

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

PRINTED: 06/19/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 06/19/2015
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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504
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{F 000} INITIAL COMMENTS

An offsite revisit was conducted and based on the acceptable Plan of Correction (POC), the facility was deemed to be in compliance as alleged on 06/15/15.

{F 000}

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

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 000	INITIAL COMMENTS An Abbreviated Survey investigating KY00023228 was initiated on 05/14/15 and concluded on 05/15/15 with deficiencies cited at a highest Scope and Severity of a "D".	F 000	Plan of Correction Cambridge Place Abbreviated Survey 5/15/15	
F 282 SS=0	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 ensure the Comprehensive Care Plan interventions were implemented for one (1) of five (5) sampled residents (Resident #4). Resident #4 had an indwelling urinary catheter which the facility had care planned the resident for and that had an intervention to "avoid pulling" on the catheter tubing. However, observation revealed Resident #4's Foley Catheter was not secured in a manner to avoid pulling on the catheter tubing, and the tubing was stretched over the resident's leg and lying directly on the floor. The findings include: Interview, on 05/15/15 at 4:25 PM, with the Administrator revealed the facility did not have a policy on ensuring staff implemented residents'	F 282	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Administrative</i>	TITLE	(X6) DATE 6/11/15
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282 Continued From page 1

care plan interventions. However, per the Administrator, it was the facility's expectation for all residents' care plan interventions to be implemented and the facility's policies to be followed by its staff.

Review of the facility's policy titled, "Indwelling Urinary Catheter", dated 04/27/13, revealed residents who had indwelling urinary catheters would have an individualized plan of care developed to address the individualized needs of the resident. Continued review of the Policy revealed each resident who had an indwelling catheter would have a care plan to address potential catheter-related complications. Per the Policy, residents who had an indwelling catheter would receive the care and services necessary to prevent infection to the extent possible.

Review of Resident #4's medical record revealed the facility admitted the resident on 04/03/14, with diagnoses which included Chronic Kidney Disease, Neurogenic Bladder, Urinary Retention, Bladder Sphincter Hypertonicity (overactive), Diabetes and Dementia. Continued review revealed an order dated 02/27/15, for a 20 French (a measurement which denotes the size of the catheter) Foley Catheter to bedside drainage related to a diagnosis of Bladder Sphincter Hypertonicity. Review of the 05/05/15, Quarterly Minimum Data Set (MDS) Assessment revealed the facility assessed Resident #4 to have a Brief Interview for Mental Status (BIMS) score of eight (8) out of fifteen (15), indicative of moderate cognitive impairment. Continued review of the MDS Assessment revealed the facility assessed Resident #4 to require extensive physical assistance of one (1) to two (2) staff for most Activities of Daily Living (ADLs).

F 282 F282 483.2(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

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

Criteria 1: Resident # 4 had his Foley catheter secured and positioned properly to prevent discomfort on 5/14/15 by the Nurse.

Criteria 2: Residents with Foley catheters were audited on 5/21/15 by the Staff Development Coordinator to ensure catheters were secured and positioned properly to prevent discomfort.

Criteria 3: -L.P.N's, R.N.'s, C.M.T.'s and SRNA's will have received in-service education from the Staff Development Coordinator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and/or Unit Coordinators by 6/14/15 on compliance with the security/positioning of Foley catheters to ensure the resident's comfort and appropriate treatment. A Continuous Quality Improvement (CQI) audit tool addressing the security/positioning of Foley Catheters, ensuring the care plan is being followed, and addressing potential infection control concerns has been developed and approved by the Quality Assurance (QA) committee.

Criteria 4: The CQI audit tool addressing the security/positioning of Foley catheters, following the care plan, and addressing potential infection control concerns will review 50% of residents with Foley catheters. The CQI audit tool will be utilized on different shifts by the Unit Coordinators and/or Staff Development Coordinator weekly x 4 weeks, monthly X 3 months, then quarterly thereafter as per the established CQI calendar, under the supervision of the Director of Nursing.

Criteria 5:

6/15/15

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F 282	Continued From page 2 Review of Resident #4's Comprehensive Care Plan initiated 04/17/15, revealed the facility had care planned the resident for alteration in elimination related to an indwelling Foley Catheter. Continued review of the care plan revealed the interventions included "avoid pulling" on the catheter, catheter care every shift and as necessary, and catheter to drainage bag as ordered. Continued record review and review of the alteration in elimination care plan revealed Resident #4 had to be sent to the hospital Emergency Room (ER) on 04/04/15 and on 04/17/15 related to concerns with his/her Foley Catheter. Observation on 05/14/15 at 4:35 PM, revealed Resident #4's Foley Catheter tubing was pulled over the resident's leg and was lying on the floor. Continued observation revealed observed urine in the upper part of the tubing was unable to drain into the drainage bag and there was sediment observed in catheter tubing. Interview with Resident #4 at the time of the observation revealed the catheter tubing was pulling his/her genitalia and was hurting him/her. Interview with Licensed Practical Nurse (LPN) #1 on 05/14/15 at 4:48 PM and on 05/15/15 at 3:10 PM, revealed Resident #4's catheter tubing should not be pulled over his/her leg and it should have been secured in place by taping it to the resident's leg. LPN #1 revealed Resident #4's Comprehensive Care Plan was not followed regarding ensuring his/her Foley Catheter tubing was secured and not being pulled. Per interview, as the catheter tubing was pulled over Resident	F 282			

