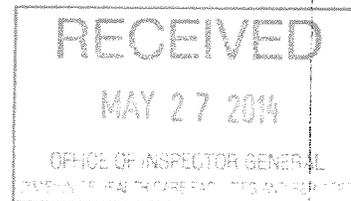


NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHABILITATION, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
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F 000	INITIAL COMMENTS A Standard Health Survey was initiated on 04/22/14 and concluded on 04/24/14 and Life Safety Code Survey conducted on 04/22/14 with deficiencies cited at the highest scope and severity of a "F".	F 000	The preparation and execution of this credible allegation of compliance 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. The facility reserves its right to dispute the facts and conclusions in any forum necessary and disputes that any action or inaction on its part created any deficient practice. This Plan of Correction is prepared and executed solely because it is required by federal and state law.	
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during	F 156	Criteria 1: The posters which display/explain written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits have been obtained by the Administrator and are displayed prominently in the facility as of 5/23/14.	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Gary A. Preece

Administrator 05/23/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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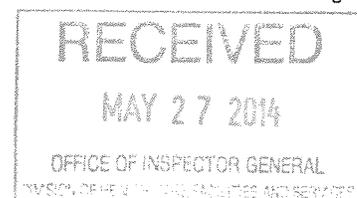
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2014
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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHABILITATION, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056
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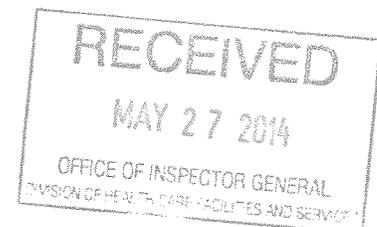
F 156	<p>Continued From page 1</p> <p>the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p>	F 156	<p>Criteria 2: The Administrator obtained the posters which display/explain written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. He then verified that these posters were prominently displayed in the facility for easy access by residents and visitors as of 5/23/14.</p> <p>Criteria 3: On 5/23/14 the Administrator and Business Office Manager reviewed the regulatory requirements for prominently displaying written information in the facility, and providing residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. They then reviewed the information displayed and provided to residents and applicants for admission to verify compliance.</p>	
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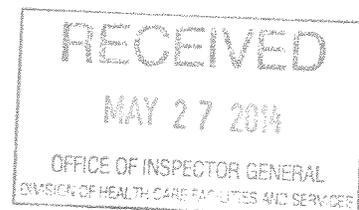
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F 156	Continued From page 2 The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review it was determined the facility failed to display how to apply for Medicaid and Medicare. The findings include: The facility could not provide a policy. Observation made during the environment tour, on 04/23/14 at 8:15 AM, revealed there was no Medicare/Medicaid posting in the facility. Interview with the Director of Nursing (DON), on 04/23/14 at 8:15 AM, revealed when the facility was remodeling the facility a couple of months back, the posters were pulled down from the walls and other posters were replaced. The DON stated she thought the Medicare and Medicaid posting was up. Interview with the Administrator, on 04/23/14 at 8:15 AM, revealed he was not aware there was no Medicare and Medicaid posting. The Administrator stated they had been renovating the building.	F 156	Criteria 4: The CQI indicator for the monitoring of notice of rights, rules, services and charges will be utilized monthly X 2 months, and then annually under the supervision of the Administrator. Criteria 5: 05/26/2014	05/26/2014	



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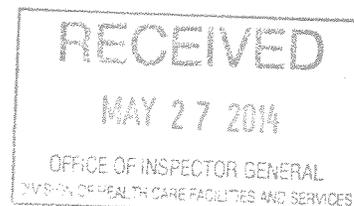
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F 252 F 252 SS=E	Continued From page 3 483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to ensure residents' personal clothing items were returned from laundry for three (3) of twenty-four (24) sampled residents, Residents #2, #10 and #16 and for four (4) of eleven (11) unsampled residents, Unsampled Residents G, H, L and K. The facility had received multiple complaints from residents and families regarding lost clothing articles. The findings include: Review of the Lost Items Policy, not dated, revealed the process of communication to report lost clothing was to check the Dot closet, notify Unit Managers, Charge Nurses and Certified Nursing Assistants (CNA). The System for Laundry for unclaimed items was to set unclaimed items on the shelf in the Laundry Room for thirty (30) days. Place unclaimed items in Laundry Room for an additional sixty (60) days. After sixty (60) days the unclaimed clothes would be put in the Dot Closet on the North Wing. What was left over would be donated to different organizations.	F 252 F 252	Criteria #1 The facility laundry staff have conducted a thorough search of the facility laundry on 5/26/14 for the items reported missing by residents #2, 10, 16, and unsampled residents G, H, L and K. Any items that were not located were reviewed with the resident and responsible party by Social Services to verify the nature of the item, and make arrangements for replacement if requested. Criteria #2: All interviewable residents (with a BIMS score of 8 or higher) were asked if they had any missing laundry items by Social Services on 05/26/14. Family members or responsible parties for those residents with BIMs score less than 8 were asked if any laundry items were missing. Laundry staff conducted a thorough search for any reported items on 5/26/14. Any items not located were reviewed with the resident/responsible party by Social Services to verify the nature of the item, and make arrangements for replacement if requested.		



