resident #13's comprehensive nursing plan of care did not reveal any mention of the Contact Precaution Isolation.</p> <p>Interview with CNA #3, on 08/16/12 at 10:30 AM, revealed she was aware Resident #13 was on Contact Precaution Isolation because there was a sign outside of his/her bedroom and because she had been told the resident had Clostridium Difficile of the stool in a nursing report. She stated it was not indicated on her CNA assignment sheet or on the Kardex which was a tool for the CNA's to use as a guide to resident care. She stated it was sometimes on the Kardex guide for resident care.</p> <p>Interview with LPN #4, at 08/16/12 at 1:00 PM, revealed isolation precautions should be on the nursing care plan and she did not know why the Contact Precaution Isolation was not on the care plan for Resident #13. She stated the Kardex guide for the CNA's was based on information on the nursing care plan and on physician orders. She further stated the CNA assignment sheet would sometimes list different types of isolation for the residents.</p> <p>Interview with the Staff Development/Infection Control Nurse, on 08/16/12 at 11:25 AM, revealed Contact Precaution Isolation should be on the comprehensive nursing care plan for each resident on such precautions. She stated she did not know why the precautions were not listed on</p>	F 279	



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

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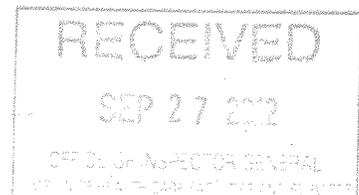
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F 279	Continued From page 10 Resident #13's nursing comprehensive care plan but she was aware the facility policy stated it should be. 3. Review of the clinical record for Resident #4 revealed the facility admitted Resident #4 on 08/08/12 with a diagnosis of Clostridium Difficile (C-Diff). Record review of the Admission Care Plan, revealed the Infection alert section was not completed by staff upon admission. Interview with the Registered Nurse (RN) #2, Unit G Charge Nurse, on 08/16/12 on 4:05 PM, revealed she was responsible for completing the initial care plan; however, another RN completed Res #4's initial care plan. RN #2 stated C-Diff would be an important thing to place into the care plan. The C-Diff concern would be something that was documented on the infection alert section of the initial care plan. Interview with the Director of Nursing (DON), on 08/16/12 at 4:20 PM, revealed she periodically checked care plans. The DON stated the weekend supervisor double checks care plans to make sure orders were placed in the appropriate place. The DON stated if there was an agency nurse whom worked, he/she would be made aware of the plan of care by utilizing the Certified Nursing Aid (CNA) care plan, the nursing care plan and the report given about the isolation. When asked; what was the potential problem for the care plan not being developed, the DON stated there was always a potential for transmission if the aid was not aware of the care to give.	F 279			
F 371 SS=F	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371			9/30/12



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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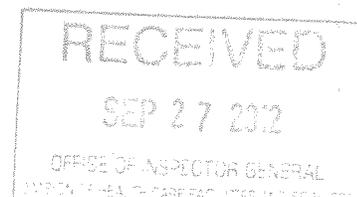
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F 371	Continued From page 11 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility staff failed to serve hot foods from the trayline with temperatures in the acceptable ranges for potentially hazardous foods. The dietary staff failed to thaw hazardous foods under running water, failed to handle food with clean utensils or gloves, failed to fully cover their hair and failed to ensure the deep fryer was free of debris and food particles. The findings include: 1. Review of the facility's policy Meal Service: Serving Temperatures, dated 2006, revealed at the beginning of the meal service, food should be maintained at the temperature range indicated on the Food Temperature Record. Hot foods should be maintain temperatures of one hundred forty (140) degrees and above while on the steam table. Review of the facility's Food Temperature Record, dated 08/01/2012 thru 08/16/2016, revealed the	F 371	F371 No Residents were found to have been affected by this deficient practice. Foods have been brought to the correct temperature, improperly thawed foods have been discarded, utensils have been cleaned, hairnets have been adjusted to cover all hair and the deep fryer has been cleaned and the grease therein has been replaced. Martha Gregory & Associates, Dietary Consultants, is providing a ServSafe certified Instructor who is also the Food Safety Instructor for the Louisville Metro Food Service Managers Certification Course (resume attached) to work in our kitchen on a weekly basis educating staff on proper food handling and sanitation procedures. She has been monitoring food temperatures, thawing of foods, use of gloves and clean utensils, use of hairnets and sanitation including cleaning the deep fryer. Formal in-service training on these topics will be conducted on 9-18-2012, 9-20-2012 and 9-21-2012 by the Food Safety Instructor. All residents have the potential to be affected by this deficient practice. Martha Gregory and Associates, Consulting Dieticians, is providing a Food Service Consultant and Food Safety Instructor who began working in the kitchen on a weekly basis on 9-6-2012, teaching and providing in-service training to staff members on how to	9/30/12



