

Accepted
POC 1/25/13
 No. 9063 P. 2

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

PRINTED: 02/07/2013
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185250	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/24/2013
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NAME OF PROVIDER OR SUPPLIER OAKMONT MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 GRANDVIEW DRIVE FLATWOODS, KY 41139
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F 000 INITIAL COMMENTS

A Recertification Survey was conducted 01/21/13 through 01/24/13. Deficiencies were cited with the highest Scope and Severity (S/S) of an "E".

F 157 483.10(b)(11) NOTIFY OF CHANGES
 SS=D (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

F 000 Oakmont Manor does not believe and does not admit that any deficiencies existed, either before, during or after the survey. Oakmont Manor reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings, or any administrative or legal proceedings.

F 157 This plan of correction does not constitute any admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is it meant to establish any standard of care, contract obligation or position, and Oakmont Manor 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 or any potentially applicable peer review, quality assurance or self-critical examination privileges which Oakmont Manor does not waive, and administrative, civil or criminal claim, action or proceeding. Oakmont Manor offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care of residents.

RECEIVED
 FEB 12 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Shanna Carver</i>	TITLE <i>Administrator</i>	(X6) DATE 2-11-13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157 Continued From page 1

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 ensure the Physician was notified of a change in condition for one (1) of sixteen (16) sampled Residents (Resident #2). Resident #2's Physician was not notified on 01/17/13 of a change in skin condition, noted by Registered Nurse (RN) #2 as excoriation and scattered broken areas to the buttocks, therefore no treatment was ordered and on 01/22/13 Resident #2 was noted with three (3) Stage II pressure sores.

The findings include:

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's Physician of changes in the resident's condition and/or status. The policy continued on to state nursing staff would contact the Physician if there was a significant change in the resident's physical, mental, emotional, or psychosocial status. Continued review of the policy, revealed the Physician would also be contacted if there was a need to alter the resident's treatment significantly or if the notification was deemed necessary or appropriate for the best interest of the resident.

Record review revealed the facility admitted Resident #2 from the hospital on 11/21/12 with diagnoses which included Acute Renal Failure, Sepsis, Urinary Tract Infection, Diabetes Mellitus Type II, Stage II Decubitus, Severe Debility,

F 157 It is and was on the day of survey the policy of Oakmont Manor to immediately inform resident, consult with resident's physician and if known, notify the legal representative of a need to alter treatment significantly.

Resident #2's physician stated on 1/22/13 that he could not remember specifically if he had been notified of skin condition. Administrator and DON spoke with attending physician on 1/22/13 to confirm notification.

All residents had head to toe assessments completed by either an LPN or RN on 1/23/13 and 1/24/13 to ensure that there was no significant change in residents' condition that needed to be reported to the physician. This audit was reviewed by the DON and the ADON on 1/24/13. The DON, ADON, and QA nurse review all daily shift reports and physician's orders to ensure the resident's physician has been notified of any need to alter treatment significantly.

An in-service was conducted on 1/22/13 by the ADON for all licensed nursing staff reviewing physician notification requirements.

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F 157 Continued From page 2
Degenerative Disc Disease, and Chronic Lower Back Pain.

Review of Resident #2's Admission Minimum Data Set (MDS) Assessment, dated 11/28/12, revealed the facility assessed Resident #2 with a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact. Further review of the MDS revealed the facility assessed Resident #2 as requiring extensive assistance of two (2) persons for bed mobility, transfers, toilet use, personal hygiene, and bathing. In the Bowel and Bladder Section of the MDS it was indicated that Resident #2 had an indwelling urinary catheter, but was always incontinent of bowel. Under section M (Skin Conditions), the MDS identified Resident #2 as being at risk for pressure ulcer development.

Review of the current Comprehensive Plan of Care for Resident #2, onset 11/29/12, revealed he/she was at risk for impaired skin integrity related to history of healed areas, being bedridden, and decreased mobility. The stated goal for the plan of care was for Resident #2 to have no further preventable skin breakdown. Interventions included nursing staff was to monitor for skin impairment, and to monitor for skin breakdown during weekly skin assessments.

Review of the Braden Scale for Predicting Pressure Sore Risk, dated 12/12/12, revealed Resident #2 scored a fifteen (15). This score indicated Resident #2 was at high risk for pressure sores.

Review of Resident #2's Weekly Nurse's Notes

F 157 As part of the facility's ongoing Quality Assurance Program the ADON and/or QA and weekend supervisor nurse will review six weekly head to toe assessments the following day to ensure any significant change in needs of the resident was reported to the MD. The results of the audit will be reviewed by the Quality Assurance Committee on a monthly basis for six months to determine compliance.

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F 157	<p>Continued From page 3</p> <p>(form used to document weekly skin assessments), dated 01/17/13, revealed a note indicating Resident #2 had bilateral buttocks excoriation with scattered open areas. The Weekly Nurse's Note continued on to state the areas looked like shœring. The word "Sensicare" was written at the end of the note, but no further information was given in regards to the excoriation and/or treatment. This assessment was conducted by Registered Nurse (RN) #2.</p> <p>Interview, on 01/23/13 at 4:00 PM, with RN #2, revealed she had completed the weekly skin assessment on Resident #2 on 01/17/13. She stated at the time of the skin assessment she had noted excoriation and redness with tiny open areas to Resident #2's buttocks. She stated the areas were pinpoint, so measurements were not taken. RN #2 stated she did not call the Physician because it was late at night when the areas were discovered. RN #2 stated she had planned on reporting the change in skin condition to the day shift nurse, so the day shift nurse could have called the Physician. However, she admitted that she failed to communicate the skin change during report, due to having a busy morning. She also stated, she forgot to document the findings on the shift report. Lastly, RN #2 stated that she applied Sensicare from the treatment cart to Resident #2, because it was late at night and she did not want to fax an order to pharmacy and have to wait.</p> <p>Review of the Nurses Notes, from 01/17/13 through 01/22/13, revealed there were no notes addressing the assessment finding on 01/17/13 prior to the skin assessment on 01/22/13. The notes did not indicate, any Physician or Family notifications.</p>	F 157		