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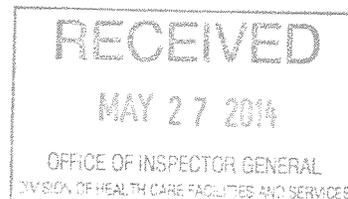
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F 252	<p>Continued From page 4</p> <p>1. Observation of the Dot Closet, on 04/24/14 at 2:10 PM, revealed the Dot Closet was not labeled for family or resident use.</p> <p>Observation of the Laundry Room, on 04/23/14 at 5:18 PM, revealed three (3) boxes, dated April 2014, observed to be full of clothing. Observation of the closet, in the Laundry Room, revealed eleven (11) boxes of clothing and two shelves of blankets.</p> <p>Interview with CNA #4, on 04/24/14 at 2:15 PM, revealed when residents complained about missing laundry, she would go to the laundry area first. CNA #4 stated when staff wanted to access the Dot Closet, the family would have to ask staff where the closet was because the closet was not labeled. CNA #4 stated she was not aware the facility was donating the missing clothes.</p> <p>Interview with a Laundry Aid, on 04/23/14 at 5:18 PM, revealed she was aware the residents were complaining about lost clothing items. The Laundry Aid stated it was usually the new residents who complained about the lost clothing because if she could not get to the resident in time to label the clothes, the clothes could come up missing.</p> <p>Further interview with the Laundry Aid, on 04/23/14 at 5:30 PM, revealed when the family members complained about clothing items that were missing, she would allow the family members to come to the basement to search the Laundry Closet. She stated they would hold the clothes for about three months, then either donate the clothes or place them in the Dot Closet. The Laundry Aid stated when she donated the clothes to other organizations, she would not</p>	F 252	<p>Criteria #3 Laundry staff have received inservice education as provided by the Administrator on 5/23/14, on the need to inspect all resident clothing for proper identification labels and to re-label any items where it is fading or becoming illegible. Any unlabeled/unidentified items are to be taken to Social Services for determination of ownership.</p> <p>Criteria #4 Social Services will maintain a missing laundry log for all items reported by residents/family or staff. This log will be reviewed with laundry weekly to locate the items, and to determine ownership of any unlabeled/unidentified items.</p> <p>Criteria #5 05/27/14</p>	05/27/14



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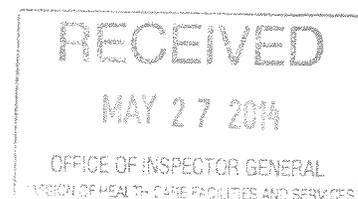
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F 252	<p>Continued From page 5</p> <p>inform the residents that the clothes were leaving the facility.</p> <p>Interview with the Housekeeping Director, on 04/24/14 at 1:43 PM, revealed each unit had a different colored bag. The CNA's collected the linen in the colored bags and dropped the linen bags down the laundry shoot. The colored bag had a mixture of personal resident items and facility linen. The Housekeeping Director stated as soon as a new resident was admitted to the facility, she would try to introduce herself to them and then take the resident clothes to the laundry room to get them labeled. The laundry would label the resident's clothing even if the family would be doing their laundry to ensure the clothing was not lost. If the CNA gives a new resident a shower, and placed the clothes that were not labeled in a colored bag on accident, the clothes would get mixed in with the facility's laundry and that is how some clothes became lost. The Housekeeping Director stated it was the responsibility of the CNA's and family members to look for lost items. The Housekeeping Director stated the Dot Closet was a closet of clothes that was not identified by anyone. Residents who were in need of clothing were welcomed to the closet. Once the closet was full with clothes, the clothes were then donated to charities or churches. The Housekeeping Director stated when the clothes were to be donated she communicated by word of mouth to the Unit Managers and CNA's. She stated there was no other way to communicate, but by word of mouth. However, interview with the Unit Manager revealed her policy did not talk about informing the family and or the residents about clothing being donated. The Unit Manager stated she had not brought this concern to the morning meetings.</p>	F 252			



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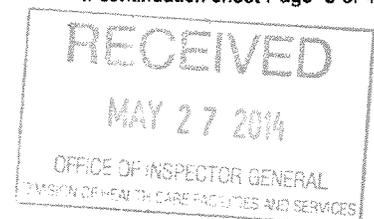
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F 252	Continued From page 6 2. Review of the Resident Council Minutes for February, March, and April of 2014 revealed reports of missing clothing or articles. In February, Unsampld Resident H reported sweat pants and two missing watches which had disappeared at Christmas. In March, Unsampld Resident L reported four pairs of underwear missing and stated the Laundry Department had mixed up his/her roommates (Unsampld Resident G) and his/her clothing. In April, Resident G stated she/he was missing three articles of clothing, two pairs of pants, one navy, and one black and one white nightgown with blue flowers on it. Unsampld Resident G stated they all had his/her name on them. In addition, Unsampld Resident L revealed he/she was missing a pair of black checked pajamas. Interview with residents during the group meeting, on 04/22/14 at 3:00 PM, revealed Residents #16 and Unsampld Residents G and K had problems with receiving their laundry after it was sent to be laundered. Interview with Resident #16 during the group meeting revealed he/she had lost 12 pair of new diabetic socks recently and frequently had clothing missing from the laundry. The resident also stated he/she had some missing shirts over the past few months. Resident #16 stated the facility was aware of the missing items; however, it continued to happen. In addition, the resident stated they had found women's panty hose and underwear in their drawer after laundry had been delivered. The resident scored a 15 out of 15 on the Brief Interview Mental Status (BIMS) test on the 06/25/13 Comprehensive Assessment, which	F 252			



