

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

PRINTED: 07/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/03/2013
NAME OF PROVIDER OR SUPPLIER RIDGWAY NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360		
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F 000	INITIAL COMMENTS The Abbreviated Survey to investigate KY00020371 was initiated on 07/02/13 and concluded on 07/03/13. Both allegations were substantiated with identified deficiencies.	F 000	Ridgeway Nursing and Rehabilitation does not believe nor does the facility admit that any deficiencies exist.		
F 282 SS-D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure staff provided care to one (1) of three (3) sampled residents (resident #1) in accordance with the residents written Plan of Care (POC). Resident #1's personal alarm was not turned on resulting in a fall. The findings include: Review of the facility's policy, "Care Plan - Using the Plan", dated 01/09/13, revealed it was the policy of this facility that the care plan be used in developing the resident's daily care routines. Daily care and documentation must be consistent with the resident's care plan. Record review revealed the facility admitted Resident #1 on 05/09/13 with diagnoses which included, Alzheimer Dementia, Paralysis Agitans.	F 282	Ridgeway Nursing and Rehabilitation reserves all rights to contest the survey findings through informal disputes resolution, legal appeal proceedings or any administrative or legal proceeding. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard care, contract, obligation or position. Ridgeway Nursing and Rehabilitation reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance of self critical examination privileges which		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Sally Baxt* TITLE: *Administrator* (X6) DATE: *08-09-13*

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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F 282	<p>Continued From page 1</p> <p>Difficulty in Walking, Lack of Coordination, Muscle Weakness, and History of a Fractured Coccyx related to a fall.</p> <p>Review of the Fall Risk Assessment dated 05/17/13, revealed the facility had assessed Resident #1 as high risk for falls. Review of Resident #1's Admission Minimum Data Set (MDS), dated 05/22/13 revealed the facility assessed Resident #1 with a Brief Interview for Mental Status (BIMS) of three (3) out of fifteen (15), indicating the resident was severely impaired in cognition. Continued review revealed Resident #1 required limited assistance of one (1) person physical assistance for transfer, to walk in room and the corridor.</p> <p>Review of the POC revealed a focus area of risk for falls related to resident being unaware of safety needs, confusion, vision/hearing problems wandering secondary to Alzheimer, Dementia and Parkinson's. Interventions included bed and chair alarm at all times.</p> <p>Interview with the Licensed Practical Nurse (LPN) #4, on 07/02/13 at 1:55 PM, revealed Resident #1 had a fall on 06/05/13. She stated Resident #1 was found on the floor by a housekeeper. LPN #4 stated while investigating the cause of the fall, it was found that the alarm on the wheelchair had not been turned on.</p> <p>Interview with the Restorative Aide (RA) #1, on 07/02/13 at 2:00 PM, revealed she had just completed Resident #1's restorative therapy of transfers and ambulation, when the resident stated he/she needed to be toileted. RA #1 said she took the resident to the bathroom, then put</p>	F 282	<p>Ridgeway Nursing and Rehabilitation does not waive, and reserve the right to assert in any administrative, civil, or criminal claim, action, or proceeding. Ridgeway Nursing and Rehabilitation offers its responses, credible allegations of compliance and plan of correction as part of its ongoing effort to provide quality care to resident.</p> <p>F282</p> <p>It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to provide or arrange services by a qualified person in accordance with each resident's plan of care.</p> <p>1. The employee who failed to turn the resident's alarm back on has been re-educated and disciplined on the following the residents plan of care. Resident #1 did not sustain significant injury related to her fall on 06-05-13. She has been assessed by her physician.</p>	
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F 282	Continued From page 2 him/her back in the wheelchair. She stated she was aware of the care plan intervention for the alarm when in the bed and in the wheelchair. She stated she thought she had turned the alarm back on, but must not had.	F 282	2. All employees (RN, LPN and SRNA's) were re-educated on 07-19-13 by the Staff Development Nurse (RN) on the following resident's plan of care. Resident's with special care needs are reviewed weekly in the facility's Quality of Care meeting. Those attending this meeting are the Administrator, Director of Nursing, QA nurse, Dietary manager, Activities and maintenance. 3. Weekly the Director of Nursing or the Staff Development Nurse will audit those residents who are scheduled for an assessment to ensure the resident's plan of care and the care being provided are the same. This will ensure each resident is reviewed at least quarterly. 4. As part of the facility's ongoing quality assurance program, weekly, the Staff Development RN will audit 10% of the residents to ensure staff		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies/forms it was determined the facility failed to ensure each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being in accordance with the comprehensive assessment and plan of care for two (2) of three (3) sampled residents (Residents #1 and #2). Resident #2 was found to have a bruised area to his/her left foot, on 06/28/13. However, the facility	F 309			