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F 157	<p>Continued From page 4</p> <p>Review of the Treatment Record and Medication Record for 01/01/13 through 01/31/13, revealed there were no orders in place to apply any type of protective barrier cream or other intervention to bilateral buttocks for excoriation or open areas identified on 01/17/13.</p> <p>Review of the Physician's Orders for 01/01/13 through 01/31/13, revealed there were no treatments ordered for the excoriation with open areas noted to bilateral buttocks on 01/17/13.</p> <p>Interview with SRNA #5, on 01/22/13 at 2:20 PM, revealed he had cared for Resident #2 on 01/21/13 during second shift. He reported the last time he changed Resident #2 for incontinence care was on 01/21/13 at around 9:30 PM. He stated during this time, he did not note any open areas, but stated Resident #2's bilateral buttocks had red areas present. However, he thought the nurses had a treatment in place for those areas, so he did not notify anyone. He denied having applied Sensicare during incontinence care to Resident #2. He stated the nurses applied the Sensicare cream as a preventative measure.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 01/23/13 at 11:15 AM, revealed she had cared for Resident #2 on 01/21/13 during day shift. She reported she was the nurse responsible for administering Resident #2's medications and treatments on that day. She stated she was unaware of reddened areas or open areas to Resident #2's buttocks. LPN #2 further stated she was unsure if Resident #2 had an order for Sensicare, but stated applying Sensicare did require a Physician's Order. In addition, she was</p>	F 157		
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F 157	<p>Continued From page 5</p> <p>unsure if Resident #2 was receiving Sensicare or any other treatments related to his/her buttocks.</p> <p>Interview with SRNA #4, on 01/22/13 at 3:20 PM, revealed she had cared for Resident #2 on 01/21/13 during second shift. She stated Resident #2's buttocks was red with irritation on both sides during care on 01/21/13, but she denied having noted any open areas. She believed the nurses were applying Sensicare as a treatment for the irritation. So, she did not notify the nurses of Resident #2's skin condition.</p> <p>Interview, on 01/23/13 at 3:20 PM, with LPN #1, revealed she had cared for Resident #2 on 01/21/13 from 2:00 PM to 10:00 PM. LPN #1 stated she was not aware of any open areas to Resident #2's buttocks. LPN #1 did state Resident #2's buttocks stayed red from him/her lying on it, but she did not feel Sensicare needed to be applied. She denied having notified the Physician of the reddened area to Resident #2's buttocks. Also, LPN #1 stated Sensicare did require a Physician's Order and that it was kept in the treatment cart, labeled from pharmacy. In addition, she stated if skin breakdown was noted the Physician would be notified to obtain a treatment.</p> <p>Interview, on 01/23/13 at 3:45 PM, with SRNA #2, revealed she had provided care to Resident #2 on 01/21/13 during night shift. She stated she did check Resident #2 for bowel incontinence during this shift and had noted Resident #2's buttocks to be red, but did not notify the nurse. SRNA #2 stated this was "usual" for Resident #2 and "sometimes" she would apply Sensicare to the red areas. She denied noting any open areas on</p>	F 157		
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F 157	<p>Continued From page 6</p> <p>01/21/13. SRNA #2 further stated she thought a Physician's Order had to be present to apply the Sensicare, but was unsure if Resident #2 had an order to apply Sensicare. SRNA #2 stated the cream was obtained through the nurses from the treatment cart.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #6, on 01/22/13 at 12:10 PM, revealed he had been caring for Resident #2 for the last three (3) days from 8:00 AM to 2:00 PM. He stated on 01/22/13, he had provided incontinence care to Resident #2 in the morning and noticed his/her buttocks to be red. He denied noting open areas to Resident #2's buttocks, until after the skin assessment on 01/22/13. He stated he applied Sensicare to Resident #2 during incontinence care, but was unsure if there was a Physician's Order for the cream. He also, did not know how long he had been applying the cream to Resident #2, but stated the nurses kept the Sensicare cream in the treatment cart and would give him a cup to use on Resident #2. In addition, he did not know if the application of Sensicare barrier cream was being documented anywhere.</p> <p>Observation of a skin assessment performed by RN #3, on 01/22/13 at 10:05 AM, revealed three unidentified stage II areas to Resident #2's buttocks. Resident #2 had a right buttock stage II area measuring 3 millimeters (mm) in length x 0.8 mm in width, a right inner buttock stage II area measuring 0.8 mm in length x 0.5 mm in width, and a left inner buttock stage II measuring 0.4 mm in length x 0.4 mm in width. Interview at the time of the assessment, with RN #3 who was performing the skin assessment, revealed she was not aware of these areas prior to the skin</p>	F 157	

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F 157 Continued From page 7
assessment. The Assistant Director of Nursing (ADON) was also present during the skin assessment and stated she conducted measurements of resident wounds on a weekly basis and was not aware of any open areas on Resident #2's buttocks prior to the skin assessment on 01/22/13.

