

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

PRINTED: 11/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185259	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/01/2012
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059
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F 000	INITIAL COMMENTS A standard health survey was conducted 10/30/12 through 11/1/12. A Life Safety Code survey was conducted on 10/30/12 through 10/31/12. Deficiencies were cited with the highest scope and severity of a "F" with the facility having the opportunity to correct before remedies would be recommended for imposition.	F 000	<p>Plan of Correction Disclaimer for Rivers Edge Nursing and Rehabilitation Center Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) ten days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed of considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	
F 279 SS=E	<p>This was a Nursing Home Initiative survey with entrance on 10/30/12 at 7:00 AM.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 279		

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

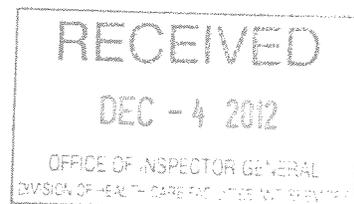
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Gettie M. Parker-Sumner* TITLE: *Administrator* (X6) DATE: *12/3/12*

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

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F 279	<p>Continued From page 1</p> <p>Based on observation, interview, record review and review of the facility's policy Resident Care Plan, it was determined the facility failed to develop, review or revise the care plan for five (5) of eighteen (18) sampled residents and nine (9) unsampled residents (#1, #2, #4, #7 and #12). The facility failed to develop a plan of care to include the infection control/isolation precautions for Residents #4 and #12. The facility failed to develop a plan of care for behaviors for Resident #4. The facility failed to update/revise care plans for Residents #1 and #7. The facility failed to incorporate music into the care plan for Resident #2.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Resident Care Plan from the Social Services Manual, dated 10/2005, revealed the development and implementation of the care plan would occur by participating disciplines available in the facility at a team conference under the direction of the Registered Nurse Coordinator. The policy revealed the development of the care plan came from identified problems and needs of the residents and each problem or need had specific goals that were measurable and had a timetable. The policy also revealed the care plan should be a working tool for the facility to use in providing care to the resident and a review would determine whether the goals had been reached or met.</p> <p>1. Record review for Resident #12 revealed the care plan did not identify the resident as requiring isolation with contact precautions for which the resident was placed under or listed any</p>	F 279	<p><i>Start F 279</i></p> <p>F279 483.20(d), 483.20(k) (1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>1. During the annual survey conducted on 10/30/12 it was determined by the surveyor that the facility failed to develop, review, or revise care plans for five (5) of eighteen (18) sampled residents and nine (9) unsampled residents (#1, #2, #4, #7, and #12). The facility failed to develop a Plan Of Care to include infection control//isolation precautions for residents #4 and #12. The facility failed to develop a Plan Of Care for behaviors for resident #4. The facility failed to update/revise care plans for resident #1 and #7</p> <p>2. Resident #1 care plan was reviewed/revise/resolved on 11/21/12 to reflect current Plan Of Care, resident #2 care plan was reviewed and revised on 11/21/12 to reflect current Plan Of Care, resident #4 care plan reviewed and revised on 11/6/12 to reflect current Plan Of Care, resident #7 care plan was reviewed/revise/resolved on 11/2/12 to reflect current PLAN OF CARE, resident #12 care plan was reviewed and revised on 11/2/12 to reflect current PLAN OF CARE. 100% of all sampled and unsampled residents care plan audit implemented on 11/21/12. Education/in-service completed with the Interdisciplinary Care Plan Team regarding facility policy for care plan review/revisions and resident invitation</p>		