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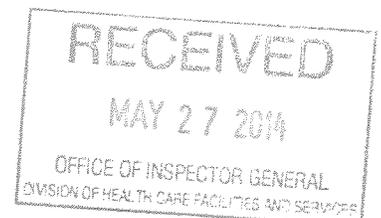
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F 252	<p>Continued From page 7</p> <p>determined the resident to be cognitively intact and interviewable.</p> <p>Interview with Unsampled Resident G during the group meeting revealed he/she had lost a pink shirt and brown slacks recently. Although the resident stated it had been reported, the resident stated it happened frequently. The resident had a BIMS score of 15, which determined the resident to be interviewable.</p> <p>Interview with Unsampled Resident K, on 04/22/14 at 3:00 PM, revealed he/she had two missing gowns about 6 months ago, which were never found and a pair of navy blue and light blue socks missing. The resident stated he/she frequently gets other residents' socks in their drawer.</p> <p>Interview with Resident #10, on 04/24/14 at 10:05 AM, revealed a family member gave the resident four (4) pair of pants; three were blue and the other pair golden yellow. The resident stated about three to four months ago they were missing and he/she talked with the laundry department about the missing pants. Resident #10 stated facility staff would look for the pants, but none of the pants had been returned.</p> <p>Interview with Resident #2, on 04/23/14 at 8:30 AM, revealed the resident's daughter laundered the resident's personal clothing and the staff was supposed to place the resident's soiled laundry into a clothes basket in the resident's room. However, the resident voiced concern because on the resident's shower days, the nurse aides sometimes mixed the resident's personal clothing with facility's linen. The resident stated there had been several clothing articles missing because of</p>	F 252		



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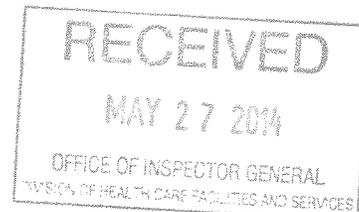
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F 252	<p>Continued From page 8</p> <p>this practice. The resident stated the daughter would inform the laundry department and the laundry staff would search for the missing clothing, but had always found them. The resident stated this was expensive because the resident would have to purchase additional clothing to replace those lost clothing articles. The resident could not name any specific staff who may have put the resident's clothing into the wrong basket during a shower.</p> <p>Review of the resident's Kardex, that instructed the nurse aide on resident care, revealed it was documented on the Kardex that Resident #2's family did the resident's laundry, not the facility.</p> <p>Interview with the North Unit Manager, on 04/23/14 at AM, revealed the nurse aides are to follow the Kardex and if the family did the resident's laundry, they were not to place it in the same bin with facility laundry. When asked who would over see this, she replied she would but she was unaware Resident #2 had clothing missing.</p> <p>Interview with the Social Services Director (SSD), on 04/24/14 at 9:40 AM, revealed the facility had a labeling system where all new resident's laundry would be dropped off with the receptionist and sent down to laundry to be labeled. The SSD stated most laundry went down on Friday's and was delivered to resident's the next Tuesday or Wednesday by the laundry attendant</p> <p>Interview with CNA #4, on 04/24/14 at 2:00 PM, revealed if a resident was missing an item, they would go to the laundry first, and stated they would try to send all clothing to the laundry for labeling. CNA #4 stated that problems with lost</p>	F 252			



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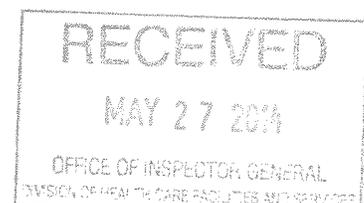
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F 252	Continued From page 9 clothing had been bad lately. Interview with the Housekeeping/Laundry Director, on 04/24/14 at 1:45 PM, revealed there had been staffing problems in the laundry, but was trying to hire enough staff to get the laundry done. She also stated she had pulled the housekeeping staff to the the laundry to work, and revealed if everything was labeled there should not be a problem. The Director further stated she had loads of missing items and did not know the process for training laundry staff. She indicated the staff were not double checking the names and she had gone to the owner about the problem.	F 252			
F 257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, it was determined the facility failed to ensure air temperatures were within 71 to 81 degrees Fahrenheit (F). Observations during two of the three days of the survey, revealed air temperatures were 66-68 degrees F for one (1) of three (3) units, the East Wing. Two (2) of twenty-four (24) residents, Resident #19 and #20 and four (4) of eleven (11) unsampled residents, Residents A, B, C and D were observed wrapped in blankets and shivering from the cold.	F 257	Criteria 1: On 4/24/14 the thermostat on the East Hall was adjusted to between 71 – 81 F, and a lock out box was placed over the thermostat to determine that only designated staff can adjust the temperature. Residents #19, 20, and unsampled A, B, C and D were interviewed by the Administrator to verify that they were comfortable at the adjusted temperature. Criteria 2: All thermostats in common areas of the facility were inspected by the Maintenance Director/Administrator on 4/24/14 to determine that the temperature was		