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F 309	<p>Continued From page 3</p> <p>failed to immediately initiate an investigation to identify the cause of the bruise and there was no documented evidence of the bruise in Resident #2's medical record. Resident #1's was found with a bruise to the right axillary but the facility did not investigate it until after reported to the facility by the resident's daughter on 05/31/13. In addition, there was not documented evidence the bruise found during the skin assessment, on 07/02/13 during the survey, had been identified.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Changes in a Resident's Condition or Status", dated 01/09/03, revealed it was the policy of the facility to notify the resident, his/her attending physician, and his/her representative of changes in the resident's condition and/or status. The policy continued onto state nursing services at the facility would be responsible for notifying the resident's attending Physician and responsible party when a resident is involved in any accident or incident that resulted in injury, including injuries of unknown source. In addition, the policy stated all changes in the resident's medical condition would be properly recorded in the resident's medical record.</p> <p>Review of the facility form titled, "Early Warning Tool Stop and Watch", undated, revealed when staff members identified changes such as those in skin color or condition, they were to indicate the change observed on the form, and then discuss the change with the Charge Nurse before the end of the shift. The form contained an area for the resident's name, staff reporting, as well as date, time and who the change was reported to.</p>	F 309	<p>is providing services as outlined in the plan of care. This audit will continue for the next four months and if no further issues are identified the audits will be conducted periodically. The Continuous Quality Improvement committee consists of the Medical Director, Director of Nursing, Administrator and various department supervisors and direct care staff. This committee meets monthly.</p> <p>5. 07-20-13</p>		

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F 309	Continued From page 4 Review of a facility in-service, dated 06/21/13, revealed staff was to report all bruises noted to the the nurse immediately, regardless if the bruise was a new or old area to the resident's skin. Also, the in-service stated staff was to call the Director of Nursing (DON) if they felt the nurse did not take action. 1. Record review revealed the facility admitted Resident #2, on 02/14/13, with diagnosis which included Acute Ischemic Stroke, Old Left Occipital Stroke, Left Eye Blindness, Macular Degeneration, Hypertension, Chronic Kidney Disease, Dementia, Dysphagia, Dyslipidemia, Hypothyroidism, and a history of Colon Cancer. Review of Resident #2's admission Minimum Data Set (MDS) Assessment, dated 02/21/13, revealed the facility assessed Resident #2 to have a Brief Interview for Mental Status (BIMS) of nine (9) out of fifteen (15), indicating the resident was moderately impaired in cognition. Continued review revealed Resident #2 required the assistance of two (2) staff members for bed mobility, transfers, dressing, toilet use, and hygiene. The resident was also coded as an assist of one (1) staff member for locomotion and eating. Review of Resident #2's Comprehensive Plan of Care (POC), initiated 03/03/13, revealed the resident had a potential for bruising related to the use of Plavix. The goal of the POC was for Resident #2 to be free from complications related to bruising through the review date, of 08/21/13. As part of the interventions listed, nursing staff were to monitor for indications of skin impairment	F 309	F309 It is and was the policy of Ridgeway Nursing and Rehabilitation to ensure each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with comprehensive assessment and plan of care. 1. Resident #1 and #2's bruised areas have healed. 2. All residents have been assessed for any bruising or injuries by the skin assessment nurse (LPN) on 07-18-13. 3. Weekly the nurse who performs skin assessments will also complete a list of any resident who has		

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F 309 Continued From page 5
during care. Another PDC, initiated 03/03/13, related to Resident #2's Activities of Daily Living (ADL) self care performance deficits stated staff were to observe the resident's skin for bruises and report to the nurse when found. Review of Resident #2's Physician's orders dated, 05/04/13, revealed he/she received Plavix (a medication used to thin blood cells) 75 milligrams daily.