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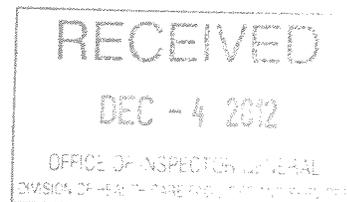
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F 279	<p>Continued From page 2 interventions related to the contact precautions.</p> <p>Observation, on 10/30/12 at 7:40 AM, during the tour of the facility revealed no isolation precaution sign on the door to the room of Resident #12. Personal protective equipment (PPE) was noted outside the door to the room of Resident #12.</p> <p>2. Record review of the care plan for Resident #1 revealed an intervention under Focus (problem or concern) of Potential for or Actual fluid volume deficit due to taking a daily diuretic to monitor the intravenous site for signs and symptoms of infection and physician notification as indicated.</p> <p>Observation, on 10/30/12 at 10:00 AM, of Resident #1 while in Physical Therapy revealed the resident had no intravenous site on his/her person. Interview with Resident #1 following the observation revealed the Resident #1 stating he/she had no intravenous site.</p> <p>3. Record review of the care plan for Resident #7 revealed a Focus (problem or concern) of Actual Skin Integrity Impairment related to a skin tear between the third and fourth digits of the left hand. The care plan included goals and interventions for this focused area. The focus was noted as created on 02/10/12 and revised on 09/14/12.</p> <p>Observation, on 10/30/12 at 10:15 AM, with Resident #7 revealed no open area to the left hand of the resident. Interview with Resident #7 that followed revealed he/she had not had an open area to his/her left hand for months.</p> <p>Interview, on 10/30/12 at 7:40 AM, with Licensed</p>	F 279	<p><i>F-279 Continued</i></p> <p>to participate in individual PLAN OF CARE. Care plan meeting structure changed to ensure MDS Coordinator is reviewing care plans weekly during this meeting.</p> <p>3. DON completed retraining of all members of the interdisciplinary care plan team on 11/21/12 regarding developing, reviewing and revising care plans. Education/in-service completed with the Interdisciplinary Care Plan Team regarding facility policy for care plan review/revisions and resident invitation to participate in individual PLAN OF CARE. Care plan meeting structure changed to ensure MDS Coordinator is reviewing care plans weekly during this meeting to ensure timely review and revision on all resident care plans</p> <p>4. MDS Coordinator will complete weekly care plan audits beginning 12/1/12 to consist of 10% of resident population to ensure Plan Of Care is current. MDS Coordinator will also audit an additional 10% of resident population monthly beginning 12/1/12 x 12months to ensure care plans are reviewed and revised timely. All finding will be forwarded to the DON/NHA for review and follow up if indicated per</p>	
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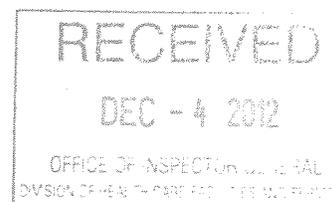
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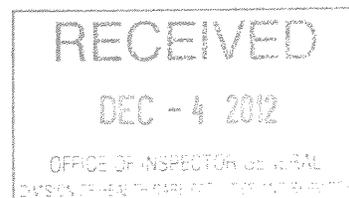
F 279	<p>Continued From page 3</p> <p>Practical Nurse (LPN) #7 revealed Resident #12 was on contact isolation precautions. She noted the sign was missing from the door to alert staff and those who may enter the room that Resident #12 was on contact isolation.</p> <p>Interview, on 11/01/12 at 6:00 PM, with the MDS Coordinator revealed she was the person that wrote the care plans. Reviews were done by each department except Physical Therapy and Occupational Therapy. She revealed the care plans were updated quarterly and/or when there was a change with the resident. She stated for the updates she uses the Physicians Order, nurses' notes and reports. She stated she was responsible to update the care plans. She revealed information was shared about the care of the residents by her talking to the nurses. She revealed she did not know when the intravenous site for Resident #1 was discontinued; however, stated she reviewed the orders for the residents each morning. She further revealed that in her review of the care plan for Resident #7 she referenced the Treatment Administration Record (TAR) and the skin assessments, but did not do that weekly. She had missed the contact precautions for Resident #12 as being the reason it was not care planned. She stated the facility did have a system in place, morning meetings, orders, communication with nurses. However, she stated there were significant things she had missed.</p> <p>Interview, on 11/01/12 at 8:15 PM, with the Director of Nursing (DON) revealed the MDS Coordinator was responsible for the content of the care plans. The Interdisciplinary Team (IDT) was to ensure each department completed their</p>	F 279	<p><i>F-279 Continued</i></p> <p>weekly audit beginning 12/1/12. The results of these rounds will be forwarded to the Quality Assurance Committee at least quarterly for review and recommendations. If concerns are identified during QA process, the committee will reconvene for additional recommendations until sustained compliance.</p> <p>5. Completion Date 12/2/12</p>	12/2/12
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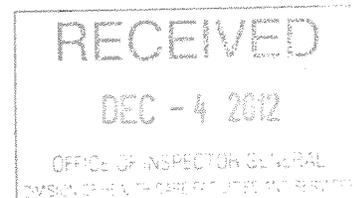
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F 279	Continued From page 4 own part of the care plan as it related to their area. She revealed the care plans were to be updated as things change with the resident. She stated the MDS Coordinator was responsible for updating the care plans. She revealed the Focus for skin integrity should have been removed from the care plan of Resident #7. 4. Review of the Activity Assessment, dated 09/27/12, for Resident #2 revealed the resident enjoyed listening to music and watching movies in room. Review of the resident's care plan addressed at risk for alteration in recreation characterized by little or no involvement related to cognitive impairment; did not capture the resident's interest in listening to music or watching movies in the resident's room. Observations of Resident #2, on 10/30/12 at 10:45 AM, 12:00 Noon, 2:30 PM and on 10/31/12 at 9:30 AM and 10:30 AM, revealed no staff were interacting with the resident. There was no television or radio observed in the resident's room. Interview with Resident #2, on 11/01/12 at 8:30 AM, revealed the resident did not feel good enough to attend activities outside of the room, but would like to listen to music. Resident commented that there used to be a TV in the room. 5. Observation of Resident #4 during initial tour, on 10/30/12 at 7:45 AM, revealed an isolation cart parked next to the resident's bed and a contact isolation sign on the resident's door. Interview with Licensed Practical Nurse (LPN) #9 during tour, on 10/30/12 at 7:45 AM, revealed the	F 279			



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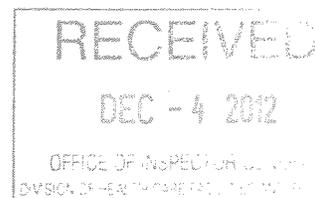
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F 279	<p>Continued From page 5</p> <p>resident was in isolation for Clostridium Difficile (an infection of the bowel).</p> <p>Review of the resident's clinical record revealed a final positive stool sample for clostridium difficile on 09/02/12. Further review of the clinical record revealed the Minimum Data Set (MDS) assessment, dated 10/19/12, revealed resident #4 triggered for behaviors based physical behavioral symptoms directed toward others.</p> <p>Interview with the MDS Coordinator, on 11/01/12 at 5:50 PM, revealed the resident was observed trying to kick at the nursing staff on one (1) occasion.</p> <p>Review of Resident #4 comprehensive plan of care revealed an infection control care plan including contact isolation precautions, and a comprehensive care plan to address behaviors was not developed.</p> <p>Interview with the Nurse Practitioner, on 10/31/12 at 10:00 AM, revealed she had a difficult time controlling the resident's loose stools associated with the Clostridium Difficile infection and the resident remained in contact isolation.</p> <p>Interview with the Director of Nursing (DON), on 10/31/12 at 10:30 AM, revealed the resident did have behaviors that required the use of Klonopin as needed.</p> <p>Continued Interview with the MDS Coordinator, 11/01/12 at 5:50 PM, revealed she did not care plan behaviors. The MDS Coordinator revealed the care plan should address interventions to control the resident's behavior and without a care</p>	F 279			



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F 279	Continued From page 6 plan the behaviors could escalate potentially resulting in someone getting hurt. The MDS Coordinator revealed she did not care plan the isolation precautions because she was told it was not necessary since the resident was incontinent and the stool was contained in a brief. Interview with the DON, on 11/01/12 at 8:07 PM, revealed the MDS Coordinator was responsible to develop the care plans and the interdisciplinary team ensured their area was completed. The DON revealed care plans were monitored every Friday with the team and the care plans were compared to the old care plan, the MDS, and anything that might have come up in between. The DON did not know how the development of a comprehensive plan of care including behaviors and isolation precautions were missed.	F 279			
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280	<i>Start F 280</i> F 280 483.20(d) (3), 483.10(k) (2) RIGHT TO PARTICIPATE PLANNING CARE-RERVISE CP 1. During the annual survey conducted on 10/30/12 it was determined by the surveyor that the facility failed to ensure resident opportunity to participate in the planning of their care by not inviting three (3) of eighteen (18) sampled residents (#1, #7 and #12) and nine (9) of the unsampled residents (A,B,C,D,E,F,G,H, and I) to the facilities care plan conference		



