

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

PRINTED: 07/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185390	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/06/2011
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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7380 WOODSPPOINT DRIVE FLORENCE, KY 41042
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS An abbreviated survey investigating KY16170 and KY16543 was initiated on 07/06/11 and concluded on 07/06/11. KY16170 was substantiated with deficiencies cited at 483.65 Infection Control, 483.15 Quality of Life, 483.25 Quality of Care and 483.60 Pharmacy Services with the highest scope/severity of an "E". KY16543 was found to be unsubstantiated.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, BridgePoint Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	8/5/11
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, resident record review and the facility policy on Care and Services, the facility failed to promote care for the residents in a manner and environment that maintains or enhances each resident's dignity for four (4) of six (6) sampled residents, Residents #1, #2, #5 and #6 and Unsampld residents F, H, and V. Resident #1 and #2 were not lathed regularly. Resident #6 and unsampled Residents G, M, N, Q, S, T, and V, both men and women, were in need of a shave to their facial hair. Unsampld Resident "V" was fed by a Certified Nursing Assistant (CNA) at the nurses station while she stood. Unsampld Resident "P" did not receive a shampoo for three weeks. In addition, the facility staff failed to knock on doors before entering resident rooms. Resident #6 was observed partially exposed during the breakfast	F 241		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>[Signature]</i>	(X6) DATE 7/21/11
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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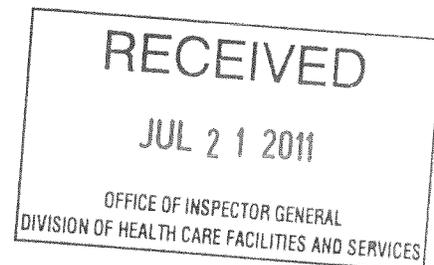
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/06/2011
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F 241	Continued From page 1 meal. Resident "F" was observed with nasal drainage. Resident "H" was observed to wear soiled clothing. The findings include: Review of the facility's policy on Care and Services (01/08) revealed "It is the policy of the center to provide residents with the necessary care and services to maintain his/her highest level of practicable functioning in an environment that enhances each resident's quality of life in the scope of a long term care facility." 1. Record review of the current Minimum Data Set (MDS) assessment for Resident #1 dated 06/11/11 revealed the facility assessed the resident as being totally dependent upon staff for bathing. Record review of the CNA Resident Functional Performance Record for Resident #1 revealed for the month of June 2011 the resident was given a shower twice. The July 2011 record through July 5, 2011 revealed there had not been a shower or tub bath provided. 2. Record review of the current MDS for Resident #2 dated 06/13/11 revealed the facility assessed the resident as needing physical help in part of the bathing activity. It further assessed the resident to need extensive assist with toilet use. The facility assessed Resident #2 as interviewable. Record review of the CNA Resident Functional Performance Record for Resident #2 revealed for 06/06/11 through 06/30/11, the resident was given	F 241	F241 Resident #1 was given a shower on 7-6-11 by a certified nursing assistant. Resident #2 was given a shower and oral care on 7-6-11 by a certified nursing assistant. Resident #6 and unsampled residents G, M, N, Q, S, T and V were shaved on 7-6-11 by a certified nursing assistant. Unsampled resident P was given a shower with hair washed on 7-6-11 by a certified nursing assistant. Unsampled resident F had face cleaned by a certified nursing assistant on 7-6-11. The clothing of unsampled resident H was changed on 7-6-11 by a certified nursing assistant. Resident #5 was bathed and dressed in clean clothes on 7-6-11 by a certified nursing assistant. 2. The Director of Nursing completed rounds of the center on 7-14-11 to identify residents in need of grooming/hygiene care, staff knocking on doors and no staff standing while feeding residents. Any resident identified was provided with a shower, grooming, shaving, and dressing as appropriate. Staff re-education was completed immediately as indicated.	8/5/11
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F 241 Continued From page 2
a shower once. The July 2011 record through July 5, 2011 revealed the resident was provided a shower one time.