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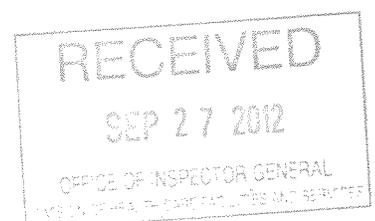
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F 371	<p>Continued From page 12</p> <p>recommended temperature was one hundred thirty-five (135) degrees or higher for hot foods when leaving the kitchen. The Food Temperature Record did not specify a time the temperatures were taken nor identify a specific food. The temperature at lunch, on 08/08/12, revealed a pureed temperature of one hundred (100) degrees. Lunch, on 08/10/2012, revealed an entree temperature at one hundred thirty (130) degrees and a chopped entree at one hundred thirty-two (132) degrees. Lunch, on 08/14/2012, revealed an entree temperature at one hundred thirty-three (133) degrees. Lunch, on 08/15/12, revealed gravy was one hundred twenty-five (125) degrees and a starch was one hundred twenty (120) degrees.</p> <p>The facility provided an incomplete Meal Quality Monitor, dated 07/13/12 that detailed only three (3) food items had been checked for temperature readings. The facility did not provide additional monitoring of any meal services.</p> <p>Review of the manufacturer's guidelines for the food thermometer revealed the thermometer should be recalibrated to thirty-two (32) degrees.</p> <p>Observation, on 08/15/12 at 11:20 AM, of the trayline service for lunch revealed chicken breasts on the steam table had a temperature of one hundred twenty (120) degrees, mashed potatoes had a temperature of one hundred twenty-five (125) degrees, gravy temperature was one hundred thirty (130) degrees, and the ground chicken was one hundred twenty (120) degrees.</p> <p>Interview with the Cook, on 08/16/12 at 8:35 AM, revealed she was the person responsible to take</p>	F 371	<p>safely store, prepare and serve food. This will continue until the consultant feels that all staff have been properly trained and have demonstrated their competency via a competency test which will be retained in the employees' files. The consultant has scheduled the following in-service trainings: 9-18-2012- Food Safety and Control, Thermometer Calibration and Cleaning Schedule. 9-20-2012- Food Service Gloves, Food Service Equipment, Personal Hygiene Practices. 9-21-2012- Thawing Foods Properly, Prevention of a Food Borne Illness. All of these in-services will be verified with a sign-in sheet for the trainees and the signature of the instructor who performed the training. Thereafter, the consultant will make weekly scheduled as well as unannounced inspection exams to ensure ongoing compliance until such time as the consultant determines that the problem has been resolved and the facility is in compliance with regulations, policies and procedures and is capable of maintaining compliance. Any observations of deficient practice shall be addressed immediately by the consultant and a report of each visit and all in-service training shall be kept in a Q.A. binder in the Dietary Manager's office. The Dietary Manager shall make a weekly report to the Quality Assurance Committee regarding compliance and shall bring copies of food temperature logs and cleaning</p>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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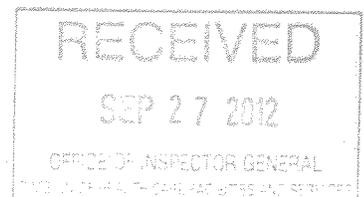
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F 371	<p>Continued From page 13</p> <p>the food temperatures for all foods on the steam table and hot foods should be above one hundred thirty-five (135) degrees. The Cook stated she calibrated the thermometer every morning to zero (0) degrees and there was no evidence of the calibration.</p> <p>Observation of the trayline lunch service, on 08/16/12 at 11:17 AM, revealed whipped sweet potatoes at a temperature of one hundred twenty (120) degrees, and boneless pork chops at one hundred twenty-five (125) degrees. The Cook switched to a second thermometer to finish the food temperatures. The Cook then began to plate the food from the trayline without ensuring the food was at the proper temperature.</p> <p>Interview, on 08/16/12 at 11:17 AM and 11:53 AM, with the Cook revealed the meat temperature was taken when removed from cooking and was not written down. The Cook stated she did not calibrate the second thermometer used for the food temperatures. She also stated the air in the kitchen may have cooled the food on the trayline</p> <p>Observation, on 08/16/12 at 11:53 AM, the Cook tempted the pork chops at one hundred twenty (120) degrees. The Cook used another thermometer and the pork chops tempted at ninety (90) degrees. With a third thermometer the pork chops tempted at one hundred thirty (130) degrees at which time the Cook put the food back into the oven.</p> <p>Interview, on 08/16/12 at 11:53 AM, with the Director of Nutritional Services revealed the third thermometer was straight from the box and had not been calibrated.</p>	F 371	<p>schedules to the meeting to demonstrate compliance. A summary of the findings will be presented at each quarterly Quality Assurance meeting by the Dietary Manager whose responsibility it shall be to ensure compliance with all policies, procedures and food safety regulations. A copy of each report shall also be given to the Administrator who shall read and initial each report and keep a copy in his office. Staff members who do not comply with regulations and/or abide by policies and procedures will be replaced with employees who are able and willing to do the job properly.</p>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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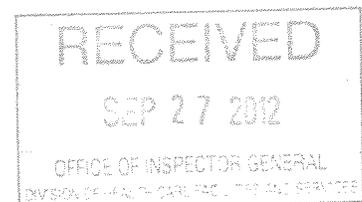
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F 371	<p>Continued From page 14</p> <p>Observation, on 08/16/12 at 12:00 PM, revealed all three (3) food thermometers calibrated in ice water. One (1) thermometer calibrated to zero (0) degrees, a second thermometer calibrated to twenty (20) degrees, and the third thermometer calibrated to thirty-two (32) degrees.</p> <p>On 08/16/12 at 12:05 PM, interview with the Director of Nutritional Services revealed the three (3) thermometers calibrated at different temperatures and was unsure which thermometer was accurate. The Director stated thermometers were to calibrate to one (1) degree. After review of the manufacturer guidelines the thermometer should be calibrated to thirty-two degrees and should be recalibrated every meal not daily. She also stated two of the thermometers did not calibrate properly. The Director did not have evidence of thermometer calibration. She stated she periodically watched trayline and conducted inservice training for kitchen staff. The Director stated she had started a trayline audit on 07/13/12 but did not finish it. She stated she reviewed the temperature log at the end of the month to ensure temperatures were taken but does not review the actual temperatures. She stated food should be held at one hundred thirty-five (135) degrees and if food was served at inappropriate temperatures residents could become sick.</p> <p>Interview, on 08/16/12 at 2:30 PM, with the Cook revealed safe range for hot food was over one hundred thirty-five (135) degrees and if it was less it should be put back into the oven. The Cook stated the thermometer should be calibrated to zero (0) degrees. She stated the</p>	F 371			