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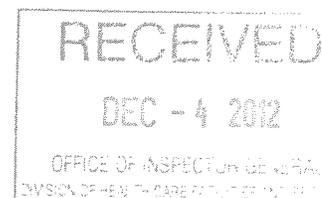
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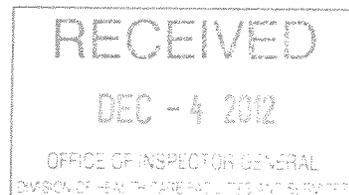
F 280	Continued From page 7 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's handout Residents' Rights for Residents in Kentucky Long-Term Care Facilities, it was determined the facility failed to ensure residents had the opportunity to participate in the planning of their care by not inviting three (3) of the eighteen (18) sampled residents (#1, 7 and 12) and nine (9) unsampled residents (A,B,C,D,E,F,G,H,and I) to the facility's care plan conferences. The findings include: Review of the facility's handout Residents' Rights for Residents in Kentucky Long-Term Care Facilities, not dated, revealed the resident has a right to participate in planning his or her care and treatment or changes in care and treatment unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State. During the Group interview, on 10/30/12 at 10:00 AM, nine (9) unsampled residents	F 280	<i>F 280 Continued</i> 2. Residents #1, #7, #12, A, B, C, D, E, F, G, H, and I care plans all reviewed 11/2/12-11/21/12, and SSD met with these residents/responsible parties from 11/2/12-11/21/12 to ensure they are aware of their rights and facility policy as it relates to care plan conferences. DON completed retraining with SSD and MDS Coordinator regarding invitation and documentation of invitation to resident care conferences 3. DON completed retraining of all members of the interdisciplinary care plan team on 11/21/12 regarding developing, reviewing and revising care plans. Education/in-service completed with the Interdisciplinary Care Plan Team regarding facility policy for care plan review/revisions and resident invitation to participate in individual PLAN OF CARE. Education also completed with SSD/MDS Coordinator regarding method of notification of resident invitations to care plan conference and documentation of resident refusals to attend resident care plan conference to ensure staff is following facility policy and resident right guidelines for involving residents in their Plan Of Care 4. SSD will utilize an audit tool to track resident notification of individual care plan conferences. MDS Coordinator will follow facility policy and document in the care plan progress note resident attendance and refusal s to	
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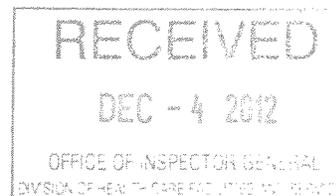
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F 280	<p>Continued From page 8</p> <p>(A,B,C,D,E,F,G,H and I) revealed they were not being invited to their care plan meetings and expressed an interest in attending. When asked if they had informed the facility, the group replied at one time, they had been invited, but recently they were not being informed of when the care plan conference was to be held.</p> <p>Interview, on 11/01/12 at 10:30 AM, with Resident #1, identified by the facility as interviewable with a Brief Interview of Mental Status (BIMS) of 15 signified cognitively intact, revealed he had not been invited to the care plan conference.</p> <p>Interview, on 10/31/12 at 10:15 AM, with Resident #7, identified by the facility as interviewable with a BIMS of 15 revealed he had not been invited to the care plan conference.</p> <p>Interview, on 11/01/12 at 12:25 PM, with Resident #12, identified by the facility as interviewable with a BIMS of 14 revealed he had not been invited to the care plan conference.</p> <p>Interview with the Social Service Director, on 11/01/12 at 10:30 AM, revealed she typically printed out a care plan report and sent an invitation to the family. The Social Service Director revealed residents were invited verbally and documented in the electronic medical record.</p> <p>Review of the medical record with the Social Service Director revealed the following:</p> <p>Resident #1 and Resident #7 had not been invited to the care plan conferences. Resident #12 had not been invited to a care plan conference since 09/2011. Unsampled Resident</p>	F 280	<p><i>F 280 continued</i></p> <p>participate in their care plan. MDS Coordinator will complete a weekly audit beginning 12/1/12 x12weeks then monthly x9months to consist of 10% of resident population to ensure residents are invited to participate in Plan Of Care. All finding will be forwarded to the DON/NHA for review and follow up if indicated per weekly/monthly audit beginning 12/1/12. The results of these rounds will be forwarded to the Quality Assurance Committee at least quarterly for review and recommendations. If concerns are identified during QA process, the committee will reconvene for additional recommendations until sustained compliance.</p> <p>5. Completion Date 12/2/12</p>	12/2/12



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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185259	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/01/2012
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F 280	<p>Continued From page 9</p> <p>A, identified by the facility as interviewable with a BIMS of 14, had not been invited to a care plan conference since 07/2012. Unsampied Resident B, C, and D identified by the facility as interviewable had not been invited to a care plan conference. Unsampied Resident E, identified by the facility as interviewable with a BIMS of 15, had not been invited to a care plan conference since 06/2012. Unsampied Resident F, identified by the facility as interviewable with a BIMS of 15, had not been invited to a care plan conference since 07/2012. Unsampied Resident G, identified by the facility as interviewable with a BIMS of 13, had not been invited to a care plan conference since 04/2012. Unsampied Resident H, identified by the facility as interviewable with a BIMS of 15, had not been invited to a care plan conference since 07/2012. Unsampied Resident I, identified by the facility as interviewable with a BIMS of 15, had not been invited to a care plan conference since 01/2012.</p> <p>Continued interview with the Social Service Director (SSD), 11/01/12 at 10:30 AM, revealed she either would not or could not definitively answer whether residents were invited to care plan conferences or explain why this process was stopped. She did state residents were encouraged to ask for a care plan meeting because this was the easiest way for a resident to know about the medical record. Review of the care conference logs with the SSD revealed residents were invited at one time, and had stopped as far back as September 2011.</p> <p>On 11/01/12 at 2:50 PM, the Social Service Director provided Resident Satisfaction Survey results completed by Resident #1. Unsampied</p>	F 280		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