Review of the care plan for Resident #2 revealed a "Focus" area of Urinary Tract Infection related to: poor hygiene. However, there were no interventions for the staff, to provide the resident with a bath or shower. There were no interventions to assist with toileting of the resident's needed hygiene.

Interview, on 07/06/11 at 10:55AM, with Resident #2 revealed he/she did not receive a regular shower. If the staff get busy with other things, the shower was not given. The resident also stated his/her teeth are not cleaned regularly.

3. Observation, on 07/06/11 during the survey, revealed the following individuals, both men and women, with facial hair in need of a shave: Resident #6 and Unsampled Residents G, M, N, Q, S, T and V.

Observation, on 07/06/11 at 8:35AM, revealed CNA #8 standing while feeding Unsampled Resident V at the nurses station.

Observation, on 07/06/11 at 9:40AM, revealed Housekeeper #1 walking into room 306, occupied by a resident, without knocking.

Observation, on 07/06/11 at 8:50AM, revealed CNA #8 walking into rooms 101 and 102, occupied by residents, without knocking.

Observation, on 07/06/11 at 9:10AM, revealed Licensed Practical Nurse (LPN) #1 walking into

F 241 3. The Administrator and Director of Nursing were re-educated on 7-6-11 by the Regional Director of Clinical Operations on completing facility rounds to identify grooming and hygiene needs and resident dignity, to include knocking on doors and staff sitting while feeding a resident.

The nursing staff have been re-educated to the Care and Services procedure to provide residents with hygiene and grooming in a manner and in an environment that maintains or enhances each resident's dignity and respect of his or her individuality by the Assistant Director of Nursing and Unit Managers as of 8-4-11.

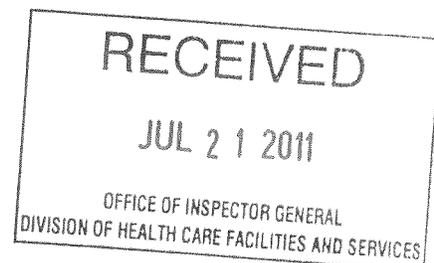
The housekeeping and nursing staff have been re-educated to maintain resident dignity by knocking on resident doors before entering and assisting residents with meals by staff who are at eye level with the residents by the Director of Nursing, Assistant Director of Nursing and Unit Managers as of 8-4-11.

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F 241	Continued From page 3 room 320, occupied by a resident, without knocking. 4. Interview, on 07/06/11 at 9:16AM with Unsampld Resident P revealed he/she had not had his/her hair washed in two to three weeks. Interview, on 07/06/11 at 3:10PM with CNA #4 and CNA #5 revealed the CNA's are trained to sit with the resident while feeding, to maintain eye contact with the resident and to knock on doors before entering a resident room. Interview, on 07/06/11 at 1:45PM, with CNA #2 revealed residents are to receive their bath according to the bath schedule. Showers and baths are not always given due to the number of call lights that are going off and need to be answered and "not enough staff". Interview, on 07/06/11 at 1:15PM, with LPN #2 revealed the charge nurse is responsible to assure the residents have been given their bath/shower as scheduled. The CNA's fill out the Activities of Daily Living (ADL) sheets and the nurse should be monitoring those sheets. Showers do not occur when there are a lot of sick residents because they take up so much of the staff time, then sometimes the showers/baths are not given if it is a "bad day". 5. Observation of Unsampld Resident F, on 07/06/11 at 8:55AM, revealed the resident was seated in a wheelchair in the hall. The resident's head was leaning forward and clear drainage was running out of the nose onto the resident's chest.	F 241	4. The Administrator and Director of Nursing or Weekend Manager will complete rounds of the center daily times 2 weeks and then weekly times 10 weeks to ensure that Care and Services are being provided. The rounds will include dressing, grooming and hygiene of residents, staff knocking on doors prior to entering room and any staff member sitting at eye level with resident they are assisting with feeding. A summary of findings will be submitted by the Director of Nursing to the Performance Improvement Committee for review and further recommendations.		