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

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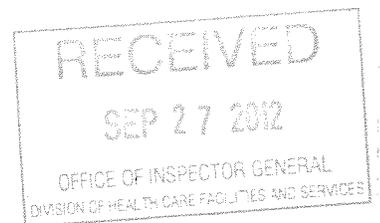
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F 371	<p>Continued From page 15</p> <p>temperatures were documented on the log and turned in to the Director of Nutritional Services at the end of the month. The Cook stated if residents were served food less than one hundred thirty-five (135) degrees, the food could grow bacteria and residents could have diarrhea, get sick to their stomachs, vomit, or kill them.</p> <p>2. Review of the facility's policy Food Preparation and Safety: Defrosting Frozen Foods, dated 2006, revealed frozen food should be thawed in a refrigerator with enough advance time to thaw prior to preparation. Frozen food may be thawed in emergencies under cold running water with force to agitate and dislodge loose food particles in the overflow. Additionally, frozen food should not be thawed at room temperature or in standing water.</p> <p>Observation, on 08/14/12 at 8:35 AM, revealed two (2) bowls of raw chicken in standing water sitting in the sink with no running water over the chicken.</p> <p>Interview, on 08/14/12 at 8:35 AM, with Dietary Aide #3 revealed the chicken was for the day's lunch and had been removed from the freezer that morning. The aide stated the meat was usually thawed in soaking water and sometimes was set in the refrigerator overnight.</p> <p>On 08/14/12 at 10:20 AM, 08/16/12 at 8:35 AM, and 2:30 PM, interview with the Cook revealed the chicken was removed from the freezer that morning, on 08/14/12, at 7:30 AM and placed under running water. The Cook stated she did not know who had turned off the water or when. She stated she did not check the temperature of the</p>	F 371		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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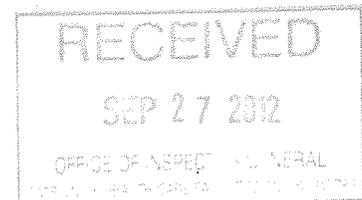
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F 371	<p>Continued From page 16</p> <p>chicken before she began to cook it at 10:00 AM. The Cook stated the frozen chicken should have been thawed under cold running water. It is usually left under the running water, unsupervised, while she begins trayline for breakfast at 7:30 AM. The Cook stated she did not verify the temperature of the chicken once she changed the water the chicken was standing in. The Cook said she was the person responsible for the thawing chicken and leaving the chicken standing in water to thaw could grow bacteria.</p> <p>Interview with the Director of Nutritional Services, on 08/16/12 at 3:05 PM, revealed the Cook was responsible to thaw the frozen chicken and it should have been thawed in the refrigerator. The Director stated the chicken could be thawed under lukewarm running water at seventy (70) degrees to wash away waste. She stated the cook was responsible to serve the trayline and should have prepared the chicken before she started the trayline or after trayline service was completed. The cook should not have left the chicken thawing in the sink in standing water.. The Director said food temperatures were not taken during thawing process and the temperature of the chicken should have been taken to make sure the food was not in the danger zone. She stated leaving the chicken in standing water could lead to the growth of bacteria which could lead to residents becoming sick.</p> <p>3. Review of the facility's policy regarding Food Preparation and Safety: Use of Disposable Gloves, revised 2010, revealed gloves should be discarded when they become contaminated and</p>	F 371			



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

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F 371	<p>Continued From page 17</p> <p>hands should be washed before putting on new gloves. Utensils such as tongs should be used when handling food that is ready to eat.</p> <p>Observation, on 08/15/12 at 12:00 PM, revealed during trayline, the cook handled a grilled cheese sandwich with the same gloved hand that she had been handling resident meal tickets and plates. The cook also rested a pair of serving tongs on the trayline counter, on top of the resident meal tickets. At 12:05 PM the cook placed the tongs into a pan of chicken. At 12:20 PM the cook then served the chicken with the same pair of tongs.</p> <p>Interview, on 08/16/12 at 2:30 PM, with the Cook revealed tongs are usually used to serve grilled cheese. The cook stated she should have removed her gloves, washed her hands, and put on clean gloves before handling the sandwich. She also stated the tongs used for the chicken should not have been on the counter or on top of the meal tickets and should have been replaced with clean tongs. The cook stated soiled gloves and utensil could have germs and should not touch the food.</p> <p>Interview with the Director of Nutritional Services, on 08/16/12 at 3:05 PM, revealed the grilled cheese sandwich should have been served with tongs and the tongs used for the chicken should have been replaced with fresh tongs. The Director stated the meal tickets could be handled by several people and the tongs should stay inside the food. She stated soiled gloves and utensils could spread germs to residents.</p> <p>4. Review of the facility's policy Environmental</p>	F 371			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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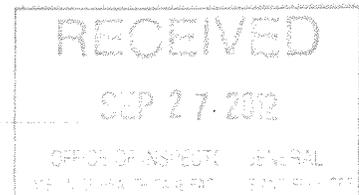
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2012
NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205		
(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 371	<p>Continued From page 18</p> <p>Sanitation/Infection Control: Cleaning Frequency of Equipment and Kitchen Area, dated 2006, revealed equipment used in preparing potentially hazardous food should be cleaned and sanitized after use. Additionally, the Recommended Cleaning Frequency and Cleaning Schedule forms should be followed.</p> <p>Review of the Recommended Cleaning Frequency, dated 2006, revealed the deep fryer should be cleaned weekly.</p> <p>The facility did not provide the kitchen's cleaning schedule.</p> <p>Observation during initial tour of the kitchen, on 08/14/12 at 8:10 AM and again on 08/16/12 at 3:05 PM, revealed the deep fryer grease contained food particles floating on the grease surface.</p> <p>Interview, on 08/14/12 at 8:10 AM, with the Director of Nutrition Services revealed the deep fryer had been used the previous evening and was cleaned once a week.</p> <p>On 08/16/12 at 2:30 PM, interview with the Cook revealed the deep fryer was cleaned once a week and no particular day was scheduled. The cook stated the grease was dark and she had removed food particles that morning before using the fryer to prepare lunch. She stated if the deep fryer contained food debris it was possible the grease could grow bacteria and the temperature not as hot as it would be with fresh grease.</p> <p>Interview, on 08/16/12 at 3:05 PM, with the Director of Nutritional Services revealed the deep</p>	F 371			



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

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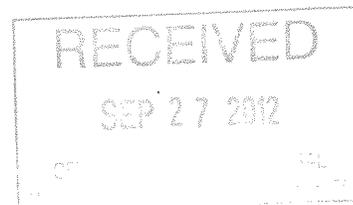
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F 371	<p>Continued From page 19</p> <p>fryer oil was changed every week. The Director stated she orders the oil once a week and is delivered to the facility on Wednesdays. She stated the deep fryer oil is cleaned on Thursday or Friday; however, there was no assigned day. The Director stated the fryer had been used for the last three days and the fryer needed to be cleaned. She also stated food was prepared that day even though the fryer had food debris in it. The Director stated the oil with food debris could set up bacteria which could make residents sick.</p> <p>5. Review of the facility's policy regarding Environmental Sanitation/ Infection Control: Personal Hygiene, dated 2006, revealed a hair net should restrain head hair and be worn in food preparation areas.</p> <p>Observation, on 08/16/12 at 11:05 AM, revealed two (2) dietary aides in the kitchen wearing hair restraints that did not cover all of their hair. Aide #1 had a the front top of the hair uncovered and Aide #2 had the front and top of the hair uncovered.</p> <p>Interview, on 08/16/12 at 11:05 AM, with Dietary Aide #1 revealed her hair was not fully covered and the aide then covered her hair better.</p> <p>On 08/16/12 at 11:06 AM, interview with Dietary Aide #2 revealed the hair net was to cover all of the hair and stated the hair net sometimes slips. The aide stated the purpose of the hair restraint was to keep hair from falling into the food.</p> <p>Interview, on 08/16/12 at 12:15 PM with the Director of Nutritional Services revealed the</p>	F 371			