Record review of Resident #2's Nurse's Notes revealed there was no documented evidence Resident #2 had a bruised area to his/her left foot. Continued review revealed there was no documented evidence Resident #2's Physician or Responsible Party had been informed of the bruised area to Resident #2's left foot.

Record review of Resident #2's Weekly Skin Assessments, last dated 06/26/13, revealed there was no documented evidence he/she had a bruised area to his/her left foot.

Record review of Resident #2's 24 Hour Nursing Assessment, dated 06/28/13, revealed the section to identify whether or not the resident had bruising, was not completed. Continued, review of the 24 Hour Nursing Assessments for Resident #2, dated 06/29/13 and 06/30/13, revealed the resident was assessed to have bruising; however, the location nor origin was noted.

An additional, Weekly Nurse's Note, dated 07/01/13, revealed Resident #2 was assessed to have multiple healing/old bruises. Yet, there was no indication as to the location or origin of the assessed bruised areas to Resident #2's skin.

Observation of Resident #2's head to toe skin

F 309 bruising noted. This list will be reviewed by the Administrator to ensure that the causative factors and documentation has been completed. An in-service was conducted on 07-19-13 by the Staff Development RN for all nursing staff discussing reporting of bruises and utilizing the "stop and watch" documentation. Stop and Watch tool is part of the SBAR documentation system. Stop and Watch is an early warning tool for staff to utilize.

4. As part of the facility's ongoing quality assurance program the Director of Nursing will conduct head to toe skin assessment on at least five residents weekly to ensure all noted skin conditions are documented correctly. The Continuous Quality Improvement Committee consists of the Medical Director, Administrator, Director of Nursing and various department managers and direct care staff.

5. 07-20-13

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F 309	<p>Continued From page 6</p> <p>assessment, on 07/02/13 at 10:54 AM, revealed a blue bruised area to his/her left foot that was approximately half dollar sized. Resident #2's Responsible Party was present during this assessment.</p> <p>Interview with Resident #2, on 07/02/13 at 4:34 PM, revealed she was unaware how the bruise to his/her left foot occurred.</p> <p>Interview with Resident #2's Responsible Party, on 07/03/13 at 10:50 AM, revealed prior to the skin assessment performed, on 07/02/13 with the surveyor present, she was unaware of the bruised area to Resident #2's left foot.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 07/02/13 at 2:43 PM, revealed she had worked with Resident #2, on 06/28/13, and had noted a bruised area to his/her left foot while removing Resident #2's shoes. CNA #1 reported she informed Licensed Practical Nurse (LPN) #2 of the bruised area noted to Resident #2's left foot during second shift, on 06/28/13. CNA #1 stated she was unaware what actions were taken by the LPN, and she further stated she did not complete any documentation or forms related to this area.</p> <p>Interview with LPN #2, on 07/03/13 at 10:00 AM, revealed she had been assigned to Resident #2, on 06/28/13. However, LPN #2 could not recall staff reporting a bruise to Resident #2's left foot. LPN #2 stated she was unaware of any bruised areas to Resident #2's left foot. The LPN stated if the bruise to Resident #2's left foot had been reported to her, she would have completed an incident report and investigation to determine the</p>	F 309		

