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

PRINTED: 07/29/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185446	A. BUILDING _____ B. WING _____	C 07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

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F 000	INITIAL COMMENTS A Standard Recertification Survey and Abbreviated Survey investigating ARO#KY00016733 was conducted 07/12/11 through 07/15/11 with the highest scope and severity of an "F". ARO#KY00016733 was substantiated with deficient practice cited.	F 000	**F 246** **Immediate Corrective Action For Residents Found To Be Affected** ◆ Resident #1's Call light was placed back within reach on July 15, 2011 as care planned and staff were re-educated, by the ADON *(Assistant Director of Nursing)* ~~/licensed designee~~ July 15, 2011, on this resident's need for the call light to be within reach when within resident room. Resident was assessed to ensure no negative outcome relative to this alleged deficient practice.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review it was determined the facility failed to ensure reasonable accommodations were made for one (1) of twenty (20) sampled residents, Resident #1. The facility failed to ensure staff followed the call light system policy. Facility staff failed to ensure Resident #1's call light was with in the residents reach. The findings include: Review of the facility's policy titled "Call Light System", dated January 2003, revealed each resident is provided with a functional call light system within his/her reach.	F 246	**Identification of Other Residents With The Potential to be Affected** ◆ An audit, *which included observation and interview, if applicable,* of ~~all~~ *100% of the* residents~~-~~*population* was completed on July 15, 2011 by the DON*(Director of Nursing), ADON, MDSN(Minimum Data Set Nurse), Restorative Nurse,* ~~and~~ *or SSD (Social Services Director)* ~~designated licensed staff members~~ reviewing call light placement for all residents to ensure 100% compliance. No other resident(s) were identified as being effected. **Measures Taken To Assure There Will Not Be a Recurrence** ◆ Inservicing is being provided by the SDC *(Staff Development Coordinator), DON, ADON, MDSN, Restorative Nurse, Weekend RN Supervisor or SSD/designee from*	

RECEIVED SEP 13 2011 BY:

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

[signature] ADMINISTRATOR AMENDED SEPTEMBER 02, 2011

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 246	Continued From page 1 Record review revealed the facility admitted Resident #1 on 09/16/08 with diagnoses which included Paraplegia (paralysis of the legs or lower part of the body), Cerebral Palsy (refers to any one of a number of neurological disorders that appear in infancy or early childhood and permanently affect body movement and muscle coordination but don't worsen over time), Idiopathic Scoliosis (curvature of the spine to one side or the other), and Abnormal Posture. Observation, on 07/15/11 at 4:15 PM, revealed Resident #1's call light was lying on a night stand. The resident's bed was positioned so the night stand was approximately three (3) feet from Resident #1. Interview with Resident #1, on 07/15/11 at 4:15 PM, revealed the resident could not reach the call light. He/she further indicated the State Registered Nursing Aide (SRNA) from the previous shift frequently left the call light on the night stand after providing care. Further interview revealed the resident was unable to reach the call light on the night stand. Interview with SRNA #4, on 07/15/11 at 4:25 PM, revealed she began working at 3:00 PM, was assigned ten (10) residents and had been in all the rooms. She further stated Resident #1 could not have reached the call light when it was placed on the night stand.	F 246	August 1- 6, 2011 for ~~the nursing~~ *all facility* staff regarding the importance of having call lights within reach of residents at all times. ♦ SDC, *DON, ADON, MDSN, Restorative Nurse or Weekend RN Supervisor* ~~licensed designee~~ will inservice on August 1-6, 2011 of the responsibility of the licensed staff to monitor care that is being provided to the residents by the SRNA's under their supervision. ♦ SDC, *DON, ADON, MDSN, Restorative Nurse or Weekend RN Supervisor*~~licensed designee~~ will reeducate licensed staff August 1-6, 2011 of their responsibility for ensuring call lights are within reach of each resident during routine rounds. Any findings of non-compliance will be immediately corrected by the direction of the licensed nurse. The SRNA responsible for the non-compliance will receive re-education and/or disciplinary action by the DON or ~~designated~~ licensed staff member *on duty*. ♦ Beginning July 18, 2011 the Social Services Director/~~designee~~ *Quality of Life Director (QoLD)* will complete weekly audits for 4 weeks on a 10% alert and oriented resident selection to ensure call lights are within reach.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280	**Monitoring Changes To Assure Continuing Compliance** Social Service Director/~~designee~~ *QoLD* audit results will be submitted to the	

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F 280	Continued From page 2 participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure Care Plans were reviewed and revised to reflect changes in assessment for one (1) of twenty (20) sampled residents, (Resident #5). The facility failed ot ensure Resident #5's Care Plan was revised to reflect the resident's current code status. The findings include: Review of the Clinical Record revealed Resident #5 was initially admitted on 09/16/08 with diagnoses which included Quadriplegia, Seizure Disorder, Cancer, and Depression. Review of the Advance Directive dating from the original admission of 09/16/08 revealed Resident #5 was a DNR status at that time. (DNR indicates no	F 280	**F 246 (cont)** Quality Assurance Committee for review and revision until the Quality Assurance committee has determined 100% compliance is achieved. **Date of Completion:** 08-29-11 **F 280** **Immediate Corrective Action For Residents Found To Be Affected** ♦ Resident #5's comprehensive care plan was revised *by the MDSN* on July 15, 2011 to reflect the resident's current code status. **Identification of Other Residents With The Potential to be Affected** ♦ An audit of all residents was completed on July 15, 2011 by the MDS staff reviewing code status for all residents to ensure 100% compliance. No other resident(s) were identified as being effected. **Measures Taken To Assure There Will Not Be a Recurrence** ♦ Inservicing was provided by the DON on July 15, 2011, for the MDS staff regarding the importance of comprehensive care plan to reflect accurate and current code status for each respective resident at all times. ♦ SDC, *DON, MDSN or ADON/~~licensed designee~~* will inservice by August 6, 2011 of the responsibility of the licensed staff to monitor comprehensive care plans to ensure	

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F 280	Continued From page 3 lifesaving measures are to be taken if the resident suffers a cardiac or respiratory arrest.) Continued review of the Clinical Record revealed the resident was readmitted to the facility on 05/11/11 after a hospitalization. Review of the active Physician's Order dated 05/11/11, revealed the resident's status had been changed to Full Code. (Full Code status indicates the resident should receive all life-saving measures in the event of cardiac or respiratory arrest.) Review of the revised Advance Directive Form, dated 05/11/11, revealed Resident #5 chose to be a Full Code status. However, review of the current active Care Plan, reviewed on 05/26/11 and continued through 08/11/11 revealed Resident #5 was DNR status. Interview with Licensed Practical Nurse #8 on 07/15/11 at 10:15 AM revealed she would look at the Advance Directives to determine a resident's code status. She stated she was not aware Care Plan interventions for Resident #5 did not agree with the physician's order or the resident's Advanced Directives. She stated the Minimum Data Set (MDS) Nurse usually updated the Care Plans, but any nurse could revise them as well. Interview with the MDS nurse, on 07/15/11 at 10:50 AM, revealed she developed the Care Plans based on data obtained from the comprehensive assessments, including assessment information from other care disciplines, e.g. dietary. She stated she updated the Care Plans daily based on physician's orders,	F 280	accurate and current code status of each respective resident at all times. ◆ MDS staff, *DON, SDC or ADON/~~designee~~* will complete weekly audits for 4 weeks on a 10% resident selection to ensure code status is accurate and current for each respective resident. **Monitoring Changes To Assure Continuing Compliance** ◆ MDS staff, *DON, SDC or ADON/~~designee~~* audit results will be submitted to the Quality Assurance Committee for review and revision until the Quality Assurance committee has determined 100% compliance is achieved. **Date of Completion:**	08-29-11