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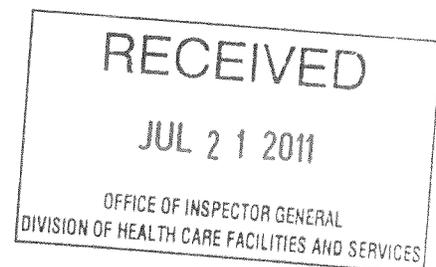
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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042
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F 241	<p>Continued From page 4</p> <p>A staff member walked by the resident and commented that there was drainage present; however, the staff member went to talk with another resident, and then went into another resident's room without addressing the drainage. It was five (5) minutes elapsed before the resident was able to have his/her nose wiped.</p> <p>6. Observation of Unsampled Resident H, on 07/06/11 at 9:15AM, revealed the resident walking up and down the 200 hallway wearing a cardigan sweater with a large area of dark dried food.</p> <p>7. Observation of Resident #5, on 07/06/11 at 9:20AM, revealed the resident sitting up in a wheelchair at the bedside wearing a gown loosely tied in the back and the left shoulder was exposed. The resident had no socks or shoes on and the door to the room was fully open. The resident was eating breakfast independently and food was spilled down the resident's clothing, feet and onto the floor.</p> <p>8. Observation of CNAs #6 and #7, on 07/06/11 at 4:15PM, revealed they entered resident rooms on the 300 Hall without knocking on doors.</p> <p>Interviews with CNA #6 and #7, on 07/06/11 at 4:20PM, revealed they were aware you could not enter a resident room without knocking. Both CNAs stated residents needed privacy. CNA #6 stated baths and grooming were completed when scheduled; however, things get too busy at times. She indicated that women were not shaved and men were shaved several times a week. Residents' clothing was to be changed when soiled.</p>	F 241		
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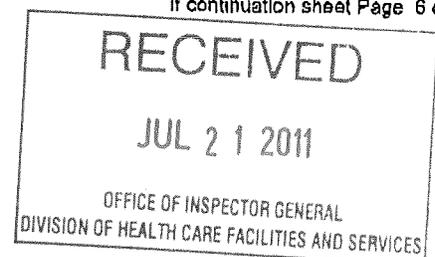
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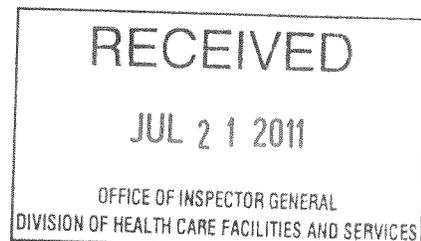
F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy for Infection Control it was determined the facility failed to provide a sanitary environment for residents. A Housekeeper was observed mopping residents' rooms with dirty mop water.</p> <p>The findings include:</p> <p>Review of the facility's Housekeeping Infection Control Procedures, dated 01/01/00, revealed mop water was to be changed often. Failure to change the water often resulted in clotting and sedimentation which lessened the effectiveness of the germicide.</p> <p>Observation of Housekeeper #2, on 07/06/11 at 11:15Am, in the hallway outside Room 301 revealed her removing a mop from the bucket on the housekeeping cart. The mop was placed in the wringer then taken into Room 301 and used to mop the floor. The water was black in color and totally opaque. She replaced the mop into the water and continued to clean.</p> <p>Interview with Housekeeper #2, on 07/16/11 at 11:30AM, revealed the mop water in the bucket</p>	F 253	<p>F253</p> <ol style="list-style-type: none"> Room 301 was re-mopped with clean water on 7-6-11 by a housekeeper. The Housekeeping Supervisor made rounds of all housekeeping mop buckets on 7-6-11 to ensure clean water is being used. The housekeeping staff have been re-educated to the housekeeping infection control procedures regarding changing mop water as of 8-4-11 by the Housekeeping Supervisor. The Administrator, Housekeeping Supervisor or Weekend Manager will audit mop water cleanliness daily times 2 weeks and then weekly times 10 weeks. Any identified issue will be corrected immediately. A summary of findings will be submitted by the Housekeeping Supervisor to the Performance Improvement Committee for review and further recommendations. 	8/5/11
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F 253	Continued From page 6 was not clean enough to be used to mop residents' rooms. She stated the water was changed every three (3) to four (4) rooms or more frequently if needed. She offered no reason for why the water had not been changed. She stated she received training when she started work six (6) months ago. Interview with the Housekeeping Supervisor, on 07/06/11 at 3:55PM, revealed the housekeeper had spent one (1) day of orientation with him and one (1) more day orienting with another housekeeper. He indicated the mop water was to be changed every four (4) to five (5) rooms or more frequently if the water became too soiled.	F 253		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, resident record review, interview and the facility policy on Care and Services, the facility failed to provide the necessary services of grooming, and personal and oral hygiene to three (3) out of six (6) sampled residents, Resident #1, #2 and #6. Resident #1 and #2 did not receive their scheduled bath/shower, and Resident #2 did not receive oral care. In addition, the facility failed to provide adequate grooming to Resident #6 and Unsampled Residents G, M, N, S, T, J and Q, as	F 312	F312 1. Residents #1, #2, and #6 in addition to unsampled residents G, M, N, S, T, U, and Q were given showers, and shaved as indicated on 7-6-11 by a certified nursing assistant. Unsampled resident P had hair washed on 7-6-11 by a certified nursing assistant. 2. The Director of Nursing completed rounds of the center on 7-14-11 to identify residents in need of grooming/hygiene care. Any resident identified was provided with a shower, grooming, and dressing as indicated.	8/5/11