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

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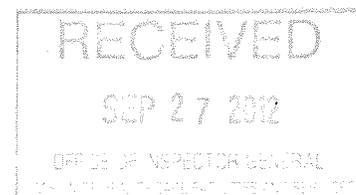
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F 371	Continued From page 20 purpose of wearing hair restraints was to prevent hair from dropping into food and no one should be in the kitchen without a hair restraint. The Director stated she monitors periodically to make sure everyone has hair restrained and did not have documentation of the monitoring.	F 371	F431 No residents were affected by this deficient practice. The opened but undated medications in the A, CD and EF Medication Rooms were discarded.		
F 431 SS=E	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, 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	F 431	All residents who utilize biological solutions have the potential to be affected. "Date Opened" labels are now placed onto all biological solutions by Central Supply staff prior to the solutions being stocked at the nurses stations. All nursing staff will be in-serviced on the requirement to date, time and label biologicals when opened and discard them within 24 hours after opening. These in-service trainings will occur on 9-24-2012, 9-25-2012 and 9-28-2012 and will be conducted by the Infection Control Nurse. The location of the Pharmacy Resource Manual and the policy on the expiration date of biologicals and the need to date them and discard them when expired will also be explained during this in-service program. All attendees will be required to sign an attendance sheet verifying their attendance and understanding of the policy and their agreement to abide by the policy. A Biological Solution Check Log has been developed (see attached) on which each vial will be recorded with the date and time opened and the expiration date and time. This log will be checked by	9/30/12	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 431	Continued From page 21 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's Pharmacy Services and Procedures Manual and the facility's policy on Irrigations Solutions, it was determined the facility failed to store biological products in a safe and sanitary manner. Three (3) of the five (5) Medication Rooms observed during the survey contained multiple use containers of irrigation solutions that were opened and not dated. One (1) container of irrigation solution was observed opened and undated in the Hall A's Medication Room. One (1) container of irrigation solution was observed opened and undated in Hall C/D's Medication Room. Two (2) opened and undated containers of irrigation solution were observed in Hall E/F's Medication Room. The findings include: Review of the facility's Pharmacy Services Policy, revision date 10/31/11, entitled Medication Expiration Dating, revealed, Sodium Chloride Irrigation solution should be dated once opened and expires twenty (24) hours after opened. Review of the facility's policy entitled, HA 8: Irrigation Solutions, undated, revealed irrigation solutions are labeled with the date and time immediately upon opening and solutions without preservatives, such as water and sodium chloride, for irrigation are disposed of with twenty	F 431	the nurses on each unit at the change of shift and initialed. All biological solutions will be stored on the medication carts or at the nurse's stations on each unit after opening and shall be examined by the nurses at shift change when counting medications at which time they will be discarded if expired. If opened but undated biologicals are found they will be discarded and an Medication/Lab Error Form will be completed and sent to the Infection Control Nurse so that she can contact the nurse who did not date the solution and provide additional training to her/him. The Infection Control Nurse will compile this data and make a report to the Quality Assurance Committee on a monthly and quarterly basis. The Administrator shall attend the Q.A. meetings and shall indicate his presence by signing the attendance sheet. If the Infection Control Nurse is not completing this monitoring as specified, the Administrator shall counsel her/him to do so or shall assign the duty to another person to ensure that compliance is maintained.	



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

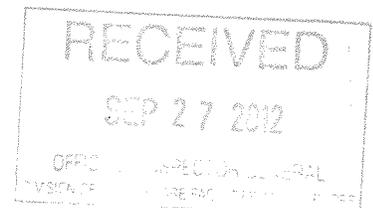
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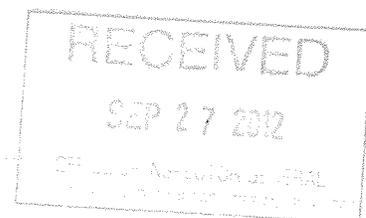
F 431	<p>Continued From page 22 four (24) hours after opening.</p> <p>Observation, on 08/15/12 at 2:25 PM, of the Treatment Shelf in the Medication Room on Hall E/F revealed two (2) multi-dose containers of Normal Saline (Sodium Chloride) irrigation solution that were opened and not labeled with time and date opened.</p> <p>Observation, on 08/16/12 at 2:20 PM, of the Treatment Shelf in the Medication Room on Hall C/D revealed one (1) multi-dose container of Normal Saline (Sodium Chloride) irrigation solution was opened and not labeled with time and date opened.</p> <p>Observation, on 08/16/12 at 2:30 PM, of the Treatment Shelf in the Medication Room on Hall A revealed one (1) multi-dose container of Normal Saline (Sodium Chloride) irrigation solution was opened and not labeled with time and date opened.</p> <p>Interview, on 08/16/12, at 2:20 PM, with Licensed Practical Nurse (LPN) #3, on Hall C/D revealed she was unsure when an opened container of irrigation solution expired.</p> <p>Interview, on 08/16/12 at 2:20 PM, with LPN #2, Unit Manager for Hall A, B, C, & D, revealed irrigation solutions should be labeled with open date, but was uncertain when the solutions expire.</p> <p>During interview, on 08/16/12 at 2:55 PM, with LPN #5, the Staff Nurse on Hall A, revealed she was certain irrigation solutions should be labeled when opened, but also stated irrigation solutions</p>	F 431		
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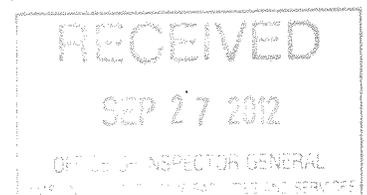
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F 431	Continued From page 23 expire thirty (30) days after opening. She commented she was sure of this, because she had learned this in nursing school. She was unaware of the facility's policy on irrigation solutions and unable to locate the Pharmacy Resource Manual. Interview with the Director of Nursing (DON), on 08/16/12 at 3:30 PM, revealed the facility's policy was to label irrigation solutions with date and time when opened and to dispose of them within twenty (24) hours of opening. The DON said all nurses should know the location of the Pharmacy Resource Manual and that an irrigation solution, such as Normal Saline, used after twenty (24) hours of opening could develop bacteria and compromise a resident if used. Interview, on 08/16/12 at 4:00 PM, with the Staff Development Coordinator, (SDC) revealed it was the facility's responsibility to ensure all nurses know the location of the Pharmacy Resource Manual and the policy on the storage, labeling, and use of irrigation solution. Not following the policy could cause bacteria to grow in a solution and compromise a resident.	F 431			
F 441 SS=E	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 -	F 441			9/30/12