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F 282	Continued From page 3 #4's it could not drain properly and exposed the resident to the potential of infection. Interview with Registered Nurse (RN) #1/Unit Coordinator (UC) on 05/15/15 at 3:20 PM, revealed rounds were performed every two (2) hours and at the change of each shift. Per interview, the State Registered Nursing Assistants (SRNAs) should have "spotted" the catheter tubing not being "anchored" properly and lying on the floor. RN #1/UC stated not having the catheter tubing properly secured could have caused the tubing to "pull out" and have to be replaced. Continued interview revealed a resident's care plan was designed to ensure the resident received the individualized care he/she was assessed to require. She stated staff had failed to follow Resident #4's care plan which had placed him/her at a risk for injury as the catheter tubing was not secured. Interview with the Assistant Director of Nursing (ADON), on 05/15/15 at 4:55 PM, revealed residents' Comprehensive Care Plan were devised to meet the resident's assessed individualized care needs, and was how the facility staff was made aware of the care needs. Continued interview revealed she expected all staff to follow each resident's care plan interventions. Per interview, staff's failure to follow Resident #4's care plan placed the resident at risk for potential injury or infection, and was not meeting the resident's assessed needs.	F 282			
F 315 SS=D	483.26(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a	F 315			

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F 315	<p>Continued From page 4</p> <p>resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to provide appropriate indwelling urinary catheter care in accordance with the Comprehensive Care Plan to prevent infection for one (1) of five (5) sampled residents (Resident #4).</p> <p>The facility care planned Resident #4 for the resident's indwelling Foley Catheter with interventions which included to "avoid pulling" on the catheter tubing and anchoring the catheter to the drainage bag as ordered. However, observation revealed Resident #4 lying on his/her bed with the Foley Catheter tubing pulled over his/her leg and lying on the floor. Interview with Resident #4 revealed the catheter tubing was pulling and hurt him/her.</p> <p>The finding include:</p> <p>Review of the facility's policy titled, "Indwelling Urinary Catheter", dated 04/27/13, revealed all residents would be assessed upon admission for the presence of an indwelling catheter. Continued review revealed the facility was to assure each resident with an indwelling catheter</p>	F 315	<p>F 315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Criteria 1: Resident # 4 had his Foley catheter secured and positioned properly to prevent discomfort on 5/14/15 by the Nurse.</p> <p>Criteria 2: Residents with Foley catheters were audited on 5/21/15 by the Staff Development Coordinator to ensure catheters were secured and positioned properly to prevent discomfort.</p> <p>Criteria 3: -L.P.N.'s, R.N.'s, C.M.T.'s, and SRNA's will have received in-service education from the Staff Development Coordinator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and/or Unit Coordinators by 6/14/15 on compliance with the security/positioning of Foley catheters to ensure the resident's comfort and appropriate treatment. A Continuous Quality Improvement (CQI) audit tool addressing the security/positioning of Foley Catheters, ensuring the care plan is being followed, and addressing potential infection control concerns has been developed and approved by the Quality Assurance (QA) committee.</p> <p>Criteria 4: The CQI audit tool addressing the security/positioning of Foley catheters, following the care plan, and addressing potential infection control concerns will review 50% of residents with Foley catheters. The CQI audit tool will be utilized on different shifts by the Unit Coordinators and/or Staff Development Coordinator weekly x 4 weeks, monthly X 3 months, then quarterly thereafter as per the established CQI calendar, under the supervision of the Director of Nursing.</p> <p>Criteria 5:</p>	6/15/15

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F 315	<p>Continued From page 5</p> <p>received the appropriate care and services necessary to prevent infections to the extent possible. Further review revealed each resident with an indwelling catheter would have a care plan to address potential catheter-related complications.</p> <p>Review of the facility's, "Infection Control Policy", dated 09/02/14, revealed the purpose of the facility's infection control policies and practices was to facilitate prevention and management of diseases and infections.</p> <p>Record review revealed the facility admitted Resident #4 on 04/03/14, with diagnoses which included Urinary Retention, Bladder Sphincter Hypertonicity (overactive), Chronic Kidney Disease, Neurogenic Bladder Morbid Obesity and Diabetes. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 05/05/15, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of eight (8) which indicated he/she was moderately cognitively impaired. Continued MDS Assessment review revealed the facility assessed Resident #4 as requiring one (1) to two (2) staff's extensive physical assistance with his/her toileting, bed mobility and hygiene Activities of Daily Living (ADLs).</p> <p>Review of Resident #4's Comprehensive Care Plan revealed the facility had care planned the resident for alteration in elimination related to an indwelling Foley Catheter, Neurogenic Bladder, Urinary Retention, Bladder Sphincter Hypertonicity and history of Urinary Tract Infections (UTIs) on 03/10/14, which was updated on 04/17/15. Review of the care plan revealed the goals included any signs of a UTI would be</p>	F 315		