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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHABILITATION, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
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F 257	Continued From page 10 The findings include: Review of the facility's Room Temperature Levels Policy, not dated, revealed it was the policy of the center to provide safe and comfortable room temperature to assure optimal health and comfort to the residents. The goal was to maintain an optimal temperature range of between 71 to 81 degrees. Observations of the East Wing, on 04/22/14 at 1:27 PM, revealed the thermometer registered sixty-six (66) degrees. Five (5) residents were observed to have blankets on. Interview with three (3) of the five (5) residents, Residents #19, #20 and Unsampld Resident A stated the unit was cold. Observations of the East Wing, on 04/22/14 at 2:11 PM, revealed Unsampld Resident B reached out to staff and was shaking. Interview with Certified Nursing Assistant (CNA) #1, on 04/22/14 at 2:11 PM, revealed she went to retrieve Unsampld Resident A a jacket because the resident was shivering. CNA #1 stated it was not usually that cold on the unit. Observation of the East Wing, on 04/23/14 at 8:40 AM, reveal the East Wing was 68 degrees F. Three (3) of nine (9) residents were observed to have blankets on. Further observations, revealed Unsampld Resident C complained to staff that it was too cold. Unsampld Resident D complained about the unit being cold and staff were observed to retrieve a blanket for Unsampld Resident D. Interview with CNA #3, on 04/23/14 at 4:55 PM, revealed sometimes the unit was cold and was	F 257	was maintained between 71 - 81 F. All areas were in compliance with these temperatures. Criteria 3: The maintenance staff were provided inservice education by the Administrator on 04/24/14, on the need to monitor the thermostats in resident common areas weekly to determine that temperatures are maintained between 71 - 81 F. Any discrepancies are to be brought to the attention of the Administrator and addressed as indicated. Criteria 4: The CQI indicator for the monitoring of facility temperatures will be utilized monthly X 2 months then quarterly as per the CQI calendar under the supervision of the Housekeeping and Maintenance Supervisors. Criteria 5: 05/26/14	05/26/14	



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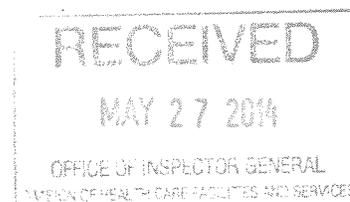
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F 257	<p>Continued From page 11</p> <p>not sure as to why. CNA #3 stated she knew the nurses had a key to adjust the thermostat.</p> <p>Interview with the Restorative Nursing Assistant (RNA), on 04/23/14 at 5:00 PM, revealed she had noticed the East Wing was cold and that the residents were wearing blankets, sometimes two (2) blankets. The RNA stated she knew the nurses could adjust the thermometer and that sometimes the nurses adjusted the thermostat to their likeness. The RNA stated she felt cold all the time.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 04/23/14 at 5:07 PM, revealed at times she noticed the halls were cold and that the residents complained about being cold. LPN #3 stated she thought it was cold because of the way the vents was pointed toward the hall. LPN #1 stated she had never adjusted the thermostat to appeal to her comfort.</p> <p>Interview with the Maintenance Assistant, on 04/24/14 at 10:44 AM, revealed the air temperature set at 66 to 68 degrees was too cold. He stated he had turned up the heat on Tuesday 04/22/14, because a family member had walked up to him and asked him if he could turn up the heat. The Maintenance Assistant agreed that the East Wing was cold. He knew the nurses had keys to the thermostat and could adjust the air if needed.</p> <p>Interview with the Maintenance Director, on 04/24/14 at 2:35 PM, revealed he liked to keep the air temperature at about seventy-two (72) degrees F. The Maintenance Director stated he knew the nursing staff had keys and that he did not expect the nursing staff to adjust the</p>	F 257		



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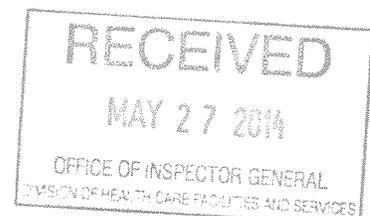
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F 257	Continued From page 12 temperatures to their personal likeness. Interview with the Administrator, on 04/24/14 at 3:10 PM, revealed the hall temperatures should be 72 to 81 degrees F. The Administrator stated he observed one resident to have a blanket on, but not a lot of residents. The Administrator stated the air temperatures should be set for the comfort of the residents and not the staff.	F 257		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). 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	F 279	Criteria 1: The care plan for resident #5 has been reviewed/ revised to address the change in status requiring the use of Ativan as ordered for restlessness, as completed by the MDS Coordinator on 05/15/14. Criteria 2: An audit to determine that the care plans for all residents reflects the results of their assessments will be completed by the MDS Nurses, Staff Development Nurse, Unit Managers as assigned by the DON by 5/30/14. Criteria 3: The IDT and nursing staff will have received inservice education by 05/30/14 on the need to develop, review and revise the resident's Comprehensive plan of care by using the results of the resident assessments, physician orders, nurse aide data MARs and TARs.	