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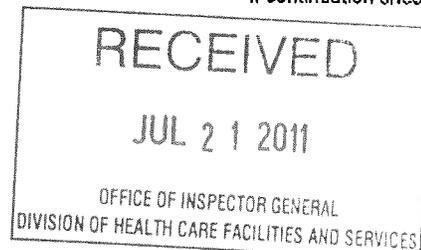
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F 312	<p>Continued From page 7</p> <p>evidenced by excessive facial hair in need of shaving.</p> <p>The findings include:</p> <p>Review of the facility's policy on Care and Services (01/08) revealed "It is the policy of the center to provide residents with the necessary care and services to maintain his/her highest level of practicable functioning in an environment that enhances each resident's quality of life in the scope of a long term care facility."</p> <p>1. Record review of the current Minimum Data Set (MDS) for Resident #1 dated 05/11/11 revealed the facility assessed the resident as totally dependent upon staff for bathing.</p> <p>Record review of the CNA Resident Functional Performance Record for Resident #1 revealed for the month of June 2011 the resident was given a shower twice. The July 2011 record through July 5, 2011 revealed there had not been a shower or tub bath.</p> <p>2. Record review of the current MDS for Resident #2 dated 06/13/11 revealed the facility assessed the resident as needing physical help in part of the bathing activity. The facility did assess Resident #2 as interviewable.</p> <p>Record review of the CNA Resident Functional Performance Record for Resident #2 revealed for 06/06/11 through 06/30/11, the resident was given a shower once. The July 2011 record through July 5, 2011 revealed the resident was given a shower once.</p>	F 312	<p>3. Nursing staff have been re-educated by the Director of Nursing Services, Assistant Director of Nursing Services and Unit Managers on providing necessary grooming, personal and oral hygiene on residents as of 8-4-11.</p> <p>4. The Administrator and Director of Nursing or Weekend Manager will complete rounds of the center daily times 2 weeks and then weekly times 10 weeks to ensure that Care and Services are being provided as appropriate. The rounds will include dressing, grooming and hygiene of residents. A summary of findings will be submitted by the Director of Nursing to the Performance Improvement Committee for review and further recommendations.</p>	
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F 312	<p>Continued From page 8</p> <p>Interview, on 07/06/11 at 10:55AM, with Resident #2 revealed he/she does not receive a regular shower. The resident stated his/her teeth are not cleaned regularly. It was stated if the staff get busy with other things, the shower is not given.</p> <p>3. Observation, on 07/06/11 during the survey, revealed the following individuals, both men and women, with facial hair in need of a shave: Resident #6 and Unsampld Residents G, N, M, Q, S, T and U.</p> <p>4. Interview, on 07/06/11 at 9:16AM, with Unsampld Resident P revealed he/she had not had his/her hair washed in two to three weeks.</p> <p>Interview, on 07/06/11 at 1:45PM, with CNA #2 revealed residents are to receive their baths according to the bath schedule. Showers and baths are not always given due to the number of call lights that are going off and need to be answered and "not enough staff".</p> <p>Interview, on 07/06/11 at 1:15PM, with LPN #2 revealed the charge nurse was responsible to assure the residents have been given their bath/shower as scheduled. The CNA's fill out the Activities of Daily Living (ADL) sheets and the nurse should be monitoring those sheets. It was further revealed, showers do not occur when there are a lot of sick residents because they take up so much of the staff time, then sometimes the showers/baths are not given if it is a "bad day".</p>	F 312		
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system</p>	F 431		