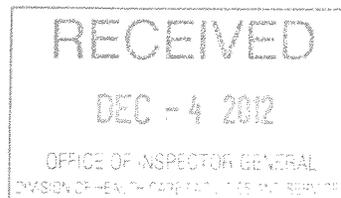
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F 280	<p>Continued From page 10</p> <p>Residents D, H and A that revealed care plan meetings were addressed and there had not been any concerns reported.</p> <p>Interview with unsampled Resident D, on 11/01/12 at 3:03 PM, revealed the resident had never seen the satisfaction survey before and stated they were unable to write so they knew they were not the one who filled out the form.</p> <p>Interview with Resident #1, on 11/01/12 at 3:10 PM, revealed the resident had never seen the satisfaction survey before. The resident revealed their spouse may have filled out a survey, but no one from the facility had ever asked him/her to fill out a survey.</p> <p>Interview with unsampled Resident H, on 11/01/12 at 3:12 PM, revealed the resident had never seen the satisfaction survey before and did not fill out the form.</p> <p>Interview with unsampled Resident A, on 11/01/12 at 4:05 PM, revealed they remembered receiving the form, but felt it was too much to read so they just signed it and did not know what was on the form.</p> <p>Interview with the Administrator, on 11/01/12 at 3:22 PM, revealed the satisfaction sheet were given out in house and filled out. The Administrator revealed the resident could fill it out themselves or the staff may have assisted them, or a family member may fill out the form.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility</p>	F 280	<p>F 282 <i>Start</i></p> <p>F 282 483.20(k) (3) (ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>1. During the annual survey conducted on 10/30/12 it was determined by the surveyor that the facility failed to follow the nursing care plans for six (6) of eighteen (18) sampled residents and nine (9) unsampled resident. The facility failed to ensure care plans related to activities for resident #1, #2, #7, #11, #12, and #14 were implemented. Corrective actions were made for effected residents.</p> <ul style="list-style-type: none"> Resident #1 was provided a radio with CD player and informed that a TV with DVD's was available for in room viewing per his request on 11/19/12. Resident #1 activity care plan was 	
F 282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p>	F 282		



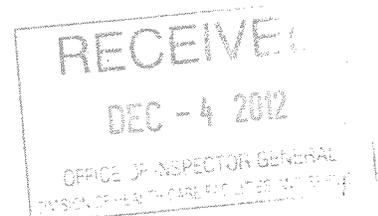
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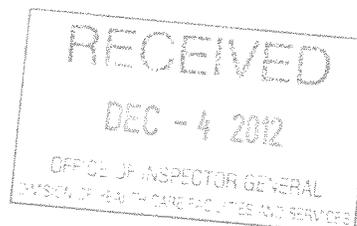
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F 282	<p>Continued From page 11</p> <p>must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review and review of the facility's policy and procedure, it was determined the facility failed to follow the nursing care plans for six (6) of eighteen (18) sampled residents and nine (9) unsampled residents. The facility failed to ensure care plans related to activities for Resident #1, 2, 7, 11, 12 and 14 were implemented.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Resident Care Plans, dated 10/2005, revealed interventions are to be provided by social services as well as other disciplines. The care plan should be individualized to the resident's unique needs, strengths, and characteristics. It should be a working tool for the facility to use in providing care to the resident.</p> <p>Review of the facility's policy regarding Activity Program, dated February 2006, revealed the objective of the Activity Program is to provide programming for residents to include group, individual, and 1:1 activities.</p> <p>1. Review of the clinical record for Resident #2 revealed the facility readmitted the resident to the facility on 10/12/12 with diagnoses of Dementia</p>	F 282	<p><i>F 282 continued</i></p> <p>reviewed and interview completed with resident regarding activities of interest on 11/21/12. Resident #1 care plan revised on 11/21/12 to reflect current activities of interest.</p> <ul style="list-style-type: none"> Resident #2 was provided a radio on 10/31/12 with noted documentation of listening to music @ 2:04 pm. Resident #2 also has noted documentation of 1:1 socialization activity on 11/1/12 at 12.52 pm and attending women group at 1pm. Her activity care plan was reviewed and interview completed with resident on 11/21/12 regarding activities of interest. Care plan revised on 11/21/12 to reflect current PLAN OF CARE. Documentation of activities noted for 1:1 activities and group activities beginning 11/1/12. Resident #7 with noted documentation of playing board game @ 7 pm on 10/30/12 and 5:08 pm on 11/1/12. Also with noted documentation of participating in holiday specific event on 11/1/12. Resident care plan was reviewed and interview completed with resident regarding activities of interest on 11/2/12 and 11/7/12. Resident #7 care plans was revised on 11/7/12 to reflect noted age appropriate activities of interest identified by the resident. Resident #11 had documented daily staff interaction for Individual independent activity and a documented group activity beginning 11/1/12. Her care plan was reviewed on 11/21/12 with 	



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F 282	<p>Continued From page 12 and Paraplegia related to a history of Poliomyelitis. The facility completed a quarterly Minimum Data Set (MDS) assessment on 09/29/12 that revealed the resident was moderately impaired for decision making and scored a 99 (unable to complete the questions on the interview) on the Brief Interview for Mental Status (BIMS) assessment.</p> <p>Review of a Progress Note, dated 09/25/12, from the clinical record of Resident #2 revealed the resident enjoyed listening to music, watching movies in the resident's room, and talking with staff and other residents.</p> <p>Review of Resident #2's care plan initiated on 05/13/12 revealed, Resident #2 was at risk for lack of involvement in activities related to cognitive impairment. Interventions were in place on the care plan to arrange 1:1 contacts with resident and to establish a daily routine with activity personnel and volunteers.</p> <p>Observations of Resident #2, on 10/30/12 at 10:45 AM, 12:00 Noon, 2:30 PM and on 10/31/12 at 9:30 AM and 10:30 AM, revealed no staff were interacting with the resident. There was no television or radio observed in the resident's room during these observations.</p> <p>Interview with Resident #2, on 11/01/12 at 8:30 AM, revealed the resident did not feel good enough to attend activities outside of the room, but would like to listen to music. Resident commented that there used to be a TV in the room.</p> <p>2. Review of the clinical record for Resident #14</p>	F 282	<p>F 282 Continued</p> <p>revisions made to reflect resident's current activity needs and likes.</p> <ul style="list-style-type: none"> Resident #12 care plan was reviewed and interview completed with resident to develop an activities plan of care specific to resident interest on 11/26/12. Resident #12 care plan revised on 11/26/12 to reflect current activity needs specified by resident. Resident out to hospital on 11/27/12. Care plans and documented activities will be reviewed upon readmission. Outlet in resident #14 room repaired and radio placed in resident room on 10/31/12. Resident #14 care plan and C.N.A care guides reviewed and revisions began on 11/2/12 and were completed 11/21/12. Documentation of activities noted for 1:1 activities and group activities beginning 11/21/12. <p>2. The facility recognizes that all residents have the potential to be effected by the alleged deficient practice. All residents with the potential to be affected to include those receiving 1:1 activities plan of care was reviewed and revised as indicated 11/2/12 and completed on 11/21/12. All residents under the age of 60 years old currently in the facility activity care plan reviewed and revised as indicated for age appropriate activities.</p>		