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F 309	<p>Continued From page 7</p> <p>cause of the bruise. Then she reported she would have contacted the Physician, Responsible Party and the Director of Nursing (DON) immediately. LPN #2 also reported when completing the 24 Hour Nursing Assessment, bruises were to be indicated by location. LPN #2 also stated any bruises noted to a resident should be documented by location in the nurse's notes.</p> <p>Interview with the DON, on 07/02/13 at 3:24 PM, revealed when bruises were noted to a resident's skin the CNA should inform the nurse and the nurse should contact the Physician and Responsible Party. The DON further reported an incident report should be completed to document the bruise and determine the cause, so action could be taken to prevent further bruising. The DON reported prior to surveyor questioning, she was unaware of the bruised area to Resident #2's left foot. The DON stated nurses were to complete a head to toe skin assessment daily in order to complete the 24 Hour Nursing Assessment Form. The DON stated an additional skin assessment was performed weekly by the Skin Nurse. Lastly, the DON stated she expected all bruising to be documented in the resident's medical record.</p> <p>interview with the Administrator, on 07/03/13 at 11:10 AM, revealed Resident #2's bruised area to his/her left foot had not been documented, and a "Stop and Watch" form had not been completed. As a result, the investigation to determine the origin of the bruise to Resident #2's foot did not immediately begin when found by the CNA, on 06/28/13.</p> <p>2. Record review revealed the facility admitted</p>	F 309		
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F 309	<p>Continued From page 8</p> <p>Resident #1 on 05/19/13 with diagnoses which included Transient Ischemic Attack, Alzheimer Dementia, Paralysis Agitans, Difficulty in Walking, Lack of Coordination, Muscle Weakness, and History of a Fractured Coccyx related to a fall.</p> <p>Review of Resident #1's admission Minimum Data Set (MDS) Assessment, dated 05/22/13, revealed the facility assessed Resident #1 with a Brief Interview for Mental Status (BIMS) of three (3) out of fifteen (15) indicating the resident was Evelyn impaired in cognition. Continued review revealed Resident #1 required limited assistance of one (1) person physical assistance for transfer, to walk in his/her room and the corridor.</p> <p>Review of Resident #1's medication orders for June and July 2013, revealed the resident was on Coumadin (anticoagulant/blood thinner medication) four (4) milligrams given daily.</p> <p>Review of Resident #1's Comprehensive Plan of Care (POC) revealed a focus area of anticoagulation therapy related to TIA's. The goal of the POC was for Resident #1 to be free from discomfort or adverse reactions related to anticoagulant use through the review date of 08/25/13. Interventions included labs as ordered, report abnormal labs to MD, Skin assessment every week and PRN (as needed), avoid activities that could result in injury and take precaution to avoid falls.</p> <p>Observation during the skin assessment on 07/02/13 with LPN #4 revealed a quarter sized purple red bruise was found on Resident #1's right inner forearm. LPN #4 stated no one had reported the bruise to her. She stated during AM</p>	F 309			

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F 309	<p>Continued From page 9</p> <p>care the CNA should have reported the bruise, so the cause could be investigated. LPN #4 continued by saying on 05/31/13 a bruise had been found under the right axilla, she stated it was fading. She stated the daughter was with Resident #1 when the bruise was discovered and an Incident report had been completed.</p> <p>Interview with Resident #1's Responsible Party, on 07/03/13 at 10:30 AM, revealed she was aware that Resident #1 was on an a blood thinner, and that people on blood thinners tend to bruise easier. She stated on two (2) occasions she found two (2) large bruises and reported them to the facility instead of the facility reporting the bruises to her. She stated the first time she found a large bruise under Resident #1's axilla and the second time it was three days after the fall which occurred 06/05/13. She stated Resident #1's arm was black. The Responsible party did not believe the bruising was due to the fall.</p> <p>Interview with the DON, on 07/02/13 at 3:00 PM, revealed the bruise in Resident #1's axillary area was investigated. She stated they came to conclusion the bruise was caused due to the way the aides were transferring Resident #1. She stated inservices were done.</p> <p>Interview with the Administrator, on 07/03/13 at 11:10 AM, revealed she had in-serviced staff recently on the reporting of bruises. The Administrator reported she had noticed a breakdown in this area, and therefore she held a staff meeting to address this concern approximately two (2) weeks ago. The Administrator reported staff/CNAs were to complete the "Stop and Watch" form when</p>	F 309		
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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 10 bruises were found in addition to reporting to the nurse verbally. The Administrator also stated she expected staff to document the presence and location of bruises on the resident's progress notes as well as on the weekly skin assessments.	F 309			
F 323 SS-D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure one (1) of three (3) sampled residents (Resident #1) received adequate supervision and assistive devices to remain as free from accidents as possible. Resident #1 had a fall while at the facility and the investigation revealed staff failed to ensure the fall prevention alarm was turned on. The finding include: Review of the facility's "Falls Program", no date, revealed the facility would identify residents at risk for falls, the Administrator and the Director of Nursing would review incident reports. Further review revealed resident falls were tracked by the	F 323	F323 It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to ensure that residents remain as free of accidents hazards as possible and each resident receives adequate supervision and assistive devices to prevent accidents. 1. Resident #1 has been assessed by her physician since the fall on 06-05-13 on 06-07-13. On 07-05-13 her falls risk was reassessed and she continues to be at risk for falls. Additional hip protection underwear have been purchased so that laundering does not interfere with the application.		