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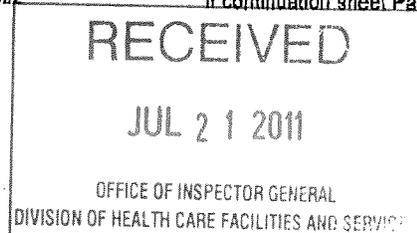
PRINTED: 07/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/06/2011
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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPOINT DRIVE FLORENCE, KY 41042
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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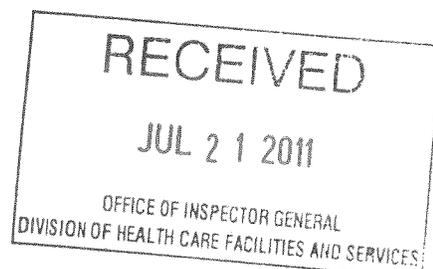
F 431	<p>Continued From page 9</p> <p>of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</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 and interview it was determined the facility failed to ensure medications were prepared and administered in a sanitary manner for two (2) of four (4) medication</p>	F 431	<p>F431</p> <p>1. The pill crushers on the medication carts for 200 and 300 halls were cleaned on 7-6-11 by the licensed nurse.</p> <p>2. The pill crushers on each medication cart were cleaned by the licensed nurses on 7-6-11.</p> <p>3. The licensed nursing staff will be re-educated to the Infection Control Guidelines with instruction provided on timeliness of cleaning the pill crushers by the Assistant Director of Nursing and Unit Managers as of 8-4-11.</p> <p>4. The Director of Nursing, Assistant Director of Nursing, Unit Manager or Weekend Supervisor will complete an audit of the cleanliness of pill crushers on each cart daily times 2 weeks and then weekly times 10 weeks. A summary of findings will be submitted by the Director of Nursing to the Performance Improvement Committee for review and further recommendations.</p>	8/5/11
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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042		
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F 431	<p>Continued From page 10</p> <p>carts. The pill crushers on the carts for the 200 and 300 Halls were heavily soiled.</p> <p>The findings include:</p> <ul style="list-style-type: none"> Review of the facility's Infection Control Guidelines for Care of Resident Care Equipment, undated, revealed no information on guidelines for cleaning the pill crushers. Observation of two (2) medication carts parked in the hallway on the 200 wing, on 07/06/11 at 10:40AM, revealed the pill crushers on the cart had a heavy black sticky build-up all around the edges and corners. In addition, there were dried dark colored spills present. Interview with Registered Nurse #1, on 07/06/11 at 4:00PM, revealed the pill crushers were not clean; however, she was unsure how they were to be cleaned, who cleaned them, or when they were to be cleaned. Interview with the Acting Director of Nursing, on 07/06/11 at 5:00PM, revealed they were to be cleaned by the nurse as needed. 	F 431		
F 441	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and Infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p>	F 441		