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F 315	Continued From page 6 noted and treated promptly. Further review of the care plan revealed interventions which included catheter care every shift and as needed, catheter to drainage bag as ordered, "avoid pulling" on the catheter and for the resident to have a Urology consult as scheduled and/or as needed. In addition, review of the alteration in elimination care plan revealed Resident #4 on 04/04/15 and on 04/17/15, was sent to the hospital Emergency Room (ER) related to concerns regarding the Foley Catheter. Review of the Urology Report of Consultation forms dated 03/20/15 and 04/20/15, revealed the Urologist had changed Resident #4's Foley Catheter and the next catheter change date was scheduled in May 2015. Review of the April 2015 monthly Physician's Orders revealed an order for Resident #4 to have a 20 French (a measurement which denotes the size of the catheter) Foley Catheter to bedside drainage to the diagnosis of Bladder Sphincter Hypertonicity, dated 02/27/15. However, observation on 05/14/15 at 4:35 PM, during the initial tour of the facility, revealed Resident #4 was lying on the bed and his/her Foley Catheter drainage tubing was pulled over the resident's leg, unsecured with the drainage bag and part of the tubing lying on the floor. Continued observation revealed urine in the upper part of the tubing which could not drain due to the tubing being over the resident's leg. Further observation revealed there was sediment (the presence of cells, bacteria, crystals, etc. in the urine which could be indicative of a UTI) also in the catheter tubing. Interview with Resident #4, during the observation, revealed the catheter	F 315			

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F 315	Continued From page 7 tubing was pulling on and hurting his/her "privates" (genitalia). Interview with State Registered Nursing Assistant (SRNA) #1 on 05/14/15 at 4:40 PM, revealed she had made rounds previously with the staff member going off duty, and had not seen Resident #4's catheter tubing and bag lying on the floor. She stated she did not look on the other side of Resident #4's bed however, where the bag and tubing were lying on the floor. Continued interview revealed the Foley Catheter tubing should have been taped to Resident #4's leg in order for the tubing not to pull on his/her private parts and possibly hurt the resident. Per interview, the catheter drainage bag should have been anchored to the side of the resident's bed. She stated if Resident #4's tubing was not taped and secured and the drainage bag not anchored to the side of the bed, it placed the resident at risk of the Foley Catheter being pulled out, and at risk for infection. Interview, on 05/14/15 at 4:48 PM and on 05/15/15 at 3:10 PM, with Licensed Practical Nurse (LPN) #1 revealed he rounded as soon as he came on duty; however, had missed seeing Resident #4's Foley Catheter tubing was not taped in place to prevent pulling, and had also missed seeing the drainage bag and tubing lying on the floor. According to LPN #1, Resident #4's catheter tubing should not have been pulled over his/her leg, and should have been anchored to the resident's leg, because he/she was very obese and the tubing pulled at his/her private parts. Continued interview revealed by not having the catheter tubing anchored and the drainage bag clipped to the resident's bed, it placed Resident #4 at risk for complications with his/her	F 315			

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F 315	<p>Continued From page 8</p> <p>Foley Catheter, such as, the tubing being pulled completely out. LPN #1 revealed having the catheter tubing pulled over the resident's leg would not allow it to drain properly and having it and the drainage bag lying on the floor all increased Resident #4's risk for infection.</p> <p>Interview, on 05/15/15 at 3:20 PM, with Registered Nurse (RN) #1/Unit Coordinator (UC) revealed her expectation was for staff to round on every resident at the beginning of each shift which included the SRNA's, nurses and Unit Manager. Per interview, staff were to round on all residents every two (2) hours also to provide incontinence care and any other necessary care required. She stated Resident #4's Foley Catheter should have been properly anchored to his/her leg, and the drainage bag anchored to the bedside, as ordered and care planned. Continued interview revealed the SRNA's should have "spotted" the catheter tubing was not anchored in place and the drainage bag was lying on the floor during their rounds. According to RN #1/UC, staff not ensuring Resident #4's catheter tubing was properly secured to his/her leg and the drainage bag was anchored at the bedside as ordered, placed the resident at risk for increased discomfort and pain, possible injury and increased his/her chances of getting a UTI.</p> <p>Interview, on 05/15/15 at 4:55 PM, with the Assistant Director of Nursing (ADON) revealed it was concerning that Resident #4 was placed at risk for infection due to not having the catheter tubing and drainage bag properly anchored. Per interview, not having the catheter tubing properly anchored increased the chance of Resident #4's Foley Catheter coming out and causing the resident trauma to his/her genitalia and pain, and</p>	F 315			

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F 315	Continued From page 9 increased his/her chance of getting a UTI. Interview, on 05/15/15 at 4:25 PM, with the Administrator revealed her expectations were for all staff to follow the facility's policies pertaining to indwelling urinary catheters and infection control. She stated failure to follow the facility's policies and residents' care plan interventions placed Resident #4 at risk for increased pain and infections.	F 315			