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

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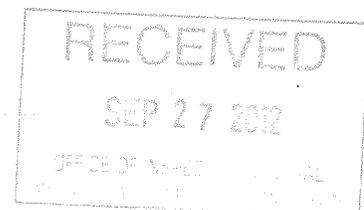
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F 441	Continued From page 24 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions 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 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to follow contact precautions for one (1) of twenty-one (21) residents, Resident #4 who had Clostridium Difficile (C-Diff). The Nursing staff failed to wash their hands with soap and water upon entering and leaving Resident #4 's room. Housekeeping failed to use appropriate Personal	F 441	F441 No residents were found to have been affected by this deficient practice. The corrective action taken for Resident #4 was that all nursing and housekeeping staff who provide services to Resident #4 were shown how to properly wash their hands and clean the room and the bathroom, bedroom and all furniture, fixtures and floors were cleaned using bleach solution to kill C-Diff. All residents had the potential to be affected by this deficient practice. All Housekeeping staff received in-service training from the Housekeeping Supervisor on either 9-14-2012 or 9-19-2012 on the proper cleaning procedures for cleaning isolation rooms, proper use of PPE, hand washing, cleaning agents to utilize when cleaning C-Diff and ensuring that PPE is stocked at nurses stations and at PPE supply stations established at the door to isolations rooms, when applicable, by the housekeeping staff. All Housekeeping personnel have now been in-serviced on Isolation Precautions, Cleaning and Disinfection Protocol for C-Diff and the Employee Performance Isolation Checklist. The Housekeeping Supervisor or his designee will conduct a weekly check of isolation supplies at each nurse's station and document that there are sufficient PPE supplies present and document such on a PPE Inventory	9/30/12



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

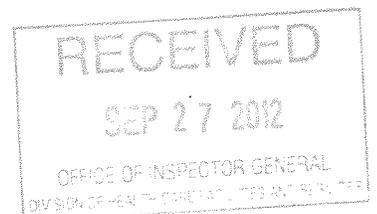
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F 441	<p>Continued From page 25</p> <p>Protective Equipment (PPE) while cleaning the commode for Resident #4. In addition, the facility failed to store PPE at four (4) of five (5) nursing stations, per policy.</p> <p>The findings include,</p> <p>1. Record review of the facility's policy regarding Contact Precautions In Addition to Standard Precautions Signage, revealed the staff were to wash their hands before entering the residents room and to wash their hands when exiting the residents room.</p> <p>Review of the clinical record for Resident #4 revealed the facility admitted the resident on 08/08/12 with a diagnosis of Clostridium Difficile (C-Diff).</p> <p>Observation, on 08/14/12 at 12:23 PM, revealed the staff placed gloves on their hands, and sat up Resident #4's tray. The staff member then removed the gloves and sanitized their hands with alcohol when leaving the room.</p> <p>Observation, on 08/14/12 at 3:05 PM, revealed a Certified Nursing Assistant (CNA) went into Resident #4's room and adjusted the resident's position while he/she was in his/her wheelchair. The CNA was observed to not utilize any gloves or PPE. The CNA then exited the room after cleaning her hands with alcohol. No soap or water was used.</p> <p>Observation, on 08/14/12 at 3:20 PM, revealed the staff entered Resident #4's room, did not wash their hands, then donned gloves and no gown. Resident #4 was then assisted into his/her</p>	F 441	<p>Record and shall make a weekly report to the Q.A. Committee as well as a quarterly report to the Q.A. Committee. Nursing staff will be in-serviced by the Staff Development Coordinator on hand washing, contact precautions, use of PPE, appropriate use of gloves, disinfectants which kill C-Diff and the appropriate use of hand sanitizers. Nursing and Housekeeping staff members will also be trained to read and abide by the instructions on the isolation cards posted at the door to the isolation room and to look at the back of the isolation cards for information on organisms for which that specific type of isolation is pertinent.</p> <p>An Infection Control Care Plan will be utilized to notify nurses of the presence of an infection which requires isolation precautions and will list persons and departments to notify and interventions to take to prevent the spread of the infection. (Copy attached.) This Infection Control Care Plan will be implemented by the Charge Nurse on duty on the unit where the resident resides when a resident is diagnosed with an infection requiring isolation precautions either by orders from the physician or when documented by lab tests. This Infection Control Care Plan will list all departments and persons to be notified of the infection and the specific interventions to be</p>	



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 CENTERS FOR MEDICARE & MEDICAID SERVICES