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F 441	<p>Continued From page 11</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review it was determined the facility failed to ensure infection control policies were implemented and followed by staff. Oxygen tubing was found draped on the floor; nasal cannulas were found on tables, wrapped around oxygen tanks and left uncovered. Face masks for the</p>	F 441	<p>F441</p> <p>1. Room 301 was mopped with a clean mop head and clean mop water on 7-6-11 by the housekeeper. The room for unsampled resident A was deep cleaned on 7-11-11 by a housekeeper. The oxygen cannulas, oxygen tubing, mini-nebulizer face masks, nebulizers and/or suction catheters were replaced and stored in plastic bags while not in use by the Unit Managers on 7-6-11 for Resident #3 and unsampled residents C, D, E, F, G, I, O and L. The pill crushers on the 200 and 300 hall cart were cleaned on 7-6-11 by a licensed nurse. The ice chest and ice scoop was cleaned on 7-6-11 by the dietary staff and then stored in a covered container when not in use.</p> <p>2. The Administrator and Housekeeping Supervisor completed rounds of the facility to include resident rooms on 7-18-11. Overbed tables in use in the center were cleaned by housekeeping staff on 7-7-</p>	8/5/11
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F 441 Continued From page 12

mini-nebulizers were uncovered and not in use. A suction catheter was found on a bedside table uncovered. An over the bed table was taken from a resident's room soiled and placed in the television area where residents were present. A wheelchair was found with food crumbs and flies were present. A housekeeper mopped a floor with heavily soiled water. Pill crushers on medication carts were soiled. The floor in Room 314-2 was covered with plastic bags some of which contained opened food and a slice of bread was found under the bed. The ice scoop or the ice cart was stored in an open bin.

The findings include:

1. Review of the facility's Procedures for Infection Control in Housekeeping, undated, revealed mop water should be changed often to prevent cloudiness and sedimentation decreasing the effectiveness of the germicide. Resident rooms would be cleaned daily to include all horizontal surfaces and bathrooms.

Observation of Housekeeper #2, on 7/06/11 at 11:15AM, in the hallway outside Room 301 revealed her removing a mop from the bucket on the housekeeping cart. The mop was placed in the wringer then taken into Room 301 and used to mop the floor. The water was black in color and totally opaque. She replaced the mop into the water and continued to clean.

Interview with Housekeeper #2, on 07/06/11 at 11:30PM, revealed the mop water and mop head were very dirty. She stated she had just changed the water three (3) rooms ago which was the facility policy. She stated the water should have

F 441

3 Floors in the center were swept and mopped on 7-7-11 with clean mop water by housekeeping staff. The Ombudsman was notified by Social Services and visited the resident in room 314-2 on 7-21-11 to assist the center with deep cleaning room 314-2 due to the residents continued refusals to cooperate with housekeeping staff and the resident's room was decluttered on 7-22-11 by the Social Services Director. Room 309-2 had clutter removed from her window sill and deep cleaned on 7-26-11 by a housekeeper. Rooms 102-2 and 321-2 were deep cleaned on 7-15-11 by a housekeeper. Rooms 302-1 and 306-2 were deep cleaned on 7-15-11 by a housekeeper. The family of residents in 319 were notified on 7-19-11 by Social Services to assist the center in removing clutter from the resident rooms.

The Director of Nursing and Unit Managers completed rounds of the facility including resident equipment. All nasal cannulas, oxygen tubing, suction catheters, and face masks for the mini-nebulizers in use for any resident in the facility were discarded and replaced on 7-6-11 and stored in a plastic bag. All pill crushers were cleaned on 7-6-11 by the licensed nurses. Each ice chest and ice scoop

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F 441 Continued From page 13
been changed sooner.

Interview with the Housekeeping Supervisor, on 07/06/11 at 3:55PM, revealed mop water was changed every four (4) to five (5) rooms at a maximum and if heavily soiled. He stated the water needed a change before heavily soiled.

2. Observation of Unsampled Resident A's room, on 07/06/11 at 9:20AM and 1:20PM, revealed empty used cups, partially empty coke cans and plastic utensils all around the sink. There was a slice of bread and numerous plastic bags were on the floor under the bed and boxes of crackers and other food items were stored on the floor. There were eight plastic bags with dolls and food stored on the floor. The shelves, AC unit, and window sills were full of dolls and a flower arrangement was located on top of the over the bed light. The overbed table was sticky and had tan particles on the top as well as a partially eaten banana.