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F 323	<p>Continued From page 11</p> <p>facility designee. At risk residents would be placed on the falling star program and the environment would be assessed after each fall.</p> <p>Record review revealed the facility admitted Resident #1 on 05/19/13 with diagnoses which included Alzheimer Dementia, Paralysis Agitans, Difficulty in Walking, Lack of Coordination, Muscle Weakness, and History of a Fractured Coccyx related to a fall.</p> <p>Review of the Fall Risk Assessment dated 05/17/13, revealed the facility had assessed Resident #1 as high risk for falls. Review of Resident #1's Admission Minimum Data Set (MDS) Admission, 05/22/13 revealed the facility assessed Resident #1 with a Brief Interview for Mental Status (BIMS) of three (3) out of fifteen (15), indicating the resident was severely impaired in cognition. Continued review revealed Resident #1 required limited assistance of one (1) person physical assistance for transfer, to walk in his/her room and the corridor. Review of Resident #1's medication orders revealed the resident was on Coumadin (anticoagulant/blood thinner medication) four (4) milligrams given daily.</p> <p>Review of Resident #1's Comprehensive Plan of Care (POC) revealed a focus area of risk for falls related to resident being unaware of safety needs, confusion, vision/hearing problems wandering secondary to Alzheimer, Dementia and Parkinson's. The goal of the POC was for Resident #1 to sustain no fall related injuries. Interventions listed to prevent falls on the POC for Resident #1 include, anticipate and meet the resident's needs, bed and chair alarm, door alarm to bathroom door, uses wheechair for mobility,</p>	F 323	<p>2. All employees (RN, LPN and SRNA) have been re-educated by the Staff Development RN on 07-19-13 on maintaining assistive devices for those residents who are care planned to require their assistance.</p> <p>3. Weekly the Director of Nursing or Staff Development Nurse will audit those residents who are schedule for assessment to ensure their environment is as free of accident hazards as possible and assistive devices are being utilized as care planned.</p> <p>4. As part of the facility's ongoing quality assurance program, the Staff Development RN will weekly audit 10% of the residents' environment as compared to their care plans to ensure each is receiving the assistive devices to prevent accidents. Weekly the Quality of Care committee reviews any incident or accident for causative factors and interventions.</p>		

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F 323	<p>Continued From page 12 ambulates with assistance of staff.</p> <p>Review of the facility's investigative report revealed Resident #1 was found on the floor in his/her room by a housekeeper on 06/05/13 at 10:45 AM. Continued review revealed Resident #1 was unable to say what precipitated the fall due to Resident #1's mental status. The investigation also indicated that a personal alarm was in use, but was turned off.</p> <p>Interview with the Licensed Practical Nurse (LPN) #4, on 07/02/13 at 1:55 PM, revealed Resident #1 had a fall on 06/05/13. She stated Resident #1 was found on the floor by a housekeeper. LPN #4 stated while investigating the cause of the fall, it was found that the alarm on the wheelchair had not been turned on. During the interview on LPN #4, on 07/03/13 at 10:15, she stated Resident #1 did try to get up without assistance, but when the alarm sounded off the staff had been able to reach the resident prior to a fall.</p> <p>Interview with Restorative Aide (RA) #1, on 07/02/13 at 2:00 PM, revealed she had just completed Resident #1's restorative therapy of transfers and ambulation, when the resident stated he/she needed to be toileted. RA #1 stated she took the resident to the bathroom and put him/her back in the wheelchair. She stated she was aware of the order for the alarm when in the bed and in the wheelchair. She stated she thought she had turned the alarm back on, but must not have.</p> <p>Interview with the Director of Nursing (DON), on 07/02/13 at 3:00 PM, revealed when the nurse went into Resident #1 room after the fall, she saw</p>	F 323	<p>The Continous Quality Improvement committee consists of the Medical Director, Administrator, Director of Nursing and various department supervisors and direct care staff members. This committee meets monthly.</p> <p>5. 07-20-13</p>		