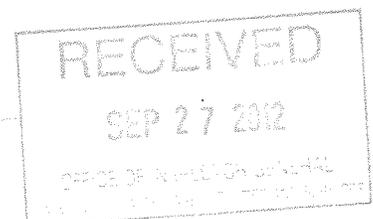
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F 441	<p>Continued From page 26</p> <p>chair. The staff member was observed to use alcohol sanitizer upon exiting Resident #4's room.</p> <p>Observation, on 08/14/12 at 5:12 PM, revealed staff entering Resident #4's room without putting on gloves. The staff member then sat up the tray for Resident #4 and placed a cloth protector around the neck of Resident #4. The staff member then left the room without disinfecting their hands.</p> <p>Observation, on 08/15/12 at 9:30 AM, revealed Licensed Practical Nurse (LPN) #1 and Certified Nursing Assistant (CNA) #2 were observed with no PPE. CNA #2 assisted LPN #1 with wrapping Resident #4's shins and placing socks on the patient's feet. LPN #1 and CNA #2 then washed their hands.</p> <p>Interview with CNA #2, on 08/15/12 at 9:30 AM, revealed CNA #2 was not aware of the contact isolation signage on Resident #4's door. The CNA also stated she did not see any gowns in the room to use. CNA #2 further stated the nurse did not inform her that Resident #4 was on isolation precautions, nor what the organism was.</p> <p>Interview with LPN #1, on 08/15/12 at 10:54 AM, revealed though Resident #4 completed her antibiotics; he/she continued to have loose stools which meant Resident #4 would have to continue on her contact precautions. LPN #1 stated if staff were going to provide care, they would still need to utilize gowns.</p> <p>Interview with Registered Nurse (RN) #2, on 08/16/12 at 4:05 PM, revealed when it came to hand washing, staff were to wash their hands</p>	F 441	<p>implemented to contain the infection and prevent transmission of the organism. Isolation Cards will be posted at the door to the room of residents for whom isolation precautions are in place to notify all staff members as well as visitors of the necessary precautions. The Infection Control Nurse will have in-service training for all nurses on 9-24-2012, 9-25-2012 and 9-28-2012 to educate them on the purpose and utilization of the care plan. The MDS nurse will review all new physician orders and notify the Infection Control Nurse of all new infections requiring isolation. The Infection Control Nurse will maintain a list of residents with infections and verify that all new infections requiring isolation precautions have an Infection Control Care Plan in place. The Infection Control Nurse shall monitor the infection control care plans on a weekly basis to ensure that they are being completed and followed appropriately and that other departments have been notified appropriately and shall document her weekly monitoring by initialing and dating the infection control care plan. The Infection Control Nurse shall also be responsible for ensuring that all nursing staff members are aware of the appropriate interventions to use. The Housekeeping Supervisor is responsible for ensuring that all housekeeping staff members are aware of the appropriate cleaning procedures and that they are abiding by</p>	



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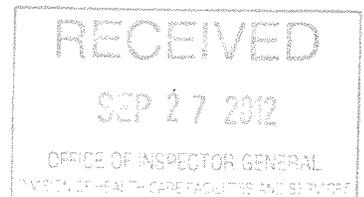
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F 441	<p>Continued From page 27</p> <p>after they provided care. RN #2 stated she thought it was ok to use sanitizer upon entering Resident #4's room. RN #2 stated staff was to wash their hands when leaving the room, because using hand sanitizer did not kill C-Diff and they would not want to spread the organism from patient to patient.</p> <p>Interview with the Director of Nursing (DON), on 08/16/12 at 4:20 PM, revealed there was always a potential for the transmission of germs to a resident if the aid was not aware of the care to give. The DON stated when it came to C-Diff precautions she expected staff to wash their hands. The DON stated she would find it disheartening if staff were not washing their hands or just using alcohol after providing care to a resident on C-Diff precautions.</p> <p>2. Record review revealed no policy could be provided on how to clean an isolation room.</p> <p>Observation of Housekeeping cleaning Resident #4's commode, on 08/16/12 at 11:13 AM, revealed Housekeeping cleaned the toilet, sink and bedside commode with gloves on and no gown. The commode was noted to have a brown substance on the rim of the commode.</p> <p>Interview with the Housekeeper, on 08/16/12 at 11:35 AM, revealed when she noticed a contact sign on the door, she always asked the nurse what type of PPE was needed. The Housekeeper stated she was told to use gloves, be cautious and not come in contact with stool. The Housekeeper stated she had not been trained, in the six years she has worked for the facility, on how to clean a C-Diff precaution room. The</p>	F 441	<p>these cleaning procedures. A weekly and quarterly report shall be made to the Q.A. committee regarding the infections in the facility and the completion of the Infection Control Care Plan by the nursing staff.</p>	



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

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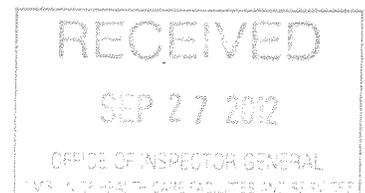
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F 441	<p>Continued From page 28</p> <p>Housekeeper stated she believed C-Diff to be an infection of the bowel in which she should try not to come in contact with.</p> <p>Interview with the Housekeeping Manager, on 08/16/12 at 2:17 PM, revealed housekeeping staff were educated on cleaning rooms with residents on C-Diff precautions last. The Housekeeping Manager stated we clean those rooms last, to wash our mops and rags last. The Housekeeping Manager stated they had an in-service on Infection control within the year. When it comes to the C-Diff Contact Isolation, staff was to wear gowns and gloves. The Housekeeping Manager stated he was aware that C-Diff was a spore and could stay on surfaces a long time. The Housekeeper stated he followed his staff and completed check offs. No check off information could be provided. He further stated he had no policy on cleaning isolation rooms with residents on C-Diff and could not provide any formal training to the Housekeepers.</p> <p>Interview with the Infection Control Nurse, on 08/16/12 at 3:04 PM, revealed she expects Housekeeping to wear gown and gloves when cleaning a commode with feces on it, in a room with contact isolation for C-Diff. Staff was to follow contact precaution signs. The Infection Control Nurse stated she did not monitor the housekeeping staff. She stated she did educate the housekeeping on infection control, but did not educate on the dynamics of how to clean a room on C-Diff precautions.</p> <p>Interview with the Director of Nursing (DON), on 08/16/12 4:20 PM, revealed she was aware the Infection Control Nurse provided education to the</p>	F 441			



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

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F 441	<p>Continued From page 29</p> <p>house keeping staff. The DON stated it was the Housekeeping Managers responsibility to make sure rooms were cleaned accordingly.</p> <p>3. Record review of the Personal Protective Equipment Policy, revised 08/09, revealed a supply of protective clothing and equipment was maintained at each nurses' station.</p> <p>Observation of five nurse's stations, B, CD, E, F and G, on 08/15/12 at 10:44 AM, revealed no PPE was available at nurse's stations B, E, F and G.</p> <p>Observation's made during tour, on 08/14/12 at 8:30 AM, revealed no PPE was noted in Res #4's room.</p> <p>Interview with LPN #1, on 08/15/12 at 10:44 AM, revealed the nurses would need to go to the infection control nurse to get the PPE supply or the supply of PPE would be provided in the contact rooms.</p> <p>Interview with RN #2, Charge Nurse on the G Unit, on 08/16/12 at 4:05 PM, revealed she was not aware there was no PPE at the nurses' station available for staff use. RN #2 also stated she was not aware there were no gowns in rooms and nurses station.</p> <p>Interview with the Infection Control Nurse, on 08/16/12 at 3:04 PM, revealed she was aware of the policy which stated there would be PPE at each nurse's station. When asked how she expected staff to provide care with no PPE available, the Infection Control Nurse stated staff knew there was PPE in the Central Supply Room.</p>	F 441			