Interview with the Assistant Director of Nursing (ADON), on 01/24/13 at 2:00 PM, revealed she was over the wound care program. As part of this, she reported that she assessed documented wounds weekly and changed treatment orders as needed. In addition, the ADON reported her expectation was for staff to inform her when new areas were found. The ADON reported she was normally informed of new skin areas by receiving a copy of the Physician's Order for treatment of that area. During continued interview the ADON reported she reviewed all new orders daily. However, she did not have an order for any treatment for the excoriation to Resident #2's buttocks and she stated RN #2 should have obtained a Physician's order on 01/17/13 when the excoriation was noted.

Interview, on 01/24/13 at 1:30 PM, with the Director of Nursing (DON), revealed RN #2 should have notified the day shift nurse of the change in skin condition for Resident #2. Then, the day shift nurse would have contacted the Physician after 6:00 AM. The DON stated if SRNAs noted a change in skin condition, they were to notify the nurses. The DON further stated this change in skin condition should be documented in the nurse's notes and on the twenty-four hour report sheet kept at each nurse's station. Furthermore, the DON stated treatments

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F 157 Continued From page 8
do require a Physician's Order.

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
SS=D

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure the plan of care was implemented for one (1) of sixteen (16) sampled residents (Resident #2). Resident #2's Pressure Ulcer Care Plan was not followed when staff failed to report changes in his/her skin condition noted on 01/17/13 as excoriation and scattered open areas to buttocks resulting in three (3) Stage II areas developing on 01/22/13.

The findings include:
Review of the facility's policy titled, "Care Plan-Using The Plan", undated, revealed it was the policy of the facility that the care plan be incorporated into the resident's daily care routines. The policy continued on to state, the nursing assistant staff was responsible for reporting to the nurse or charge nurse any change in the resident's condition. Lastly, the policy stated that daily care and documentation must be consistent with the resident's care plan.

F 157

F 282

It was and is on the day of survey the policy at Oakmont Manor to ensure that care is provided in accordance to the residents' plan of care.

Resident #2 had no adverse effect related to plan of care. Care plan was updated on 1/22/13 to reflect change in treatment.

There were no adverse effects to any residents due to the practice identified with following the plan of care as an LPN or an RN completed head to toe assessments on all residents on 1/23/13 and 1/24/13 to determine if physician needed notified or plan of care needed to be altered.

CMTs and SRNAs were educated on 1/22/13 regarding reporting changes in resident condition to charge nurse. Licensed nursing staff was educated on 1/22/13 regarding assessing/documenting changes in condition and reporting to MD to modify plan of care.