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F 280	Continued From page 4 shift reports, information obtained from direct care staff, and morning meeting discussions. She stated the floor nurse could update the Care Plan when the MDS nurse was off duty. Further interview revealed the Care Plan should be specific to each resident. She stated its purpose was to explain the care each resident required and describe the services to be provided to meet their individual needs.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. 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 services provided met professional standards of quality for one (1) of twenty (20) sampled residents, (Resident #3). The facility failed to ensure staff followed the facility's policy and procedures: "Medication administration-Administering Medications" and "Skin Management and Prevention". On 07/14/11, facility staff failed to provide wound care treatment for Resident #3 per the Physician's Orders. Further the staff failed to notify the Physician prior to applying a different treatment from the Physician's Order. The findings include: Review of the facility's policy, "Medication administration - Administering Medications", with an effective date of 12/2010, stated Medications	F 281	**F 281** **Immediate Corrective Action For Residents Found To Be Affected** Physician/*ARNP (Advanced Registered Nurse Practioner)* notified *on July 14, 2011* relative to Resident #3 ~~and~~ *with* clarification orders received and implemented *by the WCN (Wound Care Nurse) on same date.* **Identification of Other Residents With The Potential to be Affected** All resident MARs and TARs will be *reviewed by DON, SDC, ADON, MDSN, and Restorative Nurse on July 18, 2011 and* compared to physician orders to identify any resident with inconsistent medication(s) as per valid physician order occurring since last month end review. *No other resident was identified as affected by this alleged deficient practice.* **Measures Taken To Assure There Will Not Be a Recurrence** • WCN was reeducated by DON on July 15, 2011 as to the requirement to obtain	

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F 281	Continued From page 5 are administered only as ordered by the physician. Review of the facility's procedure, "Skin Management and Prevention At - A - Glance", undated, revealed if a new skin condition/issue is identified the charge nurse will follow the protocol of notifying the physician. Review of the clinical record for Resident #3 revealed the facility admitted the resident on 04/21/11 with the diagnosis of Recent Cerebral Vascular Accident with Muscle Weakness. Review of the Admission Minimal Data Set (MDS) Assessment, dated 04/28/11, revealed the facility had assessed the resident as at risk for pressure ulcers. Review of Resident #3's Treatment Administration Record (TAR), dated July 2011, revealed the facility was to provide a wound care treatment to the resident's left heel to cleanse the wound site with normal saline and pat dry and apply wound dressings to the dry wound site. Observation during Resident #3's left heel treatment and dressing change, conducted by the Wound Care Nurse (WCN), on 07/14/11 at 3:15 PM, revealed the WCN stated the wound site had become more macerated (skin surrounding injured site more white and soft) and therefore she was going to apply Calazime Creme (skin creme with a drying zinc-oxide base) to the perimeter of the wound bed before applying the dressing. However, there was no documented evidence she notified the physician or obtained an order prior to the treatment.	F 281	physician order before implementation of any medication *as well as the requirement to follow physician orders.* ◆ All clinical staff will be inserviced by SDC, *DON, ADON, MDSN, Restorative Nurse or Weekend RN Supervisor* ~~/designee~~ on August 1–6, 2011 as to the requirement to obtain physician orders before implementation of any medication *as well as the requirement to follow physician orders.* ◆ 24 hour audits of resident charts are completed by licensed staff daily *and compared to physician orders* to ensure physician orders are secured *and followed* for medication(s). **Monitoring Changes To Assure Continuing Compliance** ◆ DON, *ADON, MDSN, Restorative Nurse, SDC* or *Weekend RN Supervisor* ~~designee~~ shall review 24 hour chart audits daily, except weekends which shall be reviewed on the next business day, to assure compliance. ◆ DON, *ADON, MDSN, Restorative Nurse* or *SDC* ~~designee~~ shall report audit results to QA Committee at least monthly x 2. QA Committee shall determine cessation or continuation based on compliance achieved. **Date of Completion:**	**08-29-11**

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F 281	Continued From page 6 An interview with the WCN, on 07/15/11 at 5:40 PM, revealed she did not follow the facility's policies when she did not follow the physician's order as written for Resident #3's left heel wound treatment and initiated a treatment that included Calazime Creme to a wound site that had changed in appearance before the physician was contacted. Interview with the Director of Nursing (DON), on 07/15/11 at 6:45 PM, revealed the WCN should not have altered the treatment based on her judgement without contacting the physician for direction.	F 281		
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to follow the Comprehensive Plan of Care for one (1) of twenty (20) sampled residents, (Resident #9). On 07/13/11, the facility staff failed to ensure pillows were available to off load Resident #9's heels from the mattress. Additionally, staff failed to ensure Resident #9's heels were not resting directly on the mattress per the Care Plan, to prevent pressure ulcers. The findings include:	F 282	**F 282** **Immediate Corrective Action For Residents Found To Be Affected** ♦ Resident #9's pillows were put into place on July 13, 2011 as care planned and SRNA staff were re-educated, by the licensed staff beginning July 13, 2011 through July 14, 2011, on this resident's need for the use of the pillows when in bed to assure heels to not be resting on bed per resident comprehensive care plan to prevent pressure ulcers. Resident was assessed to ensure no negative outcome relative to this alleged deficient practice. **Identification of Other Residents With The Potential to be Affected** ♦ An audit of all residents was completed on July 19, 2011 by the DON, *SDC, ADON, MDSN, Restorative Nurse,* and *Weekend*	

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F 282	Continued From page 7 Review of the facility's policy titled, "Care Plan", with the effective date of 12/2010, revealed each resident will have an individualized care plan to be utilized by direct care staff to provide resident care. Review of Resident #9's medical record revealed the resident was re-admitted to the facility on 02/14/11 with diagnoses which included Chronic Kidney Disease, Left Hip Arthroplasty and Failure to Thrive. Review of the Minimal Data Set (MDS) Assessment, dated 02/21/11, revealed the facility assessed the resident to have impairment in cognitive skills, required extensive to total assistance with most Activities of Daily Living (ADL) and was at risk for developing pressure ulcers. The Care Area Assessment (CAA) Summary identified Resident #9 as being at risk for altered skin integrity related to decreased physical function and diagnosis of Failure to Thrive. Review of the Physician's Orders, dated July 2011, revealed Resident #9's "Plan of Treatment" included "pillows under calves to off load heels while in bed". Review of Resident #9's Comprehensive Plan of Care, reviewed July 2011, revealed the facility staff was to have pillows under calves while in bed. Observation, on 07/13/11 at 4:45 PM, revealed the resident in bed without pillows under his/her calves to off load pressure to the heels.	F 282	*RN Supervisor* ~~designated licensed staff members~~ reviewing care planned positioning devices to ensure 100% compliance. This audit included ensuring that all positioning devices were in place as indicated. ♦ Inservicing is being provided by the SDC, *DON, ADON, MDSN, Restorative Nurse, or Weekend RN Supervisor*~~licensed designee~~ from August 4-9, 2011 for the nursing staff regarding the importance of following *comprehensive* care *plan* ~~planned positioning devices~~ at all times including ensuring specific positioning devices are in place as indicated. **Measures Taken To Assure There Will Not Be a Recurrence** ♦ SDC, *DON, ADON, MDSN, Restorative Nurse or Weekend RN Supervisor*~~licensed designee~~ will inservice on August 4-9, 2011 of the responsibility of the licensed staff to monitor use of positioning devices that is being provided to the residents by the SRNA's under their supervision. ♦ The DON, *SDC, ADON, MDSN, Restorative Nurse or Weekend RN Supervisor* ~~licensed designee~~ will complete weekly audits for 4 weeks on a 10% resident selection to ensure care planned *interventions including* positioning devices are in place as care planned. **Monitoring Changes To Assure Continuing Compliance**	