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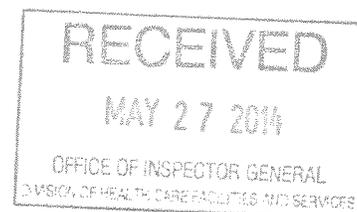
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F 279	Continued From page 13 failed to develop a care plan for one (1) of twenty-five (25) sampled residents, Resident #5. The facility staff recieved a physician's order for Ativan for restlessness and the facility failed to develop a care plan for the resident's need for this medication. The findings include: Review of the facility's policy regarding Comprehensive Care Plans (not dated) revealed a care plan would be developed based on assessed needs. Review of Resident #5's clinical record revealed the facility admitted Resident #5 with diagnoses of Carcinoma in Situ of Prostate, Urinary Obstruction, Hydronephrosis w/nephrostomy, Hypertension, Diabetes Mellitus Type 2, Coronary Artery Disease, and a history of C-Difficile Infection. Review of the comprehensive care plan for Resident #5 did not reveal a problem of restlessness or specific goals and interventions to address the care needs and treatment related to the restlessness and use of the Ativan (anti-anxiety). Interview with the Minimum Data Set (MDS) Coordinator, on 04/24/13 at 6:10 PM, revealed the nurse should have care planned the change in Resident #5's condition and the new order for the Ativan. She stated the last quarterly revision by the MDS Coordinator was on 03/07/14. She stated the nurses should revise the resident care plans from new physician orders as they come in. She further stated the resident's restlessness should have been addressed in the care plan as either a behavior or a medical change of condition. The MDS Coordinator revealed the	F 279	This will be facilitated by the SDC at the direction of the DON. Criteria 4: The CQI tool for the monitoring of use of the resident assessment to develop, review and revise the resident's comprehensive plan of care will be utilized monthly X 2 months and then quarterly as per the established CQI calendar (6/19/14, 9/18/14, 12/18/14) under the supervision of the DON Criteria #5 05/31/14	05/31/14	



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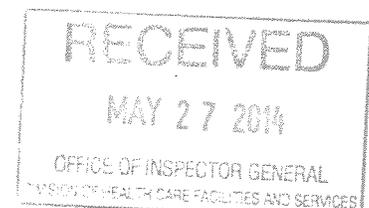
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F 279	Continued From page 14 facility had daily morning meetings to review resident antibiotic orders and falls, but they did not review new physician orders. She stated it was the nurses responsibility to review new physician orders. Interview with the Director of Nursing (DON), on 04/24/13 at 6:20 PM, revealed the facility nurses were responsible for revising and developing care plans. She stated copies of new physician orders did not come to the stand up meeting. The DON further stated Resident #5's restlessness should have been care planned as either a medical or behavioral problem. The DON revealed the night shift (11 PM-7 AM) nurse and the Unit Manager (UM) were responsible for verifying accuracy and transcription of new physician orders.	F 279		
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. 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 a palatable diet that residents would consume for five (5) of twenty-four (24) sampled residents (Resident #5, #8, #10, #16, and #19) and nine (9) of eleven (11) Unsampled Residents, (Unsampled Residents, C, D, G, H, I, J, K, L and M). In addition, a test tray on 4/23/14 (lunch)	F 364	Criteria 1: - Residents are served meals in accordance with the regulatory requirements as determined by Test Tray monitoring done daily X 1 week, then weekly X 3 weeks, and then monthly thereafter by the Dietary Manager/Registered Dietician. -Residents #5, 8, 10, 16, 19 and unsampled residents C, D, G, H, I, J, K, and L will be interviewed weekly X 2 weeks, and then monthly by the Dietary Manager/Registered Dietician to determine they are satisfied with the meals being provided.	



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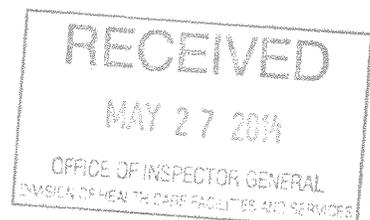
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F 364	Continued From page 15 validated the residents' concerns. The findings include: Review of the facility's policy without a title, reference, or date revealed all foods served would be attractive, palatable, and properly prepared and seasoned. Review of the facility's admission packet information related to meals revealed residents have the right to refuse the food provided by the facility and every effort would be made to provide food by asking facility staff and the facility would strive to provide nourishing food and drink in accordance with the physician's prescription and resident preferences. 1. Observation during tray line, on 04/23/14 at 11:55 AM to 12:15 PM, revealed the main course was meatloaf with ketchup on top. The ketchup on the first tray of meatloaf was brown and the second tray of meatloaf was brownish-black on the top half and the sides of the tray had brownish-black crusty edges. Tray line was stopped at 12:10 PM by the Assistant Dietary Manager (ADM) after half the pan had been plated and sent out to residents. The Dietary Manager (DM) was consulted after returning to the kitchen after speaking with a resident about dietary choices. The second tray of half served meatloaf was removed from the tray line by the cook, per the Dietary Manager, and he was instructed to cut the tops off of the remaining meatloaf and serve to the facility residents with gravy on top. The DM made beef patties while the tray line continued to plate the lunch meal for facility residents. During the same time the Lyonnaise potatoes to be served during the lunch meal ran out. The DM instructed the cook to prepare mashed potatoes to replace the	F 364	Criteria 2: Ten residents will be interviewed randomly in each dining room weekly X 2 weeks and then monthly X 2 months by the Administrator/ Social Services to determine that they are satisfied with the meals being provided. Criteria 3: -Dietary staff have received inservice education by the Dietary Manager/Registered Dietician on the preparation of food to ensure that it is palatable, attractive, and at the proper temperature as completed on 4/23/14. Criteria 4: -The CQI indicator for the monitoring of resident satisfaction with meals will be utilized monthly X 2 months, and then quarterly as per the established CQI calendar (6/19/14, 9/18/14, 12/18/14) under the supervision of the Dietary Manager. Failure to meet the established threshold will result in the development of an action plan to address the issues identified. The completed CQI indicators and action plans will be reviewed in the facility QA meeting.	