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F 282	<p>Continued From page 9</p> <p>Review of Resident #2's medical record revealed he/she the facility admitted the resident from the hospital on 11/21/12 with diagnoses which included Acute Renal Failure, Sepsis, Urinary Tract Infection, Diabetes Mellitus Type II, Stage II Decubitus, Severe Debility, Degenerative Disc Disease, and Chronic Lower Back Pain.</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment, dated 11/28/12, for Resident #2, revealed a Brief Interview for Mental Status (BIMS) score of fifteen (15). A score of fifteen (15) indicated Resident #2 was cognitively intact. Continued review of the MDS revealed the facility assessed the resident as requiring extensive assistance of two (2) staff for bed mobility, transfers, toilet use, personal hygiene, and bathing. The Bowel and Bladder Section of the MDS indicated Resident #2 had an Indwelling urinary catheter, but was always Incontinent of bowel. Under Skin Conditions, the MDS identified Resident #2 was at risk for pressure ulcer development.</p> <p>Review of Resident #2's Comprehensive Plan of Care, dated 11/29/12, revealed he/she was at risk of impaired skin integrity related to history of healed areas, being bedridden, and decreased mobility. The goal of the plan of care was for Resident #2 to have no further preventable skin breakdown. Interventions included nursing staff was to monitor for skin impairment during care daily. In addition, weekly skin assessments by Licensed staff were to be performed to monitor for any indication of skin breakdown.</p> <p>Review of the Braden Scale for Predicting Pressure Sore Risk, dated 12/12/12, revealed</p>	F 282	<p>As part of the facility's ongoing Quality Assurance Program the ADON and/or QA and weekend supervisor nurse will review six weekly head to toe assessments the following day to ensure any significant change in needs of the resident was reported to the MD.</p> <p>The DON, ADON, and QA nurse review all daily shift reports and physician's orders to ensure the resident's physician has been notified of any need to alter treatment significantly.</p> <p>The results of the audits will be reviewed monthly by the Quality Assurance committee for six months to ensure compliance.</p>	1/25/13
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185250	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/24/2013
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NAME OF PROVIDER OR SUPPLIER OAKMONT MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 GRANDVIEW DRIVE FLATWOODS, KY 41139
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F 282	<p>Continued From page 10</p> <p>Resident #2 scored a fifteen (15). This assessment tool score of fifteen (15) indicated Resident #2 was at high risk for pressure sores.</p> <p>Record review of Weekly Nurse's Notes, dated 01/17/13, revealed a note indicating Resident #2 had bilateral buttocks excoriation with scattered open areas. The Weekly Nurse's Note further stated the areas looked like sheering. "Sensicare" was written at the end of the note, but no further information was given in regards to the excoriation and/or treatment. This noted was transcribed by Registered Nurse (RN) #2.</p> <p>Interview, on 01/23/13 at 4:00 PM, with RN #2, revealed she had conducted the weekly skin assessment on Resident #2 on 01/17/13. She stated at the time of the skin assessment (01/07/13) she had noted excoriation and redness with tiny open areas to Resident #2's buttocks. She stated the areas were pinpoint, so measurements were not taken. RN #2 stated she did not call the Physician because it was at night when the areas were discovered. RN #2 stated she had planned on reporting the change in skin condition to the day shift nurse during morning report. However, she admitted that she failed to communicate the skin change during report, due to having a busy morning. She also stated, she forgot to document the findings on the shift report. RN #2 also stated that she applied Sensicare from the treatment cart to Resident #2's buttocks, because it was late at night and she did not want to fax an order to pharmacy and have to wait.</p> <p>Review of Resident #2's Nurse's Notes, from 01/17/13 through 01/22/13, revealed there were</p>	F 282		
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F 282	<p>Continued From page 11</p> <p>no notes in place addressing the assessment finding on 01/17/13 prior to the skin assessment on 01/22/13. There was no documented evidence, of any Physician or Family notifications.</p> <p>Review of Resident #2's Treatment Administration Record (TAR) and Medication Administration Record (MAR) for 01/01/13 through 01/31/13, revealed there were no orders in place to apply any type of protective barrier cream or treatments to prevent further skin breakdown of bilateral buttocks excoriation with open areas.</p> <p>Review of Resident #2's Physician's Orders, revealed there were no treatments ordered by the Physician for excoriation with open areas noted to bilateral buttocks on 01/17/13.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #6, on 01/22/13 at 12:10 PM, revealed he had been caring for Resident #2 for the last three (3) days on from 6:00 AM to 2:00 PM. He stated on 01/22/13, he had provided incontinence care to Resident #2 in the morning and noticed his/her buttocks to be red. He denied seeing open areas to Resident #2's buttocks prior the skin assessment on 01/22/13. He stated he applied Sencicare to Resident #2's buttocks daily, but was unsure if there was a Physician's Order for the cream. SRNA #6 did not know how long he had been applying the cream to Resident #2, but stated the nurses kept the Sencicare cream in the treatment cart, and would give him a cup to use on Resident #2. In addition, he did not know how the application of Sencicare barrier cream was being documented.</p> <p>Interview with SRNA #5, on 01/22/13 at 2:20 PM,</p>	F 282		
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F 282	<p>Continued From page 12</p> <p>revealed he had cared for Resident #2 on 01/21/13. He reported the last time he provided Incontinence care to Resident #2 was on 01/21/13 at around 9:30 PM. He stated during this time, he did not notice any open areas, but stated Resident #2's bilateral buttocks had red areas present. SRNA #5 thought the nurses had a treatment in place for those areas, so he did not notify anyone of the redness. He denied having applied Sencicare or any other creams during Incontinence care to Resident #2. He stated the nurses applied all treatment creams as a preventative measure.</p> <p>Interview with SRNA #4, on 01/22/13 at 3:20 PM, revealed she had cared for Resident #2 on 01/21/13 during second shift. She stated Resident #2's buttocks was red with irritation bilaterally during care on 01/21/13, but she denied having noted any open areas. She believed the nurses were applying Sencicare as a treatment for the redness. Therefore, she did not notify the nurses of Resident #2's skin condition.</p> <p>Interview, on 01/23/13 at 3:45 PM, with SRNA #2 revealed she had provided care to Resident #2 on 01/21/13 during night shift. She stated she did check Resident #2 for bowel incontinence and had noted Resident #2's buttocks to be red, but did not notify the nurse. SRNA #2 stated this was "usual" for Resident #2 and "sometimes" she would apply Sencicare to the red areas. She denied noting any open areas during care on 01/21/13. SRNA #2 further stated she believed a Physician's Order had to be present to apply the Sencicare, but she unsure if Resident #2 had an order to apply Sencicare. SRNA #2 stated the cream was obtained through the nurses from the</p>	F 282		
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F 282	<p>Continued From page 13 treatment cart.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 01/23/13 at 11:15 AM, revealed she had cared for Resident #2 on 01/21/13 during day shift. She reported she was the nurse responsible for administering Resident #2's medications and treatments on 01/21/13. She did not assess Resident #2's buttocks on 01/21/13. She stated she was unaware of reddened areas or open areas to Resident #2's buttocks. LPN #2 further stated she was unsure if Resident #2 had an order for Sensicare, but stated applying of Sensicare did require an Order from the Physician. In addition, she was unsure if Resident #2 was receiving Sensicare or any other treatments related to the bilateral buttock excoriation.</p> <p>Interview, on 01/23/13 at 3:20 PM, with LPN #1, revealed she had cared for Resident #2 on 01/21/13 during second shift. LPN #1 stated she was not aware of any open areas to Resident #2's buttocks. LPN #1 did state Resident #2's buttocks was usually red from him/her lying on it, but she did not feel Sensicare needed to be administered. She denied having notified the Physician of the reddened area to Resident #2's buttocks. However, LPN #1 stated Sensicare did require a Physician's Order and that it was kept in the treatment cart, labeled from pharmacy. In addition, she stated if skin breakdown was noted the Physician would need to be notified.</p> <p>Observation of Resident #2's skin assessment performed by RN #3, on 01/22/13 at 10:05 AM, revealed three unidentified Stage II areas to his/her buttocks. Resident #2 had a right buttock</p>	F 282		
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F 282	<p>Continued From page 14</p> <p>Stage II area measuring 3 millimeters (mm) in length x 0.8 mm in width, a right inner buttock Stage II area measuring 0.8 mm in length x 0.5 mm in width, and a left inner buttock Stage II measuring 0.4 mm in length x 0.4 mm in width. Interview during the skin assessment RN #3 who was performing the skin assessment, revealed she was not aware of these areas prior to the skin assessment. The Assistant Director of Nursing (ADON) was also present during the skin assessment and stated she conducts measurements of Resident wounds on a weekly basis and was not aware of any open areas on Resident #2's buttocks prior to the skin assessment on 01/22/13. Both nurses stated, the Physician would need to be contacted for treatment orders.</p> <p>Interview with the ADON, on 01/24/13 at 2:00 PM, revealed she oversaw the wound care program. As part of this, she reported that she assesses documented wounds weekly and makes changes to treatment plans as needed. The ADON stated her expectation is for staff to inform her when new areas are found. The ADON reported she is normally informed of new skin areas by reviewing a copy of the Physician's Order for treatment of that area. Additionally, she reported all new orders are reviewed by her daily. Although, she did not have an order for any treatment for the excoriation to Resident #2's buttocks and she stated RN #2 should have obtained an Physicians order on 01/17/13 when the excoriation was noted.</p> <p>Interview, on 01/24/13 at 1:30 PM, with the Director of Nursing (DON), revealed RN #2 should have notified the day shift nurse of the</p>	F 282		
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F 282	Continued From page 15 change in skin condition for Resident #2. The DON stated her expectation was for staff to contact the Physician after 6:00 AM, unless an emergency. The DON further stated this change in skin condition should be documented in the nurse's notes and on the twenty-four hour report. Additionally, the DON stated the care plan is monitored for implementation by the charge nurses. She also reported nurses are to look at skin during skin assessments and treatments. Also, the DON stated SRNAs should look at skin during care and report any changes to the nurses immediately.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. 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 ensure appropriate treatment and services to promote healing and prevent new pressure sores for one (1) of sixteen (16) sampled residents (Resident #2). Facility staff failed to ensure treatment orders were obtained on 01/17/13 when Resident #2 was noted with excoriation and small scattered	F 314	It was and is on the day of survey the policy at Oakmont Manor to ensure appropriate treatment and services to promote healing and prevent new pressure sores. Resident #2's plan of care was modified on 1/22/13 to reflect changes in condition.	