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F 282	Continued From page 8 Observation, on 07/13/11 at 5:06 PM, during a skin assessment conducted by the facility's Wound Care Nurse (WCN) revealed the resident's heels were in direct contact with the bed mattress. Both heels were dark pink in color but blanched when touched per the WCN. At 5:25 PM, during the completion of the skin assessment, observation revealed the resident's heels were again in direct contact with the mattress. Interview, on 07/13/11 at 5:30 PM, with the WCN revealed there were no pillows in the resident's room to effectively off load the heels. Interview, on 07/13/11 at 7:00 PM, with Licensed Practical Nurse (LPN) #6, who was assigned to provide care for Resident #9, revealed she was aware the resident was to have pillows under his/her calves to off load heels while in bed. She stated she had been in the resident's room while the resident was in bed but had failed to notice there were no pillows in use and the resident's heels were in direct contact with the mattress.	F 282	• DON, *SDC, ADON, MDSN, or Restorative Nurse* ~~licensed designee~~ audit results will be submitted to the Quality Assurance Committee for review and revision until the Quality Assurance committee has determined adequate compliance is achieved. **Date of Completion:**	**08-29-11**
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure a substitute was offered to residents who refuse	F 366	**F 366** **Immediate Corrective Action For Residents Found To Be Affected** Resident #9 was provided a substitute on July 12, 2011 immediately on notification which would have occurred on an ordinary basis. **Identification of Other Residents With The Potential to be Affected**	

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F 366	Continued From page 9 food for one (1) of twenty (20) sampled residents, (Resident #9). On 07/12/11 the facility failed to offer Resident #9 a substitute for the menu item of macaroni and cheese when cheese was listed as a dislike on the residents tray card. The findings include: Observation, on 07/12/11 at 12:30 PM, revealed Resident #9's lunch tray served in the room included pureed macaroni and cheese. Review of the resident's tray card listed cheese in bold print as a food dislike. Interview with Resident #8, on 07/12/11 at 12:35 PM, revealed he/she would not eat the macaroni and cheese because it would make him/her sick. Interview with the Nurse Manager, on 0713/11 at 10:05 AM, revealed nursing was responsible for setting residents up for meals and assisting as needed but dietary was responsible for what food was placed on the resident's meal tray. Interview, on 07/13/11 at 10:30 AM, with the Dietary Manager revealed the dislike should have been noted by dietary and mashed potatoes, the substitution for the macaroni and cheese, should have been served to Resident #9. She further stated an obvious error was made by the dietary staff.	F 366	All resident trays were reviewed by the Dietary Manager on July 15, 2011 with no other resident identified. **Measures Taken To Assure There Will Not Be a Recurrence** ◆ *All* Dietary staff was inserviced by the Dietary Manager, *Dietician, Signature Care Consultant (SCC), SDC, or Assistant Dietary Manager* ~~/designee~~ on July 20, 2011and again on August 02, 2011 relative to the need to assure the residents dislikes were not served to that respective resident. ◆ All resident tray cards were reviewed on July 12, 2011 by the Dietary Manager~~/designee~~ to assure they accurately reflect the respective resident's dislikes. ◆ Tray cards will be improved with color identification of resident dislikes *on August 29, 2011 or as soon as color printer can be secured and installed* in order to provide easier identification of resident dislikes during the meal service. **Monitoring Changes To Assure Continuing Compliance** Dietary Manager, *Dietician, Signature Care Consultant (SCC), SDC, Assistant Dietary Manager or Cook* ~~/designee~~ shall review 10% of completed trays daily *(including weekends)* for 2 weeks, then weekly for 4 weeks then as directed by the QA Committee.	
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician.	F 367		

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	185446		C 07/15/2011

NAME OF PROVIDER OR SUPPLIER: BLUEGRASS CARE & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3576 PIMLICO PARKWAY, LEXINGTON, KY 40517

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F 367	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure one (1) unsampled resident, (Unsampled Resident A), received a therapeutic diet as prescribed by the Physician. The facility failed to ensure Unsampled Resident A received the therapeutic diet ordered by the Physician. On 07/12/11 the facility served a salt packet to Unsampled Resident A with his/her lunch when the resident had a No Added Salt diet ordered. The findings include: 1. Observation, on 07/12/11 at 12:20 PM, revealed Unsampled Resident A's lunch tray was served with a salt packet on the tray. Further observation revealed the diet order listed on the resident's tray card was a No Added Salt (NAS) diet. Interview with Licensed Practical Nurse (LPN) #1, on 07/12/11 at 12:30 PM, revealed the salt packet should not have been placed on the tray because the resident had a NAS diet ordered by the Physician.	F 367	**F 366 (cont)** • Dietary Manager, *Dietician, SCC, SDC or Assistant Dietary Manager* ~~/designee~~ shall report to QA Committee monthly until QA Committee determines cessation or continuation based on compliance achieved. **Date of Completion:**	08-29-11
			F 367 **Immediate Corrective Action For Residents Found To Be Affected** Resident #A is alert and oriented x3 and is aware and capable of managing her diet order and made no attempt to utilize salt packet but rather reported the error which was corrected immediately by removing the salt packet. **Identification of Other Residents With The Potential to be Affected** 100% resident trays were reviewed by the Dietary Manager on July 12, 2011 with no other resident identified.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	**Measures Taken To Assure There Will Not Be a Recurrence** • Dietary staff was inserviced by the Dietary Manager, *Dietician, Signature Care Consultant (SCC), SDC, or Assistant Dietary Manager* ~~/designee~~ on July 20, 2011 and August 02, 2011 relative to the need to assure all prescribed therapeutic diets for each respective resident is followed per physician's order.	

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F 371	Continued From page 11	F 371	**F 367 (cont)**	

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, review of the facility's policies, and review of Kentucky Food Code, it was determined the facility failed to store, distribute and serve food under sanitary conditions. The facility failed to ensure food was properly labelled and stored. The facility failed to ensure staff stored pans and trays in a sanitary manner. The facility failed to ensure staff washed and gloved their hands per the Kentucky Food Code. The facility failed to ensure facility staff wore hair nets and beard guards per the facility policy and Kentucky Food Code.

The findings include:

Review of the facility's policy titled "Personal Hygiene", not dated, revealed if hair is long and not covered properly with a cap, a hair net must be worn. Hair spray is not an authorized substitute for a hair net. Review of the Kentucky Food Code, October 2009, revealed food employees shall wear effective hair restraints (hats, hair coverings or nets, beard restraints, clothing that covers body hair, etc.).

Observation throughout the lunch time meal service, on 07/13/11 beginning at 12:05 PM, revealed three (3) Dietary Aides working on the tray line did not have beard guards on and one was observed to not have a hair net in place.

