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

PRINTED: 05/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185144	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 05/14/2015
NAME OF PROVIDER OR SUPPLIER PROVIDENCE HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 1608 VERSAILLES ROAD LEXINGTON, KY 40504	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
	An Abbreviated Survey to investigate #00023181 was initiated on 05/13/15 and concluded on 06/14/15. #00023181 was substantiated with deficiencies cited.			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	***Residents Affected*** Immediately upon discovering the improper storage of resident oxygen tubing, the following corrective action was taken for the residents' affected: Room 104's oxygen tubing was removed from the nightstand, replaced, and properly bagged;	
	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.		• Room 106-2's oxygen tubing was removed from the resident's bed, replaced, and properly bagged; • Room 109-2's oxygen cannula was removed from the wheelchair, replaced, and properly bagged; • Room 208's oxygen cannula was removed from the nightstand, replaced, and properly bagged; • Room 214's oxygen tubing on the oxygen concentrator machine was replaced and properly bagged; • Room 405's oxygen tubing was removed from the resident's bed, replaced, and properly bagged; • Room 414-2's nebulizer mask was replaced and properly bagged.	
	(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.		***Identification/Protection of other Residents*** On 5/15/15, the facility's Quality Assurance (QA) Nurse audited twenty-six (26) residents currently using oxygen tubing/nebulizer mask treatment. Of the twenty-six (26)	
	(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.			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 6/26/15

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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	185144		C 05/14/2015

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F 441	Continued From page 1 (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 store six (6) oxygen cannulas and one (1) nebulizer face mask in a sanitary manner to help prevent the transmission of infection and disease. Observation during the initial facility tour revealed oxygen cannulas not in use were unbagged in rooms 104, 106-2, 109, 208, 214-2 and 405-2. In addition, observation revealed an unbagged Nebulizer face mask in room 414-2. The findings include: Interview with the Director of Nursing, on 05/13/15 at approximately 10:30 AM, revealed the facility did not have a written policy related to the storage of oxygen tubing and cannulas. However, she stated the facility followed its Nebulizer policy. Review of the facility's policy titled "Administering Medication through a Small Volume (Handheld) Nebulizer", dated October 2010, revealed equipment and tubing was to be stored in a plastic bag labeled with the resident's name and date. Observations during the initial facility tour, on	F 441	residents audited, one (1) oxygen tube was found on a resident's bed. The QA Nurse promptly replaced and stored the oxygen tube with proper bagging. The QA Nurse reeducated the SRNA assigned to that particular room on how to store oxygen tubing in a sanitary manner to help prevent the transmission of infection and disease. **Systemic Changes** On 5/15/15, the facility Director of Nursing revised the facility's Oxygen Policy to include the following; To ensure infection prevention is maintained for all residents who are utilizing oxygen; including residents' nebulizer machines, tubing and masks. All floor nurses will check oxygen tubing and placement every shift. SRNAs will ensure that all oxygen tubing not in use is bagged before leaving residents room. All oxygen tubing must be labeled with the date and initials of the staff member who is changing the oxygen tubing or who is starting new oxygen therapy. The nasal cannula must be changed at least every two weeks unless needed sooner due to infection control purposes. One tube will be used per resident. If a resident uses an oxygen tank, the tubing should	

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F 441 Continued From page 2

05/13/15 between 9:35 AM and 10:35 AM, revealed the following: in room 104, oxygen tubing unbagged on the nightstand; in room 106-2, unbagged oxygen tubing lying on the resident's bed; in room 109-2, oxygen cannula unbagged and lying on a wheelchair; in room 208, oxygen cannula unbagged on the nightstand; in room 214, unbagged oxygen tubing on the oxygen concentrator machine; in room 405, unbagged oxygen tubing on the resident's bed; and in room 414-2, the nebulizer mask was not in a bag.

Interview, on 05/13/15 at 11:45 AM with Certified Nursing Assistance (CNA) #1, revealed nasal cannulas were to be placed in a plastic bag on the oxygen concentrator machine when not in use.

Interview, on 05/13/15 at 2:39 PM with CNA #9, revealed when oxygen is not in use, it is to be placed in a plastic bag and sealed.

Interview with Licensed Practical Nurse (LPN), on 05/13/15 at 3:00 PM, revealed oxygen cannulas and nebulizer masks should not be lying on beds, bedside tables or in wheelchairs. LPN #1 stated when oxygen and/or nebulizers were not in use, they should be stored in a plastic bag.

Interview with the Unit Manager, on 05/14/15 at 9:20 AM, revealed oxygen cannulas and nebulizer masks were to be bagged when not in use due to infection control concerns. The Unit Manager stated the CNAs had received no training related to the storage of oxygen cannulas and nebulizer masks, because management of oxygen was a nursing responsibility. She further stated nurses were responsible for administering

F 441 be shared between the tank and concentrator.

On 5/15/15, the Director of Nursing and QA Nurse initiated in-servicing for all nursing staff, both Nurses and SRNAs from all three (3) shifts, related to these changes made to the facility's policy and procedure. The in-services will be ongoing until every member of the nursing team has received re-education.

Monitoring
On 5/15/15, the facility QA Nurse wrote up the following procedure as it relates to oxygen tubing placement, storage, and monitoring:

1. Charge nurses will be responsible to check oxygen tubing; including the nebulizer machines, tubing and masks, and placement during their shift daily.
2. Unit Supervisors will be responsible to audit the placement and storage of oxygen tubing; including nebulizer machines, tubing and masks on a weekly basis for the next three (3) months.
3. QA Nurse will be responsible to audit oxygen tubing placement and storage; including nebulizer machines, tubing and masks on all units monthly for the next six (6) months

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F 441	Continued From page 3 nebulizer treatments and placing the mask and tubing into a plastic bag when treatments were completed. Interview with the Director of Nursing (DON), on 05/14/15 at 3:20 PM, revealed nebulizer masks and oxygen cannulas should be monitored by the nurses during their rounds to ensure cannulas and masks were properly bagged.	F 441	4. SRNAs will be responsible to ensure that all oxygen tubing; including nebulizer machines, tubing and masks, not in use will be bagged before leaving residents rooms (daily). Each resident who is currently utilizing oxygen for treatment will be covered with the above stated audit. Any discrepancies found in the storage, placement, or bagging of the tubes will be promptly corrected and noted on the O2 audit sheet. The results of these audits will be reviewed weekly by the Director of Nursing and submitted by the DON to the facility's monthly Quality Assurance (QA) Committee. Based on the results of the audits, the QA Committee will determine if any changes to the plan of correction must be made in order to ensure a more efficient practice. On 5/15/15, the Director of Nursing and QA Nurse initiated in-service education for every SRNA and Nurse from all three (3) shifts on the above stated audit procedure. The in-services will remain ongoing until every member of the nursing team has received the education. ***Completion Date:*** 6/12/15	6/12/15