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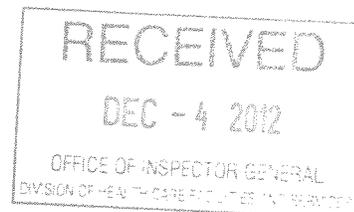
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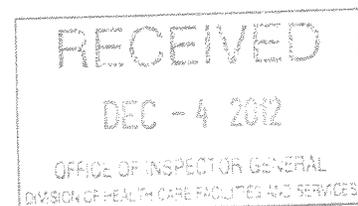
F 282	<p>Continued From page 13</p> <p>revealed the facility admitted the resident on 02/15/12 with diagnoses of Alzheimer's Dementia and Toxic Encephalopathy, (brain poisoning). The facility completed a quarterly Minimum Data Set (MDS) assessment on 08/04/12 that revealed the resident was severely impaired for decision making and scored a 99 (unable to complete the questions on the interview) on the Brief Interview for Mental Status (BIMS) assessment.</p> <p>Review of Resident #14's care plan initiated on 04/12/12 revealed Resident #14 was at risk for lack of involvement in activities related to anxiety and cognitive impairment. Interventions were in place on the care plan to arrange 1:1 contacts with resident and to arrange for the activity aide to visit and encourage resident to observe or designate activity.</p> <p>Observations of Resident #14, on 10/31/12 at 4:30 PM and on 11/01/12 at 8:30 AM and 09:30 AM, revealed no staff were interacting with the resident. There was no television or radio observed in the resident's room during these observations.</p> <p>Interview with the Interim Activity Director (IAD), on 11/01/12 at 6:55 PM, revealed the facility had no documentation that 1:1 activity services were being provided for Resident # 2 and #14. The IAD confirmed that 1:1 was doing an activity in the resident's room. The IAD commented the facility was not following the residents' individual care plans as specified.</p> <p>Interview with the Director of Nursing (DON), on 11/01/12 at 8:30 PM, revealed the facility cannot assume a resident received 1:1 activity services if</p>	F 282	<p><i>F 282 Continued</i></p> <p>3. The following measures were implemented to ensure that the alleged deficient practice does not recur. Education on following residents' care plans completed with Activities Director on 11/21/12 to ensure all residents are invited to daily activities, to ensure care plans are reviewed timely and give a current reflection of resident activity needs, and to ensure resident interviews are utilized to assist with activities plans of care. Activity Director also educated on implementation of tracking system for 1:1 activities and documentation. In-service education completed with clinical staff and activities assistant on 11/21/12 regarding activity calendars, documentation of activities and following resident plans of care related to activities. DON completed retraining of all members of the interdisciplinary care plan team on 11/21/12 regarding developing, reviewing, revising care plans, and following care plans for resident plans of care specific to activities. Education/in-service completed with the Interdisciplinary Care Plan Team regarding facility policy for care plan review/revisions and resident invitation to participate in individual PLAN OF CARE. Education completed with Activities Director on 11/21/12 to ensure all residents are invited to daily activities, to ensure care plans are reviewed timely and give a current reflection of resident activity needs, and to ensure resident interviews are utilized to assist with activities plan</p>	
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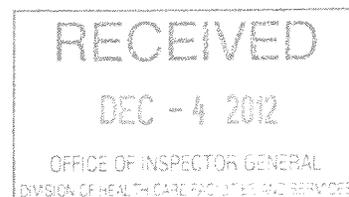
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F 282	Continued From page 14 there was no documentation of the service being provided. The DON confirmed the facility needed to implement a system to document the activity services the residents were receiving. 3. Review of the clinical record for Resident #1 revealed the facility admitted the resident on 09/07/12 with diagnoses of Frontal Lobe and Executive Function Deficit, Cerebral Artery Occlusion and Stroke. The facility completed an initial Minimum Data Set (MDS) on 09/13/12 and assessed Resident #1 as a fifteen (15) on the Brief Interview for Mental Status Assessment (BIM), indicating no cognitive impairment. Review of the care plan for Resident #1 initiated on 09/21/12 revealed the resident was at risk for alteration in organized recreation characterized by little or no involvement related to impaired mobility. The resident was dependent on the staff for his/her mobility via wheelchair or recliner. Interventions listed included transport resident to activities, attempt to engage resident in group activities, give verbal reminders of activity before the commencement of the activity and post personal activity schedule in the resident's room. Observation, on 10/30/12 at 10:00 AM, revealed Resident #1 in his/her room, in bed. There was no television in the room. There was no	F 282	<i>F 282 continued</i> of care, also implementation of tracking system for 1:1 activities. Care plan meeting structure changed to ensure MDS Coordinator/Activities Director is reviewing care plans weekly during this meeting to ensure timely review and revision on all resident care plans beginning 12/1/12. 4. The corrective measures will be monitored by audits. The MDS Coordinator /Activities Director will complete weekly care plan audits to include resident interviews as resident allows beginning 12/1/12 to consist of 10% or eight residents which ever is greater of resident population to ensure Plan of Care is current specific to resident activity needs and likes. MDS Coordinator/ Activities Director will also audit to include resident interviews as resident allows an additional 10% or eight residents which ever is greater of resident population monthly beginning 12/1/12 x12months to ensure care plans are specific to resident needs, reviewed and revised timely. All finding will be forwarded to the DON/NHA for review and follow up per the weekly audit. From the audited sample the DON/NHA will review with resident at random to ensure current care plans are initiated, followed, reviewed or revised weekly for a minimum of one quarter. In addition, NHA/DON will monitor at least one activity weekly for twelve weeks to ensure compliance. The results of these <i>Audits</i> will be forwarded to the Quality Assurance Committee monthly until sustained compliance then at at least		



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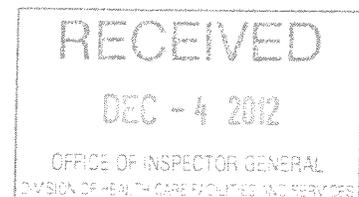
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F 282	Continued From page 15 personalized activity calendar in the room. Interview, on 11/01/12 at 10:30 AM, with Resident #1 revealed an activity person came to interview him/her and asked what his/her favorite television show was, but he/she had not been invited to go watch any shows. Resident #1 stated he/she had not been to activities and no one had stopped by his/her room to invite him/her to attend any activity. 4. Review of the clinical record for Resident #7 revealed the facility admitted the resident on 09/30/11 with diagnoses of Unspecified Hemiplegia affecting non-dominant side, Chronic Pain, Acute Kidney Failure and Chronic Airway Obstruction. The facility completed the Annual Minimum Data Set (MDS) on 09/01/12 and assessed Resident #7 as a fifteen (15) on the Brief Interview for Mental Status Assessment (BIM), indicating no cognitive impairment. Review of the care plan for Resident #7 initiated on 03/30/12 revealed the resident was at risk for alteration in supervised/organized recreation characterized by little or no involvement, lack of attendance related to not being interested in the activities offered and an unstable health condition. Interventions included arranging for the activity aide to visit and encourage resident to observe or designate activity and to visit the resident one (1) time a day to develop or sustain contact using conversation. Review of the care plan for Resident #7 initiated on 03/30/12 also revealed a goal of identifying at least two (2) activities that the resident would like to participate in. After six (6) months this has	F 282	<i>F 282 Continued</i> quarterly for review and recommendations. If concerns are identified during QA process, the committee will reconvene for additional recommendations until sustained compliance. 5. Completion Date 12/2/12	12/2/12