Interview with the Administrator, on 07/14/11 at 10:05 AM, revealed he believed as long as the

- All resident tray cards were reviewed on July 12, 2011 by the Dietary Manager~~/designee~~ to assure they accurately reflect the respective residents therapeutic diet if applicable.

- Tray cards will be improved with color identification of resident therapeutic diet if applicable *on August 29, 2011 or as soon as color printer can be secured and installed* in order to provide easier identification of resident dislikes during the meal service.

Monitoring Changes To Assure Continuing Compliance

- Dietary Manager, *Dietician, SCC, SDC, Assistant Dietary Manager or Cook* ~~/designee~~ shall review 100% of completed trays daily *(including weekends)* for 2 weeks, then once weekly for 4 weeks then as directed by the QA Committee.

- Dietary Manager, *Dietician, SCC, SDC, or Assistant Dietary Manager* ~~/designee~~ shall report to QA Committee monthly until QA Committee determines cessation or continuation based on compliance achieved.

Date of Completion: **08-29-11**

F371
****Note of Correction:** Notes relative to interview with Administrator are inaccurately represented. Administrator was questioning whether a hair net was required for a male employee with a shaved scalp. Administrator

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F 371	Continued From page 12 Dietary staff's hair was not too long then they did not have to wear a hair net. Review of the facility's policy titled "Reusable Food Storage Containers", not dated, revealed all reusable containers must be properly labeled listing the stored food item and the date the food was stored. Observation during the initial tour, on 07/12/11 at 8:50 AM, revealed an open bag of sugar was stored on a low shelf in the dry storage area. Interview with the Dietary Manager, on 07/12/11 at 8:50 AM, revealed the sugar should not be stored this way because pests have access to the food. Observation during initial tour, on 07/12/11 at 8:50 AM, revealed taco shells which were opened in a box with a plastic lining and not sealed. Continued observation revealed graham cracker crumbs in a twenty-five (25) pound box with a plastic lining which was open and exposed. Interview with the Dietary Manager, on 07/12/11 at 8:50 AM, revealed the taco shells and graham cracker crumbs should not be stored that way, they should be sealed to prevent pests and kept fresh. Observation during initial tour, on 07/12/11 at 8:50 AM, revealed a bag of dry cereal which was not dated. Interview with the Dietary Manager, on 07/12/11 at 8:50 AM, revealed the cereal should be dated. Observation during initial tour, on 07/12/11 at 8:55	F 371	believed that if there was no hair then the hair net was not required. **Immediate Corrective Action For Residents Found To Be Affected** No specific resident(s) identified. Further, no resident was identified in Infection Control Tracking and Trending report that would have been affected by this practice. However, Dietary Manager immediately corrected all items noted within the form 2567 and further inserviced in-house *dietary* staff on July 12-15, 2011 relative to proper procedures relative to each. **Identification of Other Residents With The Potential to be Affected** ◆ Dietary Manager performed a sanitation inspection on July 13, 2011 to assure no additional issues were identified – none were noted. ◆ A review of the facilities Infection Control Program's tracking and trending report was also completed by the DON, *SDC, ADON, MDSN or Restorative Nurse* /~~licensed designee~~ on July 18, 2011 to identify any resident which may have been affected. There were no residents identified. **Measures Taken To Assure There Will Not be a Recurrence** ◆ Dietary Manager, *Dietician, SCC, SDC or Assistant Dietary Manager* inserviced all dietary staff on July 18, 19, 20 and August 05, 2011 relative to food procurement,	

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F 371	Continued From page 13 AM, revealed a five (5) pound bag of mild cheddar cheese was stored in the walk-in-refrigerator, and not dated, open and exposed. Further observation revealed cheese slices which were wrapped in plastic wrap; however, were not dated. Interview with the Dietary Manager, on 07/12/11 at 8:55 AM, revealed the cheese should be sealed with plastic wrap and dated. Observation during the initial tour, on 07/12/11 at 8:55 AM, revealed a pre-cooked ham thawing on the bottom shelf and a pool of liquid on the floor of the refrigerator underneath the ham. Interview with the Dietary Manager, on 07/12/11 at 8:55 AM, revealed the ham should be in a tray so the liquid is not on the floor. Observation during the initial tour, on 07/12/11 at 9:02 AM, of the walk-in-freezer, revealed a brown bag of potatoes had a tear in the packaging. Hamburger patties were stored on a plastic lining, not wrapped or dated. Garlic bread, shrimp, omelets and french toast were stored in plastic bags; however, were not dated. Interview with the Dietary Manager, on 07/12/11 at 9:02 AM, revealed these were not acceptable practices; the items should be sealed and dated. Observation of the stand alone refrigerator, on 07/12/11 at 9:08 AM, revealed there was a blue pitcher with approximately two (2) tablespoons of a brown liquid in it; with no date. Interview with the Dietary Manager, on 07/12/11 at 9:08 AM, revealed the pitcher should have been dated and further stated it should not have still been in the refrigerator because it was empty.	F 371	storing, preparation and serving under sanitary conditions *to include food at proper temperatures, proper hairnet/beard guard usage, proper hand washing with glove changes* as well as equipment cleaning and storage specifically as provided within Facility policies and the Kentucky Food Code. ◆ On July 13, 2011 glove distribution sites were limited to over the sink so as to require employees to be at the sink for washing during glove changes. ◆ Daily *direct observations*/monitoring for proper food procurement, storing, preparation and serving under sanitary conditions *to include food at proper temperatures, proper hairnet/beard guard usage, proper hand washing with glove changes* as well as equipment cleaning and storage was added to the weekly cleaning/ monitoring schedule on July 15, 2011. **Monitoring Changes To Assure Continuing Compliance** ◆ Dietary Manager, *Dietician, SCC, SDC, or Assistant Dietary Manager* ~~/designee~~ will monitor daily sanitation schedule for compliance beginning August 08, 2011. ◆ *Results of Daily direct observations/monitoring for proper food procurement, storing, preparation and serving under sanitary conditions to include food at proper temperatures, proper hairnet/beard guard usage, proper hand washing with glove changes as well as*	

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F 371	Continued From page 14 Review of the facility's policy titled "Pot and Pan Washing", not dated, revealed pots and pans must be air dried and inspected and then stored in a clean, dry, protected area. Observation during initial tour, on 07/12/11 at 9:25 AM, revealed four (4) regular hotel pans were stored wet and two (2) of which had yellow and brown speckles of a substance on them. Interview with the Dietary Manager, on 07/12/11 at 9:25 AM, revealed the pans should be air dried and checked for cleanliness before being stored. Observation during the lunch time meal service, on 07/13/11 at 12:45 PM, revealed three (3) trays were stored wet and sent out with resident meals on them. Observation on 07/12/11 at 9:30 AM, revealed the meat slicer was stored with particles of brown and white material on it and a sticky substance was noted on the meat slicer. Interview with the Dietary Manager on, 07/12/11 at 9:30 AM, revealed the meat slicer should be cleaned after each use and it did not appear it had been. Observation during the lunch time meal service, on 07/13/11 at 11:55 AM, revealed when taking temperatures of the food, Cook #11 did not check the temperatures of the vegetable soup, the ground, pureed hamburger, and the peas. Observation during the lunch time meal service, on 07/13/11 at 12:10 PM, revealed to soups were placed on resident trays without the temperatures being taken.	F 371	*equipment cleaning and storage* ~~Monitoring for proper food procurement, storing, preparation and serving under sanitary conditions, cross contamination as well as equipment cleaning and storage~~ was added to the Monthly Dietary Quality Assurance Report beginning August 2011 report. ~~Dietary Manager shall provide results of monthly Quality Assurance monitoring to the QA Committee.~~ QA Committee shall determine cessation or continuation based on compliance achieved. **Date of Completion:**	**08/29/11**