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F 323 Continued From page 13
the alarm had not been turned on. She stated they checked the device for malfunction, but there had been nothing wrong with it. She stated they did disciplinary action with RA #1.

F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program

The facility must establish an Infection Control Program under which it -

- (1) Investigates, controls, and prevents infections in the facility;
- (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
- (3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection

(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.

(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens

F 323

F 441

It is and was the policy of Ridgeway Nursing and Rehabilitation to establish and maintain an Infection Control Program designed to prevent the development and transmission of disease and infection.

1. Resident #2 has not shown signs or symptoms of infection. This resident has been assessed on an ongoing basis by the facility's licensed nursing staff utilizing vital signs including temperature and systems assessment.

2. All licensed nurses (RN's and LPN's) have been re-educated by the Director of Nursing on 07-12-13 concerning the proper skin assessment procedure and general infection control principles. All residents are assessed weekly by a nurse who has been specifically

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F 441	<p>Continued From page 14</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to provide a safe and sanitary environment to prevent the development and transmission of disease for one (1) of three (3) sampled residents (Resident #2). Observations during a head to toe skin assessment of Resident #2 revealed Registered Nurse (RN) #1 assessed the perineal area and buttocks of the resident's body and assessed other areas of the body without changing gloves and washing or sanitizing hands.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Infection Prevention Program Overview", undated, revealed the facility would decrease the risk of infection to residents and identify and correct problems related to infection prevention practices. Also, the policy stated the infection prevention program was comprehensive and addressed detection, prevention, and control of infections among residents. Lastly, the policy stated staff followed policies, procedures and aseptic practices when performing procedures.</p> <p>Review of the facility's policy titled, "Hand Hygiene", undated, revealed the purpose of hand hygiene was to decrease the risk of transmission</p>	F 441	<p>trained in skin care. All residents are monitored on an ongoing basis for signs and symptoms of infection by the facility's license nursing staff. This assessment includes vital signs (including temperature) and system assessment.</p> <p>3. Weekly, the Director of Nursing will observe at least one head to toe skin assessment to ensure proper technique is being utilized by all nurses. In addition, the Director of Nursing tracks and trends infections, organisms and infections based on location within the facility in an effort to recognize any issues or concerns. These reports are made part of the facility's Continuous Quality Improvement Program.</p>	
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F 441	<p>Continued From page 15 of infection by appropriate hand hygiene. The policy stated handwashing/hand hygiene was generally considered the most important single procedure for preventing healthcare associated infections.</p> <p>Record review revealed the facility admitted Resident #2, on 02/14/13, with diagnoses which included Acute Ischemic Stroke, Old Left Occipital Stroke, Left Eye Blindness, Macular Degeneration, Hypertension, Chronic Kidney Disease, Dementia, Dysphagia, Dyslipidemia, Hypothyroidism and a history of Colon Cancer.</p> <p>Record review revealed a Physician's Order, dated 06/17/13, for Resident #2 to receive Nystatin Powder (an antifungal powder) to groh/back three (3) times daily for ten (10) days. This order also stated Resident #2 was to receive Diflucan (used to treat yeast infection) 100 milligrams (mg) by mouth or Percutaneous Endoscopic Gastrostomy (PEG) daily for seven (7) days.</p> <p>Record review revealed an additional Physician's Order, dated 07/02/13, for Resident #2 to receive Nystatin Powder three (3) times daily to abdominal folds and perineal area for ten (10) days. This order also stated to administer Diflucan 100 mg daily by mouth/PEG for five (5) days due to yeast/thrush.</p> <p>Observation, on 07/02/13 at 10:54 AM, of Resident #2's head to toe skin assessment, performed by RN #1 revealed during the assessment RN #1 assessed the resident's abdominal folds and perineal area first (which was affected by a Yeast Infection per RN #1) then</p>	F 441	<p>4. As part of the facility's ongoing quality assurance program each licensed nurse will conduct head to toe skin assessment utilizing proper infection control techniques. These performance evaluations will be conducted on a quarterly basis for the next year. The continuous Quality assurance committee consists of the Medical Director, Administrator, Director of Nursing, various department supervisor and direct care staff. This committee meets monthly</p> <p>5. 07-20-13</p>	