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F 282	<p>Continued From page 16</p> <p>remained a goal. The facility could not identify two (2) activities in six (6) months the resident had attended or note the goal as ever reached.</p> <p>Observation, on 10/30/12 at 10:15 AM, revealed Resident #7 in his/her bed. The room had a television. The resident was limited in movement in the bed due to paralysis on the left side of the body.</p> <p>Interview, on 10/30/12 at 10:15 AM, with Resident #7 revealed he/she enjoyed playing chess. He/she identified chess as the only activity the facility had provided of interest. Resident #7 was fifty-eight (58) years old. Resident #7 stated the other offered activities "bored" him/her. The facility had identified the resident as not being interested in the activities offered but did not offer age appropriate alternate activities.</p> <p>Interview, on 11/01/12 at 7:52 PM, with the Activities Director revealed the care plan for Resident #7 had not been updated. In addition, there was no one time a day visit with activities taking place with Resident #7. She revealed she was new in the role of Activities Director and was still learning the care plans.</p> <p>5. Review of the clinical record for Resident #12 revealed Resident #12 was admitted to the facility on 12/16/10 with diagnoses of Toxic encephalopathy, Osteomyelitis, Open wound knee/leg/ankle complicated, Open wound hip/thigh complicated, Sepsis and Need for isolation. The facility completed an annual Minimum Data Set (MDS) on 05/05/12 and assessed Resident #12 as a fifteen (15) on the Brief Interview for Mental Status Assessment</p>	F 282			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

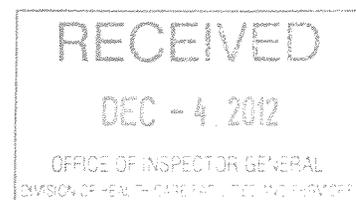
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185259	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/01/2012
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F 282	<p>Continued From page 17 (BIM), indicating no cognitive impairment.</p> <p>Review of the care plan for Resident #12 initiated on 01/04/11 revealed that Resident #12 was at risk for an alteration in supervised/organized recreation characterized by lack of attendance/little involvement/resident isolates himself/herself in room /refuses all attempts (have him/her attend) out of room activities. The goal for the resident was the resident would allow a brief daily visit until the next review. This goal was initiated on 01/04/11. There was no documentation to support a daily visit on the part of activities. This goal was over eighteen (18) months old. The care plan also stated a personal activity schedule would be posted in the resident's room.</p> <p>Interview, on 10/31/12 at 4:35 PM, with Resident #12 revealed he/she did not participate in the activities offered by the facility because no activities were offered that he/she would want to participate in. Resident #12 was forty-eight (48) years old.</p> <p>Interview, on 11/01/12 at 7:52 PM, with the Activities Director revealed the care plan for Resident #12 was not followed. An activities person did not visit with Resident #12 on a daily basis as was in the care plan. The Activities Director noted she was currently in training.</p> <p>6. Review of the clinical record for Resident #11 revealed Resident #11 was admitted to the facility on 03/06/07 with diagnoses of Chronic Kidney Disease, Dysphagia Oral Phase and Chronic Pain. The facility completed an Annual Minimum Data Set (MDS) on 01/19/12 and assessed</p>	F 282		
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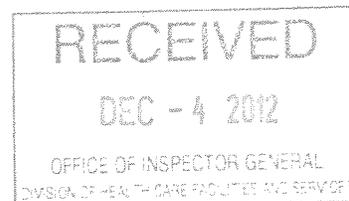
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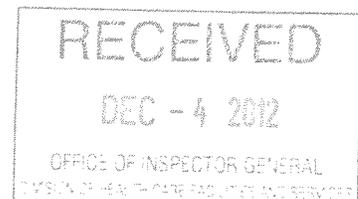
F 282	Continued From page 18 Resident #11 as unable to complete the Brief Interview for Mental Status Assessment (BIM), indicating cognitive impairment. Review of the care plan for Resident #11 initiated on 04/05/12 revealed that Resident #11 was determined to have an alteration in supervised/organized recreation characterized by little or no involvement and a lack of attendance related to: cognitive impairment, impaired mobility and intolerance. An intervention was noted as posting a personal activity schedule in the resident's room. However, there was not a calender in the room of Resident #11 that was personalized. Interview, on 11/01/12 at 7:52 PM, with the Activities Director revealed she could not answer the question about a personal calendar for the resident. She stated she was in training to learn her position.	F 282		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review	F 371	Start F 371 F 371 483.35 FOOD PROCURE, STORE/PREPARE/SERV-SANITARY 1. During the annual survey completed on 11/01/12 it was determined by the surveyor that the facility failed to ensure male employees' facial hair was covered in a food prep area. It was noted that three male employees had facial hair that was not covered. Dietary Aide #1 was noted with a mustache uncovered while assisting in the preparation of resident trays. The dietary cook was observed with an uncovered goatee as he served and cooked resident meals. The dietary manager was observed with an uncovered beard while assisting in the preparation of resident meal trays. 2. All identified employees applied beard nets immediately. Dietary Manager re-educated by the Administrator on 11/2/12 regarding facility policy and procedure and the	