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F 371	Continued From page 15 Observation during the lunch time meal service, on 07/13/11 at 12:21 PM, revealed a bowl of vegetable soup was placed on a tray for a resident. Continued observation revealed a bowl of soup was placed on a residents tray at 12:22 PM and two (2) more bowls at 12:50 PM without temperatures being taken. Observation during the lunch time meal service, on 07/13/11 at 12:25 PM, revealed two (2) ground hamburgers placed on resident trays without temperatures being taken. Observation during the lunch time meal service, on 07/13/11 at 12:37 PM, revealed pureed hamburger was placed on a residents tray without the temperature being taken. Interview with the Dietary Manager, on 07/13/11 at 1:00 PM, revealed temperatures should be taken on all food items prior to them being served to residents. Review of the Kentucky Food Code, October 2009, revealed if used, single-use gloves shall be used for only one task, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. Handwashing is still required and necessary to prevent food contamination. Observation during the lunch time meal service, on 07/13/11 at 12:15 PM, revealed Cook #11 opened the oven with gloved hands, changed gloves; however, he did not wash his hands. Observation during the lunch time meal service, on 07/13/11 at 12:17 PM, revealed Dietary Aide	F 371		

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F 371	Continued From page 16 #12 opened the stand alone refrigerator door, changed his gloves; however did not wash his hands. Observation during the lunch time meal service, on 07/13/11 at 12:26 PM, revealed Dietary Aide #12 opened the refrigerator with gloved hands and did not change gloves or wash hands. Observation during the lunch time meal service, on 07/13/11 at 12:31 PM, revealed Cook #11 placed oven mitts over his gloved hands, removed food from the oven and did not wash his hands or change his gloves prior to returning to tray line. Observation during the lunch time meal service, on 07/13/11 at 12:36 PM, revealed Cook #11 placed oven mitts over his gloved hands removed pureed hamburger from the oven and changed his gloves; however, did not wash his hands. Observation during the lunch time meal service, on 07/13/11 at 12:40 PM, revealed Dietary Aide #12 opened the stand alone refrigerator to retrieve sandwiches and did not change gloves or wash his hands. Observation during the lunch time meal service, on 07/13/11 at 12:46 PM, revealed Dietary Aide #12 opened the stand alone refrigerator two (2) times to retrieve sandwiches and did not change gloves or wash hands. Observation during the lunch time meal service, on 07/13/11 at 12:55 PM, revealed Cook #11 placed oven mitts over his gloved hands and did not wash his hands or change gloves prior to	F 371		

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F 371	Continued From page 17 returning to tray line. Interview with the Dietary Manager, on 07/14/11 at 10:05 AM, revealed she believed the Dietary staff could change their gloves after each task and did not have to wash their hands. She further indicated this was the practice they had been following. Observation during the lunch time meal service, on 07/13/11 at 12:30 PM, revealed Cook #11 laid the tongs which had been used for baked potatoes in the noodles. Observation during the lunch time meal service, on 07/13/11 at 12:35 PM, revealed Cook #11 used the tongs for baked potatoes to pick up tongs which had slipped into the ham, dipped the tips of the tongs into the liquid of the ham and then placed them back into the baked potatoes.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	**F441** **Immediate Corrective Action For Residents Found To Be Affected** ◆ Residents ~~#7, 8, 3, 10 &11 were~~ *#7 wounds* were assessed *on July 15, 2011* by the DON *for any signs and symptoms of infection, redness, drainage, foul odor and vitals were obtained with no signs or symptoms of infection. Resident #8 wounds were assessed on July 15, 2011 by the DON for any signs and symptoms of infection, redness, drainage, foul odor and vitals were obtained with no signs or symptoms of infection. Resident #3 wounds were assessed on July 15, 2011 by the DON for*	

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F 441	Continued From page 18 (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, record review, and review of the facility's policy it was determined the facility failed to maintain an Infection Control Program to provide a safe, sanitary and comfortable environment and to help prevent the developement and transmission of disease and infection by direct care staff for five (5) of twenty (20) sampled residents, (Residents #7, #8, #3, #10, and #11). In addition the facility failed to ensure the staff performed proper handwashing and hand hygiene during resident skin assessments, wound care, and medication administration. Also the facility failed to ensure	F 441	*any signs and symptoms of infection, redness, drainage, foul odor and vitals were obtained with no signs or symptoms of infection. Resident #10 was assessed on July 15, 2011 by the DON for any signs and symptoms of infection and vitals were obtained with no signs or symptoms of infection. Resident #11 wounds were assessed on July 15, 2011 by the DON for any signs and symptoms of infection, redness, drainage, foul odor and vitals were obtained with no signs or symptoms of infection.* ~~Licensed designee to ensure no negative outcome relative to this alleged deficient practice No residents were found to have any signs and symptoms of infection~~. ◆ WCN found to not wash her hands between glove changes during wound care was re-educated by the DON on July 15, 2011 which reviewed standard nursing practice and the facility's policy of washing hands after each change of gloves during wound care. ◆ SRNA #3 was removed from direct care duties July 15, 2011. ◆ *LPN #4 found not to wash hands after contact with resident and before passing a PRN medication to Resident #10 was reeducated as to appropriate infection control procedures by the DON on July 13, 2011.* **Identification of Other Residents With The Potential to be Affected**	

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F 441	Continued From page 19 a State Registered Nurse Aide (SRNA) followed infection control guidelines while filling residents' water pitchers and cleaning a resident's dentures. The findings include: Review of the facility's policy, "Dressing Procedures - Clean Technique", with an effective date of 12/2010, revealed standard precautions and hand washing procedures should be utilized to reduce the risk of infection. Procedure examples included: use clean gloves for dressing changes, change gloves after removing soiled dressing, remove gloves and wash hands between dressing changes and treat the most contaminated ulcer last. Review of the facility's policy, "Medication Administration-Administering Medications (Licensed Staff)", with an effective date of 12/2010, stated licensed staff to wash hands before passing medication. 1. Review of the clinical record of Resident #3 revealed the facility admitted the resident on 04/21/11 with the diagnosis of Recent Cerebral Vascular Accident with Muscle Weakness. Review of the Admission Minimal Data Set (MDS) Assessment, dated 04/28/11, revealed the facility had assessed the resident to be at risk for pressure ulcers. Review of Resident #3's Treatment Administration Record (TAR), dated July 2011, revealed wound care treatments including application of medication and dressings to three (3) separate	F 441	♦ A review of the facilities Infection Control Program's tracking and trending report was completed by the DON, *SDC, ADON, MDSN, Restorative Nurse or Weekend RN Supervisor* ~~/licensed designee~~ on July 18, 2011 to identify any further breach of standard infection control practice. There were no resident's identified from this audit. ♦ Re-education was provided to the nursing staff 1) proper infection control procedures during wound treatments and 2) appropriate monitoring of non-licensed staff for appropriate infection control protocol. This re-education was presented by the SDC *DON, ADON, MDSN, Restorative Nurse, or Weekend RN Supervisor*~~/licensed designee~~ August 4-9, 2011. **Measures Taken To Assure There Will Not be a Recurrence** ♦ Re-education was provided to the nursing staff to review standard infection control practice and the facility policy by the SDC, *DON, ADON, MDSN, Restorative Nurse, or Weekend RN Supervisor*~~/license designee~~ August 4-9, 2011. ♦ Inservicing is being provided by the SDC, *DON, ADON, MDSN, Restorative Nurse or Weekend RN Supervisor*~~/licensed designee~~ August 4-9, 2011 for licensed staff on the facility's policy and standard nursing practice on proper technique when performing a clean dressing change including washing hands after each change of gloves.	