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F 314 Continued From page 16
open areas to the buttocks. Resident #2's skin assessment observed by a surveyor on 01/22/13, revealed three (3) unidentified Stage II pressure sores to the buttocks.

The findings include:

Review of the facility's policy titled, "Wound Care Policy and Procedure", undated, revealed the purpose of the policy was to ensure adequate care and services to promote the prevention of pressure ulcer development, promote healing of pressure ulcers that were present, and to prevent the development of additional pressure ulcers. Under the pressure ulcer prevention section, the policy stated all residents were to receive a skin audit weekly to identify any new areas of concern. An additional section, titled Pressure Ulcer Management stated based on assessment findings, a care plan would be developed with preventions implemented, as well as a treatment plan with on-going documented evaluations.

Review of the facility's Wound Formulary, no date, revealed the Convatec Algorithms Program was the formulary used by the facility to treat wounds.

Review of Resident #2's medical record revealed the facility admitted the resident from the hospital on 11/21/12 with diagnoses which included Acute Renal Failure, Sepsis, Urinary Tract Infection, Diabetes Melitis Type II, Stage II Decubitus, Severe Debility, Degenerative Disc Disease, and Chronic Lower Back Pain.

Review of the Admission Minimum Data Set (MDS) Assessment for Resident #2, dated

F 314 All residents had head to toe assessments completed by either an LPN or RN on 1/23/13 and 1/24/13 to ensure that there was no significant change in residents' condition that needed to be reported to the physician. This audit was reviewed by the DON and the ADON on 1/24/13.

The DON, ADON, and QA nurse review all daily shift reports and physician's orders to ensure the resident's physician has been notified of any need to alter treatment significantly.

An in-service was conducted on 1/22/13 to licensed nursing staff, CMTs and SRNAs by the ADON regarding notifying charge nurse of any changes in resident condition and that daily care and documentation must be consistent with the plan of care.

As part of the facility's ongoing Quality Assurance Program the ADON and/or QA and weekend supervisor nurse will review six weekly head to toe assessments the following day to ensure any significant change in needs of the resident was reported to the MD.

ADON will audit 10% of dressing changes weekly to ensure proper plan of care.

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F 314 Continued From page 17
11/28/12, revealed a Brief Interview for Mental Status (BIMS) score of fifteen (15), indicating the resident was cognitively intact. Further review revealed the facility assessed Resident #2 as requiring extensive assistance of two (2) persons for bed mobility, transfers, toilet use, personal hygiene, and bathing. In section, H (Bowel and Bladder) of the MDS It was indicated that Resident #2 had an indwelling urinary catheter, but was always incontinent of bowel. In section, M (Skin Conditions) revealed Resident #2 was at risk for pressure ulcer development.

Review of the current Comprehensive Plan of Care, onset 11/29/12, revealed Resident #2 was at risk of impaired skin integrity related to history of healed areas, being bedridden, and decreased mobility. The goal of the plan of care stated the resident will have no further preventable skin breakdown. Interventions included nursing staff was to monitor for skin impairment during care and to monitor for any indication of skin breakdown during weekly skin assessments.

Review of the Braden Scale for Predicting Pressure Sore Risk, dated 12/12/12, revealed Resident #2 scored a fifteen (15) which indicated he/she was at high risk for pressure sores.

Review of a Weekly Nurse's Notes, dated 01/17/13, revealed a note indicating Resident #2 had bilateral buttocks excoriation with scattered open areas. The note continued on to state the areas looked like sheering. At the end of the note the word Sencicare was written, but no further information was given in regards to the excoriation and/or treatment. This assessment was signed by Registered Nurse (RN) #2.

F 314 The results of the audit will be reviewed by the Quality Assurance Committee on a monthly basis for six months to determine compliance.