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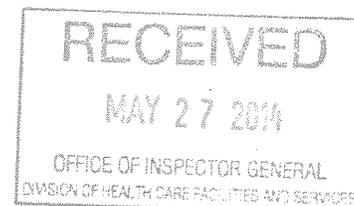
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F 364	<p>Continued From page 16 Lyonnaise potatoes.</p> <p>Observation of a test tray, on 04/23/14 at 1:25 PM, from the steam table in the kitchen revealed the beef patty replaced by the meatloaf was chewy and without flavor or seasoning. The mashed potatoes were without flavor seasoning and butter. The creamed noodles from the alternative menu were clumped together, dry, and bland. The parmesan baked fish from the same alternative menu was mushy and the cheese topping was hard. The burnt meatloaf had been modified and completely served to the facility residents leaving none for the State Survey Agency (SSA) test tray. The DM did not stay for the food tasting on the test tray. Test tray temperatures were: ground meat loaf at 123 degrees; noodles at 109.7 degrees; and buttermilk at 44 degrees;</p> <p>Interview with Resident #10, on 04/24/14 at 10:05 AM, revealed the quality of the facility food was not good and stated the food was terrible and noticed a change in the food brands which were not as good.</p> <p>Interview with Dietary Staff #1, on 04/24/14 at 1:35 PM, revealed the meatloaf was way over cooked and the meatloaf was kept in the cooking ovens, but should have been in the warming ovens during tray line service. She further stated if she had been served the burnt meatloaf she would have complained too. Dietary Staff #1 acknowledged that not enough food was prepared for lunch on 04/23/14 and the delay in the delivery of the trays was upsetting to some of the residents. She further stated the budget had changed that there was less money and the cook did not measure for large groups of people.</p>	F 364	<p>-Residents will be asked about satisfaction with meals in the monthly resident council meeting to determine effectiveness of the interventions. Findings from these interviews will be reviewed in the facility QA meeting.</p> <p>Criteria 5: 05/26/14</p>	05/26/14	



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F 364	Continued From page 17 Interview with ADM, on 04/24/14 at 1:25 PM, revealed she did not notice the second pan of meatloaf was burnt until after half the pan had been served because she was on the other side of the tray line. The ADM further stated the meatloaf should not have been served and she would not have eaten the burnt meatloaf either. Interview with DM, on 04/24/14 at 1:50 PM, revealed the ADM brought the burnt meatloaf to her attention and she acknowledged the meatloaf was over cooked and not palatable and that was why she quickly fixed the beef patties. The DM stated there was not enough food cooked for the lunch meal, but thought there might have been enough meatloaf for everyone if it had not been burnt. 2. Review of the Resident Council Minutes from February and March 2014, revealed grievances were filed as a result of resident dissatisfaction with the food received from the dietary department. In February, Resident #5 requested lunch and supper earlier and stated the potato soup was watery. In addition Resident #5 and Unsampled Resident L requested turkey sausage or bacon for breakfast. In March, Unsampled Resident M requested night time snacks be more consistent since they were receiving them anytime between 7:00 PM and 9:30 PM. Interview with three (3) of eight (8) residents present at the group interview, on 04/22/14 at 3:00 PM, revealed Resident #16 received hot chocolate this morning, however, it was cold. The resident, who was assessed as alert and oriented stated if you order an alternate meal, you have to	F 364			