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517	

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F 441	Continued From page 20 skin wound sites. Observation of Resident #3's skin assessment and wound treatments on 07/14/11, from 2:45 PM to 3:50 PM, revealed the Wound Care Nurse (WCN) failed to follow the facility policy for dressing changes which stated to remove gloves and wash hands after removing soiled dressings and also between dressing or site changes. Resident #3 had previously identified wounds including treatments to his/her left calcaneous, right calcaneous and left posterior calf. The WCN repeatedly failed to wash her hands per the facility policy while providing care during the resident's assessment and wound treatments and dressing changes. During an interview conducted, on 07/15/11, at 5:40 PM, the Wound Care Nurse (WCN) stated she did not follow the facility's policy and procedures on infection control or use proper technique during the skin assessments and wound treatments she had conducted during the survey. She further stated she should have done more frequent hand washing per the facility's policy, including washing her hands after she removed gloves during necessary glove changes required for infection control and prevention. 2. Review of Resident #11's clinical record revealed the facility admitted the resident on 09/16/08 with diagnoses which included Diabetes Mellitus, Anemia and Muscular Wasting. Review of the resident's Quarterly MDS, dated 05/09/11, revealed the facility had assessed the resident to be at risk for pressure ulcers with one (1) Stage III pressure ulcer that was not present upon admission.	F 441	◆ WCN will have *wound care treatment* competency evaluated by Ms. JoAnne Tensley, RN, BSN, ET, CWCN, Medcare Pharmacy on August 12, 2011 **Monitoring Changes to Assure Continuing Compliance** ◆ The SDC, *DON, ADON, MDSN, Restorative Nurse or Weekend RN Supervisor*/~~licensed designee~~ will audit 10% of WCN treatments daily *to include observations of hand washing and glove changes* x 2 weeks, then weekly x 4 weeks to ensure appropriate infection control protocols are utilized. ◆ *The SDC, DON, ADON, MDSN, Restorative Nurse or Weekend RN Supervisor will visually monitor overall hand washing and glove changes of 10% of the employee population weekly for 4 weeks to ensure appropriate procedures are utilized.* ◆ Results of the audits will be submitted to the Quality Assurance committee for review at least monthly and revision until the Quality Assurance committee has determined substantial compliance is achieved. **Date of Completion:**	08/29/11

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F 441	Continued From page 21 Record review of Resident #11's TAR, dated 07/2011, revealed antifungal skin treatments for the affected perineal and buttocks areas. The record review also revealed a wound treatment which included application of medication and dressing to the resident's right heel. Observation, on 07/13/11 at 5:25 PM, revealed the WCN failed to follow the facility's policy for Dressing Procedures during Resident #11's skin assessment and treatments. During the observation the WCN cleaned the resident's buttocks and applied antifungal creme. She failed to follow the facility policy and changed gloves without washing her hands. She was then observed to remove the dressing from the pressure ulcer site on the resident's ankle. She changed her gloves but again failed to observe the facility's infection control procedures and did not wash her hands prior to treatment and application of the new dressing. 3. Review of the clinical record for Resident #10 revealed the facility admitted the resident on 09/16/08 with diagnoses which included Chronic Pain and Arthritis. Review of the Signicant Change MDS Assessment, dated 06/09/11, revealed the facility assessed the resident as frequently experiencing moderate pain. Observation, on 07/13/11 at 4:18 PM, revealed LPN #4 failed to wash his hands prior to beginning a medication pass of a prn (as needed) oral pain medication given to Resident #10. Observation immediately prior to the medication pass revealed LPN #4 pushed a wheelchair with an unsampled resident from the hallway outside	F 441		

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F 441	Continued From page 22 of the resident's room to inside the room's doorway. He then pushed the medication cart down the hall to the nurses station area. Next, LPN #4 pushed the medication cart down the hallway to outside of Resident #10's room for the medication pass of a prn pain medication. Observation revealed LPN #4 failed to wash his hands prior to administering the medication. During an interview, conducted on 07/13/11 at 5:30 PM, LPN#4 stated he should have washed or sanitized his hands before passing medication ordered for Resident #10. Interview with the DON, on 07/15/11 at 7:20 PM, revealed staff should wash/sanitize their hands prior to passing medication to a resident per the facility policy. 4. Observation, on 07/15/11 at 1:20 PM, revealed SRNA #3 failed to follow infection control guidelines when completing the tasks of filling a resident's water pitcher and cleaning a resident's dentures. Observation revealed the SRNA's right arm and hand were in a cast. The SRNA was observed holding the resident's pitcher against her body for stabilization while she removed the top of the pitcher with her left hand. In addition SRNA #3 was observed attempting to brush a resident's set of dentures that were placed in water in the resident's sink with only her left hand trying to maintain the pressure with the dentures against the sink wall to keep them from moving as she attempted to brush the dentures. The toothbrush and toothpaste tube were observed to have touched her shirt during the assembly process of readying the equipment needed to brush the denture set.	F 441		

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F 441	Continued From page 23 Interview with SRNA #3, on 07/15/11 at 1:40 PM, revealed she returned to work with limitations following an injury that prohibited her from using her right hand and arm. She stated she was unable to adequately wash or sanitize her right hand and could not wear a protective glove on that hand. She stated that the facility was aware of her limitations but she was given patient care assignments which included the tasks of cleaning a resident's dentures and re-filling residents' pitchers with ice and water. Interview with Human Resources, on 07/15/11 at 3:20 PM, revealed the facility was aware and had supportive documentation that stated SRNA #3 was unable to use her right hand/fingers. Interview with the Director of Nursing (DON), on 07/15/11 at 6:40 PM, revealed she was aware the SRNA had an injured an right hand designated as dominant, was assigned "light duty" with physical work restrictions. which prohibited the use of her right hand and forearm. Further interview with the DON revealed staff were to wash their hands between each glove change while performing a dressing change and when there are multiple wound areas on the same resident, staff are to treat the most contaminated area last. 5. Review of the Clinical Record revealed Resident #8 was admitted on 04/07/11 with diagnoses which included Hypertension, Anemia, Gout, Depression and Anxiety. Observation of the dressing change to the coccyx for Resident #8, on 07/12/11 at 3:45 PM, revealed	F 441		