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

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F 371	<p>Continued From page 19</p> <p>and review of the facility's policy and the 2005 Food Code, it was determined the facility failed to ensure male employees' facial hair was covered while in the food prep/cooking area.</p> <p>The findings include:</p> <p>Review of the facility's policy, Personal Grooming, dated 09/01/98, did not address facial hair covered in a food prep area.</p> <p>Review of the 2005 Food Code, U. S. Public Health Service, Section 2-402.11, page 45, regarding hair restraints, stated food employees shall wear hair restraints such as hats, hair coverings or nets, and beard restraints that are designed to effectively keep their hair from contacting exposed food; clean equipment; utensils; and linens; and unwrapped single-service and single-use articles.</p> <p>Observation, on 11/01/12 at 11:40 AM, during trayline services, revealed three (3) male employees with facial hair and no beard covering during the meal service. Dietary Aide #1 was observed with a mustache, while assisting in the preparation of resident's trays. The Dietary Cook was observed with an un-covered goatee as he served and cooked resident meals. The Dietary Manager was observed with an un-covered beard while assisting in preparation of resident meal trays.</p> <p>Interview with Dietary Aide #1, on 11/01/12 at 2:50 PM, revealed he had been trained on hair covering while in the food prep area. He further stated he was trained if the beard was kept neat and trim, no hair covering was needed. He stated</p>	F 371	<p><i>F 371 continued</i></p> <p>need for beard coverings in food prep areas and or when preparing or assisting in preparing resident food. All male employees to wear beard nets to cover sideburns, mustaches, beards, goatees or any form of facial hair.</p> <p>3. Re-education and in-services initiated on 11/2/12 and completed on 11/13/12 by the dietary manager for all dietary staff regarding Food 2005 Code, US Public health service, Section 2-402.11 page 45 & facility policy and procedure for the need for beard coverings in food prep areas and or when preparing or assisting in preparing resident food.</p> <p>4. Starting 11/19/12, Dietary Manager will monitor dietary staff daily X five days per week for 30days then weekly x 8 weeks, then monthly x3months to ensure beard coverings are worn by all employees with facial hair to include sideburns, mustaches, beards, goatees or any form of facial hair. The results of these rounds will be forwarded to the Quality Assurance Committee at least quarterly for review and recommendations. If concerns are identified during the QA process, the committee will reconvene for additional recommendations until sustained compliance.</p> <p>5. Completion date 11/20/12</p>	11/20/12	



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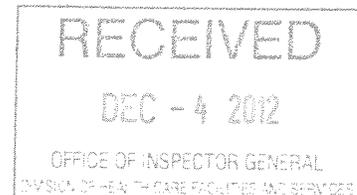
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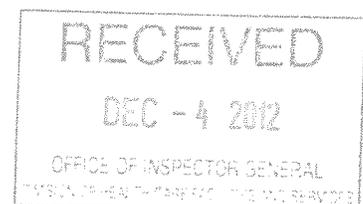
F 371	Continued From page 20 the purpose for the beard covering was to prevent hair from contaminating the food. He continue to state even with a well trimmed beard, could still contaminate the food. Interview with: Dietary Manager, on 11/01/12 at 3:00 PM, revealed he had been trained on proper hair covering. He further stated beard coverings were only needed for a full beard/mustache. He stated the purpose of hair covering was to prevent hair from contaminating the food. He stated a well trimmed beard could contaminate the residents' food.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it: (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	<i>Start F 441</i> F 441 483.65 INECTION CONTROL, PREVENT SPREAD, LINENS 1. During the annual survey conducted on 10/30/12 it was determined by the surveyor that the facility failed to ensure infection control practices were followed in order to provide a safe and sanitary environment to prevent the transmission of disease environment to prevent the spread of infection and disease. Infection control guidelines regarding contact isolation were not followed for two (2) of the eighteen (18) sampled residents and nine (9) unsampled residents (#4 and #12). Staff failed to follow isolation precautions related to probable C-diff diagnosis for resident #4. CNA #1 also failed to follow isolation precautions as it relates to resident #12. Resident #4 placed in isolation on 10/31/12 pending the results of third stool specimen per Advanced Practice Registered Nurse. Resident #4 and #12	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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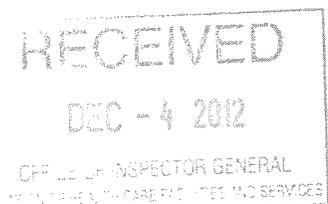
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F 441	<p>Continued From page 21</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy Contact Precautions, and the CDC Guidelines for Isolation Precautions, it was determined the facility failed to ensure infection control practices were followed in order to provide a safe and sanitary environment to prevent the transmission of disease. Infection control guidelines regarding contact isolation were not followed for two (2) of the eighteen (18) sampled residents and nine (9) unsampled residents (#4 and #12).</p> <p>The findings include:</p> <p>Review of the facility's policy Contact Precautions, dated 08/2005, revealed Clostridium Difficile (a type of bacteria) infection required contact isolation for the duration of the illness. Contact precaution recommendations included: clean gloves when entering a resident's room; change gloves after contact with infectious</p>	F 441	<p><i>F 441 Continued</i></p> <p>isolation precautions reviewed with Medical Director, MD on 11/2/12. Resident #4 and #12 remains in isolation with contact precautions in place per facility policy recommended by CDC.</p> <p>2. Education completed on 11/2/12 with DON by the administrator regarding the CDC guidelines related to C-diff. CNA assignment sheets updated on 11/2/12 to reflect isolation precautions. Results from third stool specimen received for resident #4 on 11/5/12 with negative results. CNA #1 retraining/education completed post concern on 11/2/12 by DON. All vital sign equipment currently being used in population was cleaned/sanitized or replaced if indicated on 11/2/12. All staff education/in-service initiated on 11/2/12 and completed on 11/5/12. 100% of residents with infection possibly requiring isolation precautions were reviewed and interventions in place with care plan revisions as indicated initiated on 11/2/12 and completed on 11/5/12.</p>	