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F 441	<p>Continued From page 16</p> <p>proceeded to the resident's chest, breast, legs and feet without removing the contaminated gloves and washing her hands. Prior to assessing Resident #2's posterior surface, RN #1 opened the door and left the room to obtain assistance while she continued to wear the contaminated gloves. Upon return to the room RN #1 entered Resident #2's room gloved and again touched the door handle with her gloved hands. After sliding Resident #2's brief down, RN #1 assessed the resident's buttocks and then proceeded to assess the resident's back, ears, neck and hair with the same gloves.</p> <p>Interview with Certified Nursing Assistance (CNA) #4, on 07/02/13 at 2:35 PM, revealed during skin assessments or while providing incontinence care it was important for staff to change gloves and wash hands after any contact with areas that were potentially contaminated such as the perineal area or areas affected by yeast, prior to touching other parts of the resident's body. CNA #4 reported proper handwashing and gloving was important to prevent the spread of infection. CNA #4 reported she had been trained at the facility to use a "clean to dirty" technique.</p> <p>Interview with the RN #1, on 07/03/13 at 11:10 AM, revealed skin assessments were to be conducted following a head to toe approach. RN #1 stated when gloves were soiled they were to be removed and hands should be washed. RN #1 also reported when exiting the resident's room during a skin assessment, gloves should be removed and hands should be sanitized prior to leaving the room. RN #1 denied having touched the door handle with contaminated gloves during Resident #2's skin assessment and stated she</p>	F 441		
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F 441 Continued From page 17
did not fully leave the room, but stood only in the door way. However, RN #1 stated when assessing a resident's skin she should begin with clean areas of the body and then move to areas that were potentially soiled such as the perineal area and buttocks. RN #1 stated she received training on infection control during her orientation to the facility in May 2013.

Interview with the Skin Nurse, on 07/03/13 at 10:20 AM, revealed staff was in-serviced yearly on proper infection control techniques. The Skin Nurse reported after having assessed an area potentially affected by yeast, gloves should be removed and hands should have been washed prior to moving to other areas of the body. Additionally, the Skin Nurse reported gloves should be removed and hands should be washed, prior to exiting a resident's room during a skin assessment.

Interview with the Director of Nursing (DON)/Infection Control Nurse, on 07/02/13 at 3:24 PM, revealed staff was in-serviced when hired and annually on proper infection control during skin assessments. The DON reported the nurses at the facility were taught to begin resident skin assessments by assessing clean areas such as the residents head, then proceed to the perineal areas or any area possibly contaminated by a yeast infection last. The DON also reported proper handwashing and gloving was important to decrease the spread of germs and infection.

Interview with the Administrator, on 07/03/13 at 11:30 AM, revealed staff was trained by the DON on proper infection control practices. The Administrator reported the nurses received

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F 441	Continued From page 18 annual competency related to infection control which included a "clean to dirty" approach for skin assessments. The Administrator stated staff should wash their hands and change gloves during a skin assessment after having contact with a dirty/contaminated area. Lastly, the Administrator also reported during a skin assessment, gloves should be removed and hands should be washed prior to touching the door and exiting the resident's room.	F 441		