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F 441	Continued From page 24 the Wound Care Nurse (WCN) changed her gloves multiple times throughout the procedure but did not sanitize her hands consistently prior to re-gloving. After removing the old dressing, the WCN cleansed the area around the wound of residual stool, and changed her gloves without sanitizing her hands. She stated, "I know I should have washed my hands". Continued observation revealed the nurse, after cleansing the wound, again changed gloves without proper hand sanitization prior to measuring the wound. Observation of the dressing change to Resident #8's right foot, on 07/13/11 at 9:20 AM, revealed the WCN changed her gloves four (4) times during the procedure. However, the nurse did not wash her hands or use a gel sanitizer between glove changes. In addition, the nurse was observed to put her eyeglasses on and off, placing them on top of her head when not using them, without changing gloves. Interview with the WCN, on 07/15/11 at 12:10 PM, revealed she changed her gloves frequently during wound care procedures, but did not always wash her hands. She stated she had used hand sanitizer in the past but not during the observed procedures. Continued interview revealed she had handled her glasses and touched her hair without realizing it. 6. Record review of Resident #7's Medical Record revealed the facility admitted the resident on 10/20/09 with diagnoses which included Senile Dementia, Pneumonia, Obstructive Hydrocephalus, Urinary Incontinence, Rheumatoid Arthritis, and Joint Contractures.	F 441		

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F 441	Continued From page 25 Observation of wound care, on 07/14/11 at 9:15 AM, to a Stage II Pressure Ulcer located at the coccyx area for Resident #7 revealed the WCN failed to follow the facility's policy for Clean Dressing Procedures related to performing hand hygiene after removing gloves. After the WCN performed the dressing change to the resident's coccyx area, she changed gloves but did not wash her hands before performing the dressing change to the resident's occipital Stage IV Pressure Ulcer. After the WCN performed the dressing change to the resident's occipital Stage IV Pressure Ulcer, she changed her gloves but again did not wash her hands before performing the dressing change to the resident's occipital Stage II Pressure Ulcer. Interview with the WCN, on 07/14/11 at 10:15 AM, regarding the facility's policy for Clean Dressing Procedures and the observation of the wound care provided for Resident #7 revealed she did not wash her hands between glove changes as required by the facility's policy on Clean Dressing Procedures. Further interview revealed the WCN stated she should have washed her hands between glove changes. Interview with WCN on 07/14/11 at 10:30 PM further revealed she should have started with Resident #7's occipital area before the coccyx area as required by the facility's policy on Clean Dressing Procedures. Interview with DON ,on 07/15/11 at 6:40 PM, regarding the facility's policy for Clean Dressing Procedures revealed staff were to wash their hands between each glove change while performing a dressing change. Further interview with the DON revealed when there are multiple	F 441		

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F 441	Continued From page 26 areas on the same resident, staff are to treat the most contaminated area last.	F 441		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy it was determined the facility failed to maintain clinical records on each resident with accepted professional standards and practices which were accurately documented for five (5) of twenty (20) sampled residents. Residents #3, #6, #7, #13 and #16 were documented as having gone multiple days without having a bowel movement and had no documented evidence of interventions. The findings include: Review of the facility's policy titled, "BM Regimen", dated 12/20/10 revealed the facility will monitor and track residents on a daily basis to	F 514	**F514** **Immediate Corrective Action For Residents Found To Be Affected** Residents #3~~, 6,7,13 & 16 were~~ *was interviewed and bowel sounds* assessed by the *ADON* ~~for~~ *and vitals were obtained* on 07/14/11*with no signs or symptoms of bowel elimination issues noted.* ~~*Licensed designee to ensure no negative outcome relative to this alleged deficient practice.*~~ *Resident #6 was interviewed and bowel sounds assessed by the DON and vitals were obtained on 07/16/11 with no signs or symptoms of bowel elimination issues noted. Resident #7 bowel sounds assessed by the ADON and ARNP with vitals obtained on 07/14/11 with no signs or symptoms of bowel elimination issues noted. Resident #13 was interviewed and bowel sounds assessed by the DON and vitals were obtained on 07/15/11with no signs or symptoms of bowel elimination issues noted. Resident #16 was interviewed and bowel sounds assessed by the DON and vitals were obtained on 07/14/11 with no signs or symptoms of bowel elimination issues noted.* **Identification of Other Residents With The Potential to be Affected** ◆ A review of the resident's identified on the bowel elimination concern list during the daily clinical meeting within previous two weeks were assessed by the DON, *SDC, ADON, MDSN, Restorative Nurse or*	

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F 514	Continued From page 27 determine the need for dietary and or chemical interventions to treat chronic and/or acute episodes of constipation. Interview with State Registered Nursing Assistant (SRNA) #1, on 07/14/11 at 3:05 PM, revealed the only place SRNA's document bowel movements was on the Nurse Aid Care Plan. She stated at the end of the shift, they were to document on all of their assigned residents for that shift. If the resident did not have a bowel movement they put a zero (0) in the columns. She further stated the SRNA's on night shift reviewed all of the residents' Nurse Aide Care Plans for bowel movements and made a list of residents who had not had a bowel movement for three (3) days and then gave the list to the Unit Manager. Interview with the Unit Manger for South, on 07/14/11 at 3:45 PM, revealed night shift SRNA's reviewed the resident's Nurse Aide Care Plans and made a list of residents who had not had a bowel movement in three (3) days. She stated they gave the list to the Unit Nurse, who would then review the resident's MAR and start the resident on medication ordered by the Physician for constipation. Interview with the Director of Nursing (DON), on 07/15/11 at 6:10 PM, revealed LPN #5 would bring the list of residents who had not had a bowel movement in three (3) days per the SRNAs documentation, to the Daily Clinical Meeting. Staff would review the list and then each Unit Manager took their list to their unit. Interview revealed the Unit Managers would then review the residents' chart and then assess each resident to determine if they had a bowel	F 514	*Weekend RN Supervisor/~~licensed designee~~* on July 18, 2011 to identify any other resident(s) possibly affected by this alleged deficient practice. There were no resident's identified from this review. **Measures Taken To Assure There Will Not be a Recurrence** ♦ Re-education was provided to the nursing staff 1) necessity for accurate and complete documentation relative to resident elimination and 2) necessity for appropriate assessment followed by appropriate intervention(s) for those residents identified with elimination concerns. This re-education was presented by the SDC, *DON, ADON, MDSN, Restorative Nurse or Weekend RN Supervisor/~~licensed designee~~* August 4-9, 2011. ♦ Elimination Tracking and Trending Log has been developed, *inserviced and implemented by the DON on July 18, 2011 as a tool completed by the Charge Nurse on duty and reviewed by the DON, ADON, MDSN, Restorative Nurse, Weekend RN Supervisor or SDC* to track elimination records for proper identification of those residents with elimination concerns and to further document intervention(s), outcomes and need for further intervention(s). **Monitoring Changes to Assure Continuing Compliance** ♦ Elimination Tracking and Trending Log shall be reviewed daily in clinical meeting and compared to 100% of the resident	

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F 514	Continued From page 28 movement; if the Unit Manager determined the resident had a bowel movement, they would take the resident off of their bowel movement list and the next day in the Daily Clinical Meeting the Unit Managers would review their findings with the team. Further interview with the DON revealed the Unit Managers did not document in the residents' chart if they found the resident did have a bowel movement. Interview with the DON, LPN #5/Restorative Nurse, and the North and South Unit Managers, on 07/15/11 at 6:10 PM, revealed all department managers met daily Monday through Friday, and reviewed all clinical documentation for any gaps. Continued interview revealed the Nurse Aide Care Plans were reviewed to identify any residents that had not had a bowel movement for three (3) days. According to the DON, she was aware there were periods longer than three (3) days with no documented evidence of a bowel movement. She stated those instances were investigated by the Unit Managers to determine if the residents truly had not had a bowel movement and if Bowel Protocol measures should be implemented. 1. Record review revealed the facility admitted Resident #3 on 04/02/11 with diagnoses which included Cerebral Artery Occlusion with Cerebral Infarction, Cerebrovascular Disease, Muscle Weakness, Tracheostomy, and Cholecystectomy. Review of Resident #3's bowel record revealed he/she went from 05/11/11 through 05/19/11, 05/28/11 through 06/04/11, and from 06/08/11 through 06/10/11 without having a documented bowel movement.	F 514	elimination records to assure accuracy and timely interventions. ♦ Any discrepancies will be reported to the Quality Assurance committee for review at least monthly and revision until the Quality Assurance committee has determined substantial compliance is achieved. **Date of Completion:**	08/29/11