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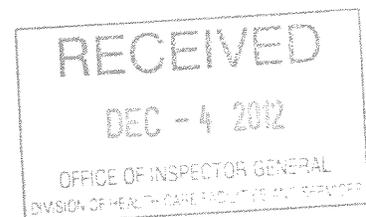
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F 441	<p>Continued From page 22</p> <p>material such as fecal material or wound drainage which may contain high levels of a given microorganism; remove gloves and wash hands before leaving resident's area; wear a gown when caring for the resident if you anticipate that soiling will occur; remove and dispose of gown before leaving the resident's room.</p> <p>Review of the CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, dated 2007, revealed direct contact transmission occurs when microorganisms are transferred from one infected person to another person without a contaminated intermediate object or person. Indirect contact transmission involves the transfer of an infectious agent through a contaminated intermediate object or person. Examples included patient care devices, hands, clothing, uniforms, laboratory coats or isolation gowns used as personal protective equipment (PPE), which may become contaminated with potential pathogens after care of a patient with an infectious agent (e.g., MRSA, VRE, C. difficile).</p> <p>Observation of Resident #4 during initial tour, on 10/30/12 at 7:45 AM, revealed an isolation cart parked next to the resident's bed and a contact isolation sign on the resident's door. Interview with Licensed Practical Nurse (LPN) #9 during tour, on 10/30/12 at 7:45 AM, revealed the resident was in isolation for Clostridium Difficile (an infection of the bowel).</p> <p>Observation, on 10/30/12 at 12:25 PM, revealed isolation signage was no longer on resident #4's room door. Concurrent interview with LPN #9 revealed she was just told the resident's stool</p>	F 441	<p><i>F 441 Continued</i></p> <p>3. Re-education and in-services initiated on 11/2/12 and completed on 11/5/12 by the DON for all clinical staff regarding facility policy and procedure for infection control specific to isolation precaution as it relates to the spread of infection. DON initiated simulated retraining of clinical staff on the different forms of isolation and utilization of PPE. Re-training conducted by the DON 11/2/12 through 11/5/12 regarding cleaning equipment used by residents in isolation. Re-education and in-services initiated on 11/20/12 and completed on 11/29/12 by the DON for all non clinical staff regarding infection control preventative measures as it relates to the spread of infection and equipment cleaning.</p> <p>4. Unit Manager/Weekend Supervisor will review all residents with diagnosis of infections requiring isolation precautions with each admission or acute change in condition beginning 12/1/12 to implement the indicated isolation measures. Unit Manager/Staff Facilitator will monitor resident rooms and CNA assignment sheets daily during isolation precautions</p>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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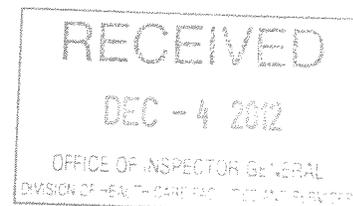
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F 441	<p>Continued From page 28</p> <p>specimens had come back negative and the resident no longer required isolation.</p> <p>Review of Resident #4's clinical record revealed a final positive stool sample for clostridium difficile on 09/02/12. Review of the Physician orders revealed an order for Vancomycin 125 mg four times a day for four (4) weeks written on 10/10/12, and an order for three (3) stool samples for Clostridium Difficile (C-diff) written on 10/25/12. Review of the lab results revealed two (2) specimens had come back negative, 10/26/12 and 10/28/12 respectively. Review of the physician orders revealed there was not an order to discontinue isolation precautions.</p> <p>Observation of Resident #4's skin assessment, on 10/30/12 at 2:25 PM, revealed Certified Nursing Assistant (CNA) #5 and Licensed Practical Nurse (LPN) #9 provided pericare, assessed the skin, and repositioned the patient without wearing a gown. The isolation cart remained parked against the wall by the resident's bed.</p> <p>Observation of Resident #4, on 10/31/12 at 9:30 AM, revealed the isolation cart no longer in the resident's room.</p> <p>Interview with the Nurse Practitioner, on 10/31/12 at 10:00 AM, revealed she had been trying to get the C-diff associated loose stool under control and recently added another medication. The Nurse Practitioner revealed two (2) of the stool specimens had come back negative and the stools were becoming more solid, but the resident remained in contact isolation.</p>	F 441	<p><i>F 441 continued</i></p> <p>period to insure all required identifiers are available and current. Beginning 12/1/12 Staff Facilitator will complete infection control audit weekly x12, then monthly x9 months to review trends and educational needs related to prevention of the spread of infection/disease. Beginning 12/1/12 Administrative nurses will complete daily rounds to resident care areas to ensure no infection control issues are noted. The findings will be documented using the clinical nurse rounds tool. All finding will be forwarded to the DON/NHA for review and follow up if indicated. The results of these rounds will be forwarded to the Quality Assurance Committee monthly until sustained compliance then at least quarterly for review and recommendations. If concerns are identified during QA process, the committee will reconvene for additional recommendations until sustained compliance.</p> <p>5. Completion date 12/2/12</p>	12/2/12	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 24</p> <p>Observation of CNA #2, on 10/31/12 at 11:37 AM, revealed the CNA taking resident #4's blood pressure with a blood pressure cuff then take the cuff up to the nurses station without cleaning the cuff. Interview with CNA #2 at this time revealed she was told the resident was no longer in isolation.</p> <p>Interview with LPN #6, on 11/01/12 at 2:30 PM, revealed she did not know who had removed the resident from isolation. The LPN revealed the resident had been in isolation the last time she had worked and she knew of only two (2) specimens that had come back negative. The LPN revealed she thought residents could come out of isolation if three (3) specimens came back negative. The LPN revealed she did not know if the third had been sent, but stated the resident continued to have loose stools during her shift that were of a pudding like consistency.</p> <p>Interview with the Unit Manager (UM), on 11/01/12 at 2:45 PM, revealed she was told by the Nurse Practitioner the resident could come out of isolation. The UM revealed the Medical Director had said residents could come out of isolation if they were asymptomatic and specimens came back negative. The UM revealed she did not know if all the specimens had been collected and sent. Continued interview, on 11/01/12 at 3:15 PM, revealed the third stool had not been collected and sent.</p> <p>Interview with LPN #8, on 11/01/12 at 4:03 PM, revealed she was aware not all of the specimens had been sent, and was told the resident was not in isolation; but she was trying to protect herself. The LPN revealed a potential for infecting other</p>	F 441			



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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 25</p> <p>people by not having the resident in isolation.</p> <p>Interview with the DON, on 11/01/12 at 8:07 PM, revealed she followed the MD orders and recommendations regarding isolation; however, the DON revealed the facility's policy did not indicate a physician's order was necessary to institute contact isolation precautions. The DON revealed she did remember the UM discussing the resident with the Nurse Practitioner and how there had been some improvement as a whole. The DON revealed she did not know the CDC recommendations for C-diff. The DON revealed a potential problem with infection control.</p> <p>2. Record review for Resident #12 revealed diagnoses included an Open Wound to the hip/thigh, an Open Wound to the toe/buttock, Sepsis and Need for isolation.</p> <p>Observation, on 10/30/12 at 7:40 AM, during the tour of the facility revealed no isolation precaution sign on the door to the room of Resident #12. Personal protective equipment (PPE) was noted outside the door to the room of Resident #12.</p> <p>Interview, on 10/30/12 at 7:40 AM, with Licensed Practical Nurse (LPN) #7 revealed Resident #12 was on contact isolation precautions. She noted the sign was missing from the door to alert staff and those who may enter the room that Resident #12 was on contact isolation.</p> <p>Observation, on 11/01/12 at 12:32 PM, revealed Certified Nursing Assistant (CNA) #1 entered the</p>	F 441		