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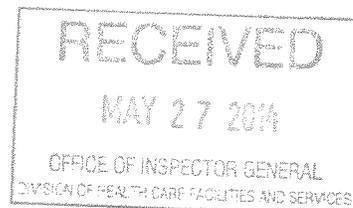
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F 364	<p>Continued From page 18</p> <p>wait a long time to get it. Unsampled Resident G, stated meals were always late and lunch and supper were never good. Unsampled Resident K stated that food is sometimes not cooked thoroughly, and revealed he/she received frozen buttermilk today. This was observed by the SSA.</p> <p>3. Observation of the lunch meal, on 04/23/14 at 11:30 AM, revealed residents sitting in the dining room at 11:45 AM. At 12:40 PM there were no lunch carts to be served. Unsampled Resident M was verbalizing a concern with sitting too long for lunch. The UM offered a small cup of water. Unsampled Resident M stated he/she was going back to his/her room because he/she was tired of waiting and asked that the tray be brought to his/her room. The resident recieved the tray at 1:10 PM.</p> <p>Observation during the lunch meal, on 04/23/14 at 12:34 PM, revealed Resident #16 and Unsampled Resident H were given meatloaf with a dark, crispy top that appeared to be burnt.</p> <p>Interview with Resident #16, on 04/23/14 at 12:34 PM, revealed the meatloaf tasted like nothing.</p> <p>Interview with Resident #H, on 04/23/14 at 12:34 PM, revealed the meatloaf tasted burned.</p> <p>4. Observation of the lunch meal in the East Dining Room, on 04/23/14 at 12:40 PM, revealed the meatloaf was served to residents with a black crispy substance on top. The DON instructed staff to offer the alternative to any resident with burnt food.</p>	F 364		
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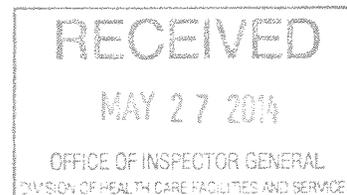
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2014
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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHABILITATION, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056
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F 364	<p>Continued From page 19</p> <p>Interview with Resident #19, on 04/23/14 at 12:40 PM, revealed the food didn't look good. The resident's daughter, who was sitting next to the resident, asked a staff member to please get something else for the resident to eat due to the meatloaf being burnt.</p> <p>Interview with Unsampled Resident J, on 04/23/14 at 12:40 PM, revealed the meatloaf was burnt and the noodles were dry. The resident revealed he/she had requested a breakfast tray to eat instead.</p> <p>Resident #8 was observed, on 04/23/14 at 12:40 PM, crinkling his/her nose while eating the lunch meal.</p> <p>Interview with Unsampled Resident I, on 04/23/14 at 12:41 PM, revealed the food was not good, while shaking his/her head back and forth and crinkling nose.</p> <p>Observation and interview with Unsampled Resident J, on 04/23/14 at 12:40 PM, revealed the meatloaf was burnt and shw wouldn't eat it and she had requested a breakfast tray, but didn't get it, she got burnt food instead.</p> <p>Observation and Interview with Unsampled Resident D, on 04/23/14 at 12:41, revealed the resident was trying to pick off the black substance on top of the meatloaf and revealed the food was "edible, I guess" while making a facial grimace.</p> <p>Observation and interview of Unsampled Resident C, on 04/23/14 at 12:42 PM, revealed the resident had a crinkled nose and stated the mashed potatoes needed salt or some type of seasoning.</p>	F 364		
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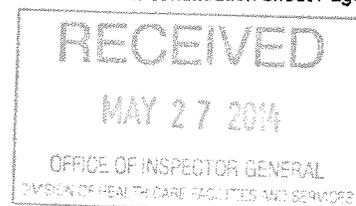
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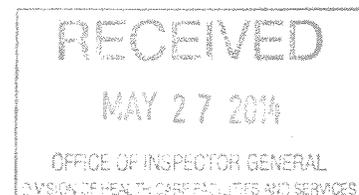
F 364	Continued From page 20 Interview with the Social Services Assistant, on 04/24/14 at 11:00 AM, revealed they received compliants on a daily basis from resident regarding the food. Interview with Unsampled Resident M, (Resident Council President), on 04/22/14 at 3:30 PM, revealed they had taken food concerns to the Administrator, however, the food had not improved yet.	F 364		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431	Criteria 1: -The lab specimen containers, IV supplies, tube of Repar ointment, and bottles of Repar wound cleanser were all removed and/or replaced by the Unit Mangers on 04/24/14. -A thermometer was placed in the refrigerator in the East Med room. Temperatures are logged daily by the nurse assigned by the Unit Manager. Criteria 2: Audits were completed of all of the medication rooms, med and treatment carts on 05/14/14 by the Clinical Educator to identify any expired or unlabeled items. All items identified were removed/replaced.	



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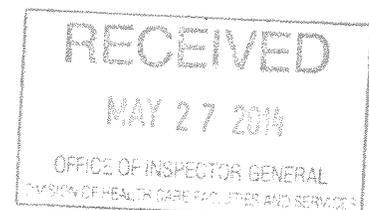
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F 431	Continued From page 21 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy for Medication Storage in the facility, it was determined the facility failed to ensure proper labeling and storage of drugs and biologicals on three (3) of four (4) units. Units East, North and South. The findings include: Review of the facility's policy regarding Medication Storage in the Facility, not dated, revealed medications that required refrigeration were kept in a refrigerator with a thermometer to allow for temperature monitoring. 1. Observation of the East Unit medication room, on 04/22/14 at 2:51 PM, revealed no thermometer in the medication refrigerator. A tiger top laboratory blood specimen container, with an expiration date of 07/2013, was found in the cabinet. Review of the East Unit Temperature Recording Chart, dated April 2014, revealed the temperature had only been check and recorded four (4) out of thirty (30) opportunities for the month.	F 431	Criteria 3: Medication Administration staff have received inservice education by the SDC on the removal/replacement of any expired or unlabeled items in the med rooms.as provided on 05/23/14. Criteria 4: -The CQI indicator for the monitoring of medication supply storage in compliance with the regulations will be utilized monthly X 2 months, and then quarterly thereafter, under the supervision of the DON. Criteria 5: 05/27/14	05/27/14	