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

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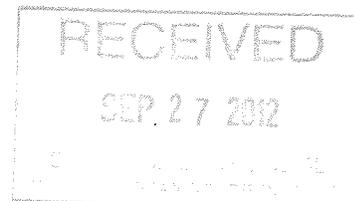
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F 441	Continued From page 30 The Infection Control Nurse stated when a resident was placed on isolation precautions; the housekeeper would stock the room and then the nurses' station. She further stated only two nurses had access to the Supply Room in the evening. Interview with the DON, on 08/16/12 at 4:20 PM, revealed gowns were available in the central supply. The DON further stated she was aware of the policy stating there would be PPE provided in the nursing stations.	F 441		
F 514 SS=D	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, record review and policy review, it was determined the facility failed to maintain an accurate medical record, related to the Do Not Resuscitate (DNR) status of one (1) of twenty-one (21) residents, Resident #4.	F 514		9/30/12



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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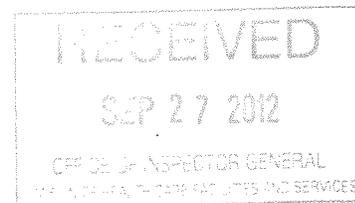
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F 514	<p>Continued From page 31</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Advanced Directives, No Code Orders and Life Sustaining Measures, revised 01/07/03, revealed the facility would abide by the directives of living wills, health care surrogates and other legitimate forms of advanced directives as required by law. The resident and/or responsible party will understand that the terms of any Advanced Directive they have executed will be followed by the health care facility and their caregivers to the extent permitted by law.</p> <p>Record review of Resident #4's orders, dated 08/08/12, revealed his/her code status was a Full Code.</p> <p>Record review of Resident #4's Do Not Resuscitate (DNR) Order, revealed the legal Surrogate signed the DNR status on 08/09/12, witnessed by two employees.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 08/15/12 at 10:54 AM, revealed on the front of charts the red stickers were DNR statuses and the White stickers were full codes.</p> <p>Review of the clinical for Resident #4 revealed Res #4 had a white sticker on the front of his/her chart identifying the resident as a full code.</p> <p>Interview with LPN #1, on 08/16/12 at 11:49 AM, revealed she would say Resident #4 was a full code status. LPN #1 stated she was not aware that Res #4 was a DNR. She stated she would error on the side of safety and would perform CPR on Res #4 in a code situation.</p>	F 514	<p>F514</p> <p>Resident #4's M.D. was contacted and the order for a DNR was received and the correct code status sticker was placed on the chart and a copy of the Advance Directive.</p> <p>Any residents who have a change of code status have the potential to be affected by this deficient practice. A chart audit of all residents in the facility was performed and no other incorrect code statuses were found.</p> <p>The Social Worker is responsible for completing full code and DNR forms upon admission and is also responsible for getting forms signed for any changes in code status made at a later date. The Social Worker notifies the nurse of a change in code status and places the updated form on the chart. The nurse is then responsible for contacting the doctor and notifying him/her of the change in code status and obtaining an order from the M.D. or N.P. A Code Status Form (copy attached) has been developed which will be maintained by the Social Worker and will list each resident's admitting code status with verification columns for the Social Worker to verify that the M.D. order was received and that the proper sticker is on the chart. Changes in code status will also be recorded and verified on this same form by the Social Worker.</p>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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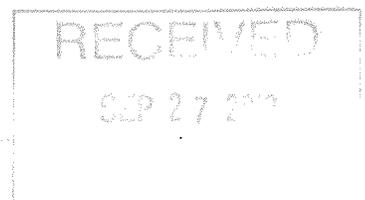
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F 514	Continued From page 32 Interview with the Registered Nurse (RN) #2, on 08/16/12 at 11:58 AM, revealed she was aware Resident #4 was a full code. RN #2 stated that looking in the record she could see Social Services made Resident #4 a DNR status and was not made aware of the change. RN #2 stated Social Services would contact nursing and inform them of the change from full code to DNR status. The Nursing staff would then call the Doctor and receive a verbal order for the DNR status. RN #2 stated she could see there was no order completed for the DNR status. Interview with Social Services, on 08/16/12 at 3:40 PM, revealed she was responsible to complete the Advanced Directive. Social Services stated she informed the nurses when a change in directives occurred. She stated she was aware the nurses needed an order to change the directives and she did not check to see if the nurse received the order. If an advance directive was not on the chart then the resident was assumed to be a full code. Social Services further stated the possible outcome would be to code someone who did not want to be coded or not code someone who was a full code, which would result ultimately in death. Interview with the Director of Nursing (DON), on 08/16/12 at 4:20 PM, revealed Social Services was responsible to make sure a DNR status was completed. If the family or the resident cannot make the decision, then the resident would be a full code status. The DON stated the process was for Social Services to complete documentation, add to the resident chart and let the desk nurse know the resident's code status had changed.	F 514	To ensure that solutions are sustained, the Social Worker will make a weekly report to the Q.A. Committee verifying that she has recorded the code status of all new admissions and has verified that any changes in code status for existing residents have an M.D. order on the chart and that the appropriate sticker is on the chart indicating the correct code status. The Social Worker shall also make a report at the quarterly Quality Assurance meeting stating any changes in code status which occurred during the past quarter. The Administrator shall attend the weekly and quarterly Quality Assurance Committee meetings to ensure that he is aware of the code status monitoring and will sign the weekly and quarterly Quality Assurance committee meetings attendance roll to verify his attendance as will the other members of the Quality Assurance Committee.	