1/25/13

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F 314	<p>Continued From page 18</p> <p>Interview with Registered Nurse (RN) #2, on 01/23/13 at 4:00 PM, revealed she had completed the weekly skin assessment on Resident #2 on 01/17/13. She stated at the time of the skin assessment she noted excoriation and redness with tiny open areas to buttocks, but believed the areas to be from shearing. She stated the areas were pinpoint and so she did not measure them. RN #2 stated she did not call the Physician because it was at night when the skin assessment was completed. She had planned on reporting the change in skin condition to the day shift nurse, so the day shift nurse could call the Physician for a treatment order. However, she admitted that she failed to communicate the skin change during report. She also stated, she forgot to document the findings on the shift report. Yet, she did state that she applied Sencicare from the treatment cart to Resident #2, because it was late at night and she did not want to fax an order to pharmacy and wait.</p> <p>Review of the Nurses Notes, from 01/17/13 through 01/22/13, revealed there were no notes addressing the assessment finding on 01/17/13 prior to the skin assessment on 01/22/13. The notes did not indicate, any treatment plans as well as any Physician or Family Notifications.</p> <p>Review of the Treatment Administration Record and Medication Administration Record, for 01/01/13 through 01/31/13, revealed there were no new or previous treatments in place or implemented on 01/17/13 to apply any type of protective barrier cream or other intervention to bilateral buttocks for excoriation or open areas identified on 01/17/13.</p>	F 314		
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F 314 Continued From page 19

Review of the Physician's Orders for 01/01/13 through 01/31/13, revealed there were no treatments ordered for the excoriation with open areas noted to bilateral buttocks on 01/17/13.

Interview with State Registered Nursing Assistant (SRNA) #6, on 01/22/13 at 12:10 PM, revealed he had been caring for Resident #2 for the last three (3) days on day shift. He stated on the day of the interview, he had provided incontinence care to Resident #2 in the AM and noticed his/her buttocks to be red with Sensicare ointment in place. He denied noting open areas to Resident #2's buttocks. He stated he applied Sensicare protective ointment to Resident #2 during incontinence care, but was unsure if there was a Physician's Order for the cream. He also, did not know how long he had been applying the cream to Resident #2, but stated the nurses kept the Sensicare cream in the treatment cart, and would give him a cup to use on Resident #2. In addition, he did not know if the Sensicare barrier cream was being documented on the Treatment Administration Record (TAR) or Medication Administration Record (MAR).

Interview with Licensed Practical Nurse (LPN) #2, on 01/23/13 at 11:15 AM, revealed she had cared for Resident #2 on 01/21/13 from 6:00 AM to 2:00 PM. She reported she was the nurse responsible for administering Resident #2's treatments and medications on that day. She stated she was unaware of reddened areas or open areas to Resident #2's buttocks. LPN #2 further stated she was unsure if Resident #2 had an order for Sensicare barrier cream, but stated application of Sensicare did require a Physician's Order. In

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F 314 Continued From page 20
addition, she was unsure if Resident #2 was receiving Sensicare.

F 314

Interview with SRNA #5, on 01/22/13 at 2:20 PM, revealed he had cared for Resident #2 on 01/21/13 from 2:00 PM to 10:00 PM. He reported the last time he had checked and changed Resident #2 for Incontinence care was on 01/21/13 at around 9:30 PM. He stated during that time, he did not note any open areas, but stated Resident #2's bilateral buttocks had red areas present. However, he thought the nurses had a treatment in place for those areas. He stated he had not applied Sensicare during incontinence care to Resident #2, but stated the nurses applied the Sensicare cream as a preventative measure.

Interview with SRNA #4, on 01/22/13 at 3:20 PM, revealed she had cared for Resident #2 on 01/21/13 from 2:00 PM to 10:00 PM. She stated Resident #2's buttocks was red with irritation on both sides during care on 01/21/13, but she had not noted any open areas. She believed the nurses were applying Sensicare as a treatment for the irritation.

Interview with LPN #1, on 01/23/13 at 3:20 PM, revealed she had cared for Resident #2 on 01/21/13 from 2:00 PM to 10:00 PM. LPN #1 stated she was not aware of any open areas to Resident #2's buttocks. LPN #1 did state Resident #2's buttocks stayed red from him/her lying on it, but she did not feel Sensicare needed to be applied. Also, LPN #1 stated Sensicare did require a Physician's Order and that it was kept in the treatment cart, labeled from pharmacy. Furthermore, she stated if skin breakdown is

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NAME OF PROVIDER OR SUPPLIER OAKMONT MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1108 GRANDVIEW DRIVE FLATWOODS, KY 41139
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F 314	<p>Continued From page 21</p> <p>noted, it would have to be documented, measured, an incident report would be completed, and the Physician would be notified to obtain a treatment.</p> <p>Interview with SRNA #2, on 01/23/13 at 3:45 PM, revealed she had provided care to Resident #2 on 01/21/13, from 10:00 PM to 6:00 AM. She stated she did check Resident #2 for bowel incontinence during her last shift and had noted Resident #2's buttocks to be red, but did not notify the nurse. She stated this was "usual" for Resident #2 and "sometimes" she would apply Sencicare to the red areas. She stated she did not note any open areas on 01/21/13 to Resident #2's buttocks. SRNA #2 further stated she thought a Physician's Order had to be present to apply the Sencicare, but was unsure if Resident #2 had an order. She reported that she obtained the Sencicare from the nurses.</p> <p>Observation of a skin assessment performed by RN #3, on 01/22/13 at 10:05 AM, revealed three unidentified Stage II areas to Resident #2's buttocks. Resident #2 had a right buttock Stage II area measuring 3 millimeters (mm) in length x 0.8 mm in width, a right inner buttock Stage II area measuring 0.8 mm in length x 0.5 mm in width, and a left inner buttock Stage II measuring 0.4 mm in length x 0.4 mm in width. Interview at the time with RN #3 who was conducting the skin assessment, revealed she was not aware of these areas prior to the skin assessment. The Assistant Director of Nursing (ADON) was also present during the skin assessment and stated she conducted measurements of resident wounds and was not aware of any open areas on Resident #2's buttocks prior to the skin</p>	F 314		
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F 314 Continued From page 22 assessment on 01/22/13.