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F 514	Continued From page 29 Review of the resident's Medication Administration Record (MAR) and Nursing Notes revealed no documentation of any interventions or notification of the Physician. 2. Review of the Clinical Record revealed Resident #6 was admitted on 10/19/09 with diagnoses which included Chronic Kidney Disease and Dementia. Review of the Nurse Aide Care Plan Record for June 2011 revealed Resident #6 had no documented bowel movement for five (5) days beginning 06/06/11. Continued review revealed no documented bowel movement for the five (5) day period including 06/26/11 through 06/30/11. 3. Clinical Record Review revealed Resident #13 was admitted on 04/07/11 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Glaucoma, and Hypertension. Review of the Nurse Aide Care Plan Record for the month of May 2011 revealed no documented bowel movement between 05/05/11 and 05/10/11, a period of six (6) days. In addition, there was no documentation indicating Resident #13 had a bowel movement for five (5) days beginning 05/24/11 through 05/28/11. Review of the Nurse Aide Care Plan Record for the month of June 2011 revealed Resident #13 had no documented bowel movement for a six (6) day period beginning 06/07/11 through 06/12/11. Continued review revealed no documented evidence the resident had a bowel movement between 06/21/11 and 06/30/11, a period of ten	F 514		

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F 514	Continued From page 30 (10) days. 4. Review of the clinical record revealed Resident #16 was admitted on 09/16/08 with diagnoses which included Osteoarthritis, Morbid Obesity and Abnormal Involuntary Movements. Record review of Resident #16's Quarterly Minimal Data Set Assessment (MDS), dated 04/25/11 revealed the facility had assessed the resident to be cognitively intact, always incontinent of bowel and dependent on staff for assistance with personal hygiene and toileting care needs. Record review of the Nurse Aide Care Plan, dated June 2011, revealed the resident did not have a documented bowel movement from 06/06/11 to 06/16/11, a period of ten (10) days. Interview with Resident #16, on 07/15/11 at 6:00 PM, revealed he/she did not have a history of constipation during the month of June. Further interview revealed the resident had a history of regular bowel movements every one (1) to three (3) days. Interview, on 07/15/11 at 6:10 PM, with the Unit Manager revealed on 06/09/11 Resident #16 was assessed related to constipation but determined a documentation error had occurred on the Bowel Movement Log Sheet. Further interview revealed the facility did not have a system in place to correct the documentation error. 5. Record review of Resident #7's Medical Chart revealed the facility admitted Resident #7 on 10/20/09 with diagnosis which included Senile	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185446		C 07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

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F 514	Continued From page 31 Dementia, Pneumonia, Obstructive Hydrocephalus, Urinary Incontinence, Rheumatoid Arthritis, and Joint Contractures. Record review of Resident #7's Nurse Aide Care Plan for the month of May 2011 revealed no documented evidence of a bowel movement for nineteen (19) of thirty one (31) days. Record review of the Nurse Aide Care Plan for the month of June 2011 revealed no documented evidence of a bowel movement for twenty (20) of thirty (30) days. Record review of Resident #7's Medication Administration Record (MAR) for the months of May and for June 2011 revealed an order for Lactulose ordered every day as needed for constipation. Further review of the resident's MAR revealed for the month of May 2011 the resident only received Lactulose on May 31, 2011. Further review of the resident's MAR for the month of June 2011 revealed the resident only received Lactulose on June 6, 2011 and June 21, 2011. Interview with the Unit Manger for South, on 07/14/11 at 3:45 PM, after reviewing Resident #7's Nursing Aide Care Plan for the month of June 2011, stated the resident would have been placed on their list to review in the Daily Clinical Meeting. She further stated Resident #7 had been reviewed and it was determined Resident #7 had not gone over three (3) days without having a bowel movement; however, they did not go back and document their findings in the resident's charts. Interview with Licensed Practical Nurse (LPN) #5,	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 07/15/2011
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517	

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F 514	Continued From page 32 on 07/15/11 at 6:10 PM, revealed she reviewed the Nursing Aide Care Plans each morning before the Daily Clinical Meetings and made a list of all the residents who, according to the Nursing Aide Care Plan, had not had a bowel movement in three (3) days. Interview with the Unit Manager on North, on 07/15/11 at 6:10 PM, revealed if they found a resident on the list that had a bowel movement, then they took the resident off of their list; however, they did not go back in the resident's chart and document the resident's bowel movement. Interview with the DON, on 07/15/11 at 6:20 PM, after reviewing Resident #7's Nursing Aid Care Plan, stated Resident #7 was reviewed in their Daily Clinical Meetings and it was determined that he/she had bowel movements on several of the days marked with zeros (0) on the Nursing Aide Care Plan. She further stated one reason Resident #7 could have been marked as not having a bowel movement because another SRNA could have changed the resident and not reported to the assigned SRNA. Or the Hospice SRNA could have changed the resident and not told the facility SRNA. She further stated they have noticed a trend in the SRNA's documenting no bowel movements when the resident had a bowel movement. Further interview with the DON, on 07/15/11 at 6:30 PM, revealed there were several possible reasons why a resident may have had a bowel movement without it being documented: Hospice patients may have had a bowel movement with Hospice staff who would not have documented on	F 514		

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	185448		C 07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

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F 514	Continued From page 33 the Nurse Aide Care Plan; families may have assisted residents to the bathroom without informing the staff of a bowel movement; independently ambulatory residents may have had a bowel movement without staff knowledge, but did not always remember if asked; or an aide may have assisted a resident not on their hall and failed to tell the aide assigned to the resident. The DON and both Unit Managers, in continued interview, stated they were aware there was a documentation problem but "just couldn't get them to do it" consistently.	F 514		

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

PRINTED: 07/29/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185446	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/12/2011

NAME OF PROVIDER OR SUPPLIER: BLUEGRASS CARE & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3576 PIMLICO PARKWAY, LEXINGTON, KY 40517

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K 000	INITIAL COMMENTS K3 Building: 0101 K6 Plan Approval: 06/15/77 Constructed K7 Survey under: 2000 existing K8 SNF Type of structure: One story Skilled Nursing Facility Type 5 protected construction. The facility was a fully sprinklered (wet system) and a complete fire alarm system. Two (2) type 2 generators were present one (1) natural gas and one (1) diesel fuel. The facility had seven (7) smoke compartments and is licensed for one hundred twenty four (124) and the census was ninety-eight (98) the day of the survey. A Life Safety Code survey was initiated and concluded on 07/12/11, for compliance with Title 42, Code of Federal Regulations, 483.70, and found the facility to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.	K 000	RECEIVED AUG - 8 2011 BY:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: ADMINISTRATOR (X6) DATE: 08/07/2011

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.