Interview with the Housekeeping Supervisor, on 07/06/11 at 3:55PM, revealed Resident A was not cooperative with allowing housekeeping to clean the room. He stated the room was thoroughly cleaned once a month when nursing would take the resident outside the room to an event. He stated no other provisions had been made to ensure the resident's room was cleaned.

3. Review of the facility's Policy Guidelines for Care of Resident Equipment, undated, revealed no information on the cleaning of pill crushers used on the medication carts and no information regarding the handling of oxygen tubing, mini-nebulizer equipment or suction catheters to

F 441 was cleaned by dietary on 7-6-11 and ice scoop stored in a covered container when not in use.

4. The housekeeping staff have been re-educated to the housekeeping infection control procedures regarding changing mop water and cleaning rooms as of 8-4-11 by the Housekeeping Supervisor. Nursing staff have been re-educated on storage of oxygen tubing, nasal cannulas, suction catheters, nebulizers, ice scoops, cleaning pill crushers and Infection Control Guidelines by the Assistant Director of Nursing and Unit Managers as of 8-4-11.

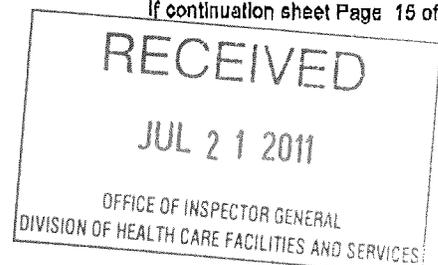
5. The Director of Nursing, Assistant Director of Nursing, Unit Managers or Housekeeping Supervisor will complete a review of resident rooms daily times 2 weeks and then weekly times 10 weeks. The rounds will include review of storage of oxygen tubing, nasal cannulas, suction catheters, nebulizers, ice scoops, cleaning pill crushers and general Infection Control Guidelines. A summary of findings will be submitted by the Director of Nursing and Housekeeping Supervisor to the Performance Improvement Committee

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F 441	<p>Continued From page 14 prevent contamination.</p> <p>Review of the facility's Infection Control Policy Statement, dated January 2008 revealed the facility would maintain an infection control program to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of disease and infection.</p> <p>Observation of the facility, on 07/06/11 at 8:45AM, 10:40AM, and 3:30PM, revealed Unsampled Residents C, D, E, F, G, I, L, and Resident #3 with oxygen cannulas, mini-nebulizer face masks, or suction catheters stored uncovered and oxygen tubing draped on the floor.</p> <p>Observation, on 07/06/11 at 9:07AM, revealed in the room of Unsampled Resident O, Room 315, a nebulizer sitting in a chair uncovered. Additionally, an oxygen cannula was wrapped around the back of a wheelchair with the nasal prongs resting against the hand grip of the wheelchair.</p> <p>Observation of two (2) medication carts parked in the hallway on the 200 wing, on 07/06/11 at 10:40AM, 2:00PM and 4:00PM, revealed the pill crushers on the carts had a heavy black sticky build-up all around the edges and corners. In addition, there were dried dark colored spills present.</p> <p>Interview with Registered Nurse (RN) #1, on 07/06/11 at 4:00PM, revealed the pill crushers were soiled; however, she was not sure who was responsible to clean the pill crushers or how frequently they were to be cleaned.</p>	F 441	<p>monthly time 3 months for review and further recommendations.</p> <p>Compliance Date 8-5-11</p>		



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F 441	Continued From page 15 Interview with Licensed Practical Nurse (LPN) #3, on 07/06/11 at 2:45PM, revealed she did not know what the facility policy was for the prevention of contamination of resident equipment not in use. She stated there were plastic bags that came with the equipment and sometimes staff placed the equipment in the plastic bags. Interviews with Certified Nurse Aides (CNA) #6 and #7, on 07/06/11 at 4:20PM, revealed the ice scoop needed to be stored in a covered container when not in use. Interview with the Acting Director of Nursing (DON), on 07/06/11 at 5:30PM, revealed the pill crushers were the responsibility of each nurse and were to be cleaned by each nurse. He indicated resident equipment such as face masks and nasal cannulas should be covered when not in use and oxygen tubing could not be in contact with the floor.	F 441			