Interview, on 01/24/13 at 2:00 PM, with the ADON revealed she led the wound care program. As part of her duties in this role, she reported that she assessed documented wounds once weekly and changed treatment orders as indicated. The ADON stated her expectation was for staff to inform her when new areas were found. The ADON reported she was normally informed of new skin areas by receiving a copy of the Physician's Order for treatment of the skin area. Additionally, she reported she reviewed all new orders on a daily basis. Although, she did not have an order for any treatment for the excoriation to Resident #2's buttocks, she stated RN #2 should have obtained a Physician's order for treatment on 01/17/13 when the excoriation was noted.

F 314

Interview with the Director of Nursing (DON), on 01/24/13 at 1:30 PM, revealed RN #2 should have notified the day shift nurse during report of the change in skin condition for Resident #2. Thus, the day shift nurse would have contacted the Physician after 6:00 AM. She further stated this change in skin condition should be documented in the nurse's notes and on the twenty-four hour report sheet. In addition, the DON stated treatments do require a Physician's Order and to ensure the treatment was followed the DON stated it is best to get a Physician's Order for treatments. Furthermore, the DON stated Resident #2 should have been started on Sencicare as soon as excoriation was noted on 01/17/13. The DON further stated Licensed nurses are to apply all ointments.

F 323 483.25(h) FREE OF ACCIDENT

F 323

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F 323
SS=D

Continued From page 23
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 observation, interview, review of facility's Material Safety Data Sheet (MSDS), and review of facility's policy, it was determined the facility failed to ensure an environment free of accident hazards. The facility failed to ensure hazardous chemicals were locked up, out of the residents' reach.

The findings include:
Review of facility's policy, "Medication Storage in the Facility", revealed potentially harmful substances (such as urine test reagent tablets, household poisons, cleaning supplies, disinfectants) should be clearly identified and stored in a locked area separately from medications.

Observation during the initial tour of facility, on 01/21/13, at 4:00 PM, revealed a bottle of Virex 256 (a Germicidal cleaner and deodorant) on top of chest in Room A-4, Bed Side B. Review of facility's MSDS sheet for Virex 256 revealed contact with germicidal cleaner and deodorant

F 325

It was and is on the day of survey the policy at Oakmont Manor to ensure that the residents' environment remains free of accident hazards.

Resident in room A4b had no adverse effect from material found behind TV.

There was no adverse effect to any residents due to the practice identified. The housekeeping supervisor observed all resident care areas for any accident hazard related to alleged practice on 1/21/13.

All staff were in-serviced on 2/8/13 by QA nurse regarding properly labeling and storage of potentially harmful substances.

An audit will be conducted weekly by housekeeping supervisor to assure that all potentially harmful substances are properly labeled and stored.

The audits will be reviewed monthly in the Quality Assurance committee to ensure compliance.

2/9/13

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F 323 Continued From page 24
could cause mild to moderate irritation and the manufacture recommendation was to seek medical attention.

Interview with Licensed Practical Nurse (LPN) #4, on 01/21/13 at 4:05 PM, revealed Virex 256 was a hazardous chemical and would have been a safety issue if a resident was to come into contact with the germicidal cleaner and deodorant product.

Interview with Director of Housekeeping, on 01/24/13 at 12:50 PM, revealed Virex 256 was stored in locked housekeeping closet and should have been kept away from residents when not in use. The Director of Housekeeping further stated Virex 256 was provided to nursing staff to clean the bathing areas and should have been stored in locked cabinet when not in use.

Interview with Director of Nursing (DON), on 01/24/13 at 1:00 PM, revealed Virex 256 should have been stored in locked cabinet in the shower room and not in a resident's room when not in use.

F 323

F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS
SS=E

F 431

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be

It was and is on the day of survey the policy at Oakmont Manor to ensure all drugs and biological are stored in locked compartments and ensure that expired medications are not available for resident use.

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F 431	<p>Continued From page 25</p> <p>labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility's policy, it was determined the facility failed to ensure all drugs and biologicals were stored in locked compartments and failed to ensure expired medications were not available for resident use.</p> <p>Observation of the medication refrigerator in the North Hall Medication Room revealed a bottle of Levemir Insulin with an open date of 11/15/13. Further observation revealed crash carts in the unlocked general bathrooms on the North and</p>	F 431	<p>There were no adverse effects to any residents related to the identified practice.</p> <p>Ammonia inhalants were removed from crash cart and placed on nurses' med cart on 1/25/13 by the DON. The Levemir was replaced on 1/24/13.</p> <p>An in-service was conducted by DON to all licensed nursing staff regarding properly storing drugs/locked compartments and biologicals and ensuring that expired medications are not available for resident use.</p> <p>An audit will be conducted weekly by CMT to ensure that drugs and biological are properly stored/locked compartments and expired medications are not available for resident use. This audit will be reviewed weekly by the DON.</p> <p>The audits will be reviewed by the Quality Assurance committee monthly for six months to ensure compliance.</p>	1/26/13
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F 431 Continued From page 26
South halls contained vials of Ammonia Inhalant which were unsecured on the crash carts and accessible to residents.