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F 514	Continued From page 33 The nurse would then notify the doctor and obtain a phone order to change the code status. The DON further stated she was not aware of any concerns with residents and their code status.	F 514			



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

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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: 1960, 1962, 1970, 1991, 1998</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story, Type III Unprotected</p> <p>SMOKE COMPARTMENTS: Twelve (12) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors, upgraded in 1998.</p> <p>SPRINKLER SYSTEM: Complete automatic, dry sprinkler system, upgraded in 1998.</p> <p>GENERATOR: Type II, 125 KW rating, fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 08/14/12. Twinbrook Nursing Home was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The facility has one-hundred and seven (107) certified beds and the census was one-hundred and one (101) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000		

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

Madford A. McLaughlin, Admin

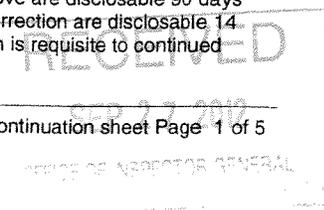
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Admin

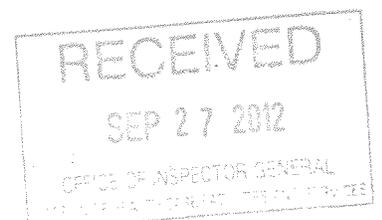
(X6) DATE

9/26/12

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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K 000	Continued From page 1 Fire)	K 000	K144 No residents were affected by this deficient practice.	9-30-12 per Brookm... by B 9-27-12
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the emergency generator in accordance with NFPA standards. The deficiency had the potential to affect each of the twelve (12) smoke compartments, all residents, staff and visitors. The facility has one-hundred and seven (107) certified beds and the census was one-hundred and one (101) on the day of the survey. The findings include: Observation, on 08/14/12 at 10:45 AM, with the Maintenance Director revealed the facility did not have any battery-powered emergency lighting installed in the room where the transfer switch for the emergency generator was located. The transfer switch room for the emergency generator	K 144	All residents have the potential to be affected. A battery powered emergency light was been installed by Long Electric Company on 8/23/2012 in the room where the main electrical panels and the transfer switch for the emergency generator are located. The Maintenance Technician will check the status of the battery monthly to ensure that it is functional and will record his inspection on his monthly inspection log and shall replace the battery immediately when necessary. The Maintenance Technician shall show the log to the Administrator on a monthly basis and the Administrator shall initial the log. The Housekeeping/Maintenance Supervisor shall make a report to the Quality Assurance Committee on a monthly and quarterly basis about the operation of the light and any repairs which were required.	



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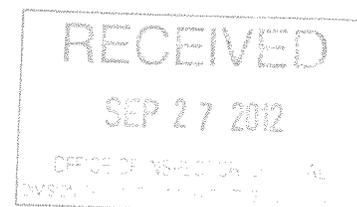
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K 144	Continued From page 2 must have battery-powered emergency lighting in case there was a failure of the emergency generator and staff must operate the transfer switch manually. Interview, on 08/14/12 at 10:45 AM, with the Maintenance Director revealed he was not aware of the requirement for the battery backup emergency lighting. Observations were confirmed with the Director of Nursing during the exit conference. Reference: NFPA 110 (1999 Edition). 5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.	K 144			
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to	K 147			



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K 147	Continued From page 3 affect one (1) of twelve (12) smoke compartments, sixteen (16) residents, staff, and visitors. The facility has one-hundred and seven (107) certified beds and the census was one-hundred and one (101) on the day of the survey. The findings include: Observation, on 08/14/12 at 10:30 AM, with the Maintenance Director revealed a power strip was being used to power medical equipment in resident room B3. Interview, on 08/14/12 at 10:30 AM, with the Maintenance Director revealed he was not aware of the misuse of a power strip in resident room B3. Further interview, on 08/14/12 at 10:35 AM, with the Nurse in charge of the B Wing revealed she was unaware of medical equipment being plugged into a power strip and acknowledged the requirement for medical equipment to be plugged directly into a wall mounted electrical outlet. Observation, on 08/14/12 at 2:00 PM, with the Maintenance Director revealed the hydrocollator (containing hot water) was located in the Physical Therapy Manager's office, and not plugged into a ground fault circuit interrupter (GFCI) outlet as required in wet areas. Interview, on 08/14/12 at 2:00 PM, with the Maintenance Director revealed he was not aware of the hydrocollator being relocated to the Physical Therapy's Manager's office and plugged into a standard electrical outlet. The hydrocollator was located within the Physical Therapy Room and plugged into a GFCI outlet before being	K 147	The medical equipment in room B3 was unplugged from the power strip and plugged directly into the wall outlet. A GFCI has been installed in the Therapy Manager's Office for the hydrocollator. All resident rooms have been inspected for medical equipment which may be plugged into power strips inappropriately. All outlets serviced by the emergency generator will be designated with red outlet covers and all nursing, housekeeping and maintenance staff received in-service training from the Housekeeping & Maintenance Supervisor on 9-14-2012 and 9-17-2012 instructing them that all medical equipment must be plugged directly into a red wall outlet powered by the emergency generator rather than into a power strip. The Housekeeping Supervisor's in-service training on 9-14-2012 and 9-17-2012 for all Housekeeping staff members also instructed them to look for medical equipment which may be plugged incorrectly into a power strip while they are cleaning the rooms and either correct the issue immediately or bring the matter to the attention of a supervisor to do so. They were instructed to complete the Housekeeper Q.A. form indicating that they had inspected the rooms for incorrectly plugged medical equipment. It shall be the responsibility of the Housekeeping Supervisor to review these logs and ensure that his staff members remedy any incorrectly plugged medical equipment when they observe it and to bring any recurrent issues to the attention of the administrator so they can be resolved.	



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - TWINBROOK NURSING H B. WING _____	(X3) DATE SURVEY COMPLETED 08/14/2012
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NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205
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K 147	<p>Continued From page 4 relocated to the Manager's office.</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147	<p>The outlet in the Therapy Manager's office into which the hydroculator is plugged was replaced with a GFCI outlet by Long Electric Company on 8-17-2012. Long Electric also installed additional electrical outlets in Room B3 on 9-18-2012 due to the large number of personal electrical devices utilized by this resident.</p> <p>The Staff Development Coordinator conducted in-service training for all nursing, therapy and Administrative personnel on 9-10-2012 and 9-17-2012 instructing them to ensure that all medical equipment is plugged into a wall outlet powered by the emergency generator, not a power strip. The Dietary Consultant will provide training on 9-25-2012 and 9-26-2012, for all dietary employees regarding power strips, as well. The Housekeeping Supervisor shall make a weekly report to the Quality Assurance Committee on compliance as well as a report at the quarterly Quality Assurance meeting.</p>	<p>9.30.12 per Bud Meloy by PBA 9.27.12</p>
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