The findings include:

Review of the facility's "Medication Storage in the Facility Policy", undated, revealed only licensed nurses, pharmacy personnel and those lawfully authorized to administer medications were allowed access to medications. Medication rooms, carts and medication supplies were locked or attended by persons with authorized access. Outdated, contaminated, or deteriorated medications and those in containers that were cracked, soiled, or without secure closures were immediately removed from stock, disposed of according to procedure to medication disposal and reordered from pharmacy.

Observation of the North Hall medication room refrigerator, on 01/24/13 at 11:30 AM, revealed a bottle of Levemir 100 Units/ml with an open date of 11/15/12. Interview with Licensed Practical Nurse (LPN) #1 at the time of the observation revealed the insulin was good for twenty-eight (28) days after opening. She stated there was no one specifically assigned to check for expired medications and all nurses should check for expired medications when assigned to the medication cart. Review of the information the facility had faxed from the pharmacy, faxed 01/24/13, revealed refrigerated insulin vials should be discarded forty-two (42) days after initial use and unrefrigerated vials should be discarded forty-two (42) days after they were first kept out of the refrigerator.

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F 431 Continued From page 27
Further observation, on 01/24/13 from 1:00 PM to 1:15 PM, revealed the North Hall Crash Cart was stored in the unlocked general bathroom on the North Hall. There were four (4) vials of Ammonia Inhalant on a shelf on the cart. Also the South Hall Crash Cart was stored in the unlocked general bathroom on the South Hall. There were two (2) vials of Ammonia Inhalant on a shelf on the cart. Although there was heavy net covers over the carts, there was no locked storage areas on the carts and the Ammonia Inhalants were not locked up, allowing access to residents.

Interview, on 01/24/13 at 1:30PM, with the Director of Nursing (DON) revealed pharmacy checked the medication room monthly for expired medications. She further stated the nurses should be checking the dates of the Insulin prior to use. Further interview with the DON revealed the nurses on the night shift checked the crash carts nightly. She stated she was aware the Ammonia Inhalants were on the unlocked crash cart and there were no wandering residents at that time. She further stated a resident would have to remove the cover to the crash carts to gain access to the Ammonia Inhalants.

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 -

F 431

F 441 It was and is on the day of survey the policy at Oakmont Manor to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection.

There was no adverse effect to unsampled resident A from the identified practice. The employee was educated by the QA nurse on 1/22/13 regarding infection control and hand washing.

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F 441 Continued From page 28

(1) Investigates, controls, and prevents infections in the facility.

(2) Decides what procedures, such as isolation, should be applied to an individual resident; and

(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection

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

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

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

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of the facility's policy, it was determined the facility failed to establish and maintain an effective infection control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection. Observations during meal service revealed a staff member picked up

F 441 No other residents were identified to have any adverse effect from identified practice as DON monitors daily shift reports.

An audit will be completed by ADON and/or QA nurse two times weekly to ensure proper infection control techniques are being utilized by staff.

The abovementioned audits will be reviewed by the Quality Assurance committee meeting monthly for six months to ensure compliance.

1/29/13

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F 441 Continued From page 29
a fall mat from the floor, then began tray set-up without washing her hands.

The findings include:

Review of the facility's policy titled, "Hand Hygiene", no date, revealed the purpose of the policy was to decrease the risk of transmission of infection by appropriate hand hygiene. The policy stated hand washing should occur when soiled or contaminated, as well as before eating.

Observation, on 01/21/13 at 5:00 PM, revealed State Registered Nursing Assistant (SRNA) #7 sanitized her hands then entered Unsampld Resident A's room. Upon entering the room, she sat the dinner tray on the bed side table, then she began moving the resident's fall mats from the floor to the other side of the room. After touching the mats, which were picked up off the floor, SRNA #7 began tray set-up for Unsampld Resident A. SRNA #7, did not wash her hands before touching Unsampld Resident A's eating utensils and drinking cups.

Interview with SRNA #7, on 01/21/13 at 5:10 PM, revealed she forgot to wash her hands after touching the floor mats in Unsampld Resident A's room. SRNA #7 reported, she realized this was not good infection control practices and further stated she should have washed her hands prior to tray set-up for Unsampld Resident A.

Interview with the Director of Nursing (DON), on 01/23/12 at 10:00 AM, revealed staff received training annually and as needed related to infection control practices. Furthermore, she stated SRNA #7 should have washed her hands

F 441

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F 441 Continued From page 30
after touching the fall mats that were on the floor, prior to providing tray set-up for Unsampled Resident A.

Interview with the Infection Control Nurse, on 01/23/13 at 4:30 PM, revealed SRNA #7 should have washed her hands prior to conducting dinner meal tray set-up for Unsampled Resident A. Furthermore, she stated the facility performed care audits to monitor infection control practices. Lastly, the Infection Control Nurse stated the facility conducted an annual in-service on infection control and hand washing.

F 441

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Plan approval: 1978</p> <p>Facility type: Skilled Nursing Facility/Nursing Facility</p> <p>Smoke Compartments: Four (4)</p> <p>Type of structure: One (1) story with basement Type V (111)</p> <p>Fire Alarm: Complete Fire Alarm</p> <p>Sprinkler System: Complete sprinkler system (Dry)</p> <p>Generator: One (Type 2) Natural Gas installed 2009</p> <p>A standard Life Safety Code survey was conducted on 01/24/2013. Oakmont Manor was found to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was ninety-six (96). The facility is licensed for one hundred three (103).</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shanna Curran TITLE: Administrator (X6) DATE: 2-11-13

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.