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F 431	Continued From page 22 Interview with Licensed Practical Nurse (LPN) #5, on 04/22/14 at 2:51 PM, revealed the refrigerator temperatures should be checked daily by the night shift nurse. Interview with the East Unit Manager, on 04/24/14 at 10:15 AM, revealed there was a potential for abnormal lab values and an incorrect diagnosis by using expired laboratory tubes. The Unit Manager revealed the night shift nurse was not aware she was supposed check and record the medication refrigerator temperatures. However, the Unit Manager revealed she had not instructed the night shift nurse to take the temperature and she had not been monitoring to ensure it was being done either. 2. Observation of the North Unit medication room, 04/22/14 at 3:40 PM, revealed two (2) expired aerobic blood culture bottles, dated 04/16/14, and five (5) expired red top laboratory blood collection tubes, with a expiration date of 01/2014. Review of the North Unit Treatment Cart, on 04/23/14 at 12:15 PM, revealed one (1) tube of Repara Skin Protectant Ointment and three (3) bottles of Repara Wound Cleanser with no open dates or a resident's name. Interview with LPN #3, on 04/23/14 at 12:20 PM, revealed all medications should be labeled with a resident's name, open date, and the discard by or expiration date. LPN #3 revealed he did not know the discard date for the opened wound cleansers and stated " sometimes it's a week" from the date opened.	F 431			



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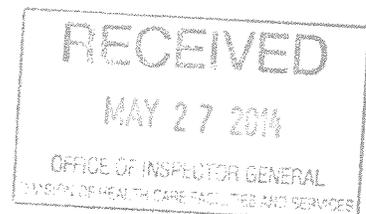
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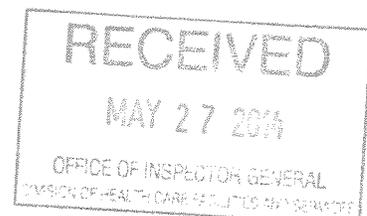
F 431	<p>Continued From page 23</p> <p>Interview with the North Unit Manager, on 04/22/14 3:40 PM, revealed there was a potential for incorrect lab results by using expired laboratory supplies. The Unit Manager revealed she had not assigned anyone to the task of checking the laboratory supplies to ensure all were within date and not expired. The Unit Manager revealed she tried to monitor the medication room weekly, but did not notice the expired laboratory supplies.</p> <p>Interview with the Pharmacist, on 04/24/14 at 3:05 PM, revealed policy and procedures are located on each nursing unit and with the Director of Nursing (DON). The Pharmacist revealed medication refrigerators should be monitored at least daily. The Pharmacist revealed medications need to be maintained around 36-42 degrees to ensure medications are not stored outside of the manufactures recommendations. The Pharmacist revealed wound cleansers can not be communal and should be labeled for each person to prevent cross contamination and ensure infection control.</p> <p>Interview with the DON, on 04/24/14 at 3:39 PM, revealed there had been no formal training on the pharmacy policy and procedures. However, medications should be maintained within the recommended guidelines. The DON revealed the night shift nurse did not know it was her responsibility to check the refrigerator temperature and although there was a list of duties outlined in the charge nurse book, monitoring the medication refrigerator temperatures was not on the list. Therefore, the task was not completed. The DON stated she conducted spot checks on the medication refrigerators, but had not checked the East Unit</p>	F 431		
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F 431	Continued From page 24 refrigerator. The DON revealed the facility did use communal barrier cream and wound cleanser in the treatment carts. The DON revealed she did not find this practice inappropriate as long the products were sprayed on a gauze and not taken into a resident's room. The DON revealed she would expect the lab to check the dates of supplies kept in the medication room, but had not talked with the lab service to see who was responsible. Continued interview with the DON, on 04/24/14 at 5:15 PM, revealed the facility completed a mock survey last week, but the medication rooms were not inspected. The DON revealed she had asked the Unit Managers to monitor the medication refrigerator temperatures, but had not followed up to ensure it was done. The DON revealed a pharmacy review was completed at the first of April and they had noticed holes in the medication refrigerator temperature monitoring and emailed the DON with their concerns. However, the DON revealed she had not yet read that email until 04/24/14.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441	Criteria #1 Wound care for Resident #6, blood glucose sticks for resident #5, and hand hygiene after removal of PPE is completed in accordance with infection control standards of practice as determined by care observations performed by the Clinical Educator on 05/19/14, 05/21/14 and 05/23/14.		



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F 441 Continued From page 25

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

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

(b) Preventing Spread of Infection

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

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

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

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

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of the facility's policy, it was determined the facility failed to consistently implement their infection control policy regarding hand hygiene to prevent transmission of disease and infection during a wound dressing and a blood glucose stick for two (2) of twenty-four (24) sampled residents (Resident #5 and #6). The nursing staff provided wound care treatments to Resident #6 and failed to wash hands in-between glove changes and when exiting and re-entering the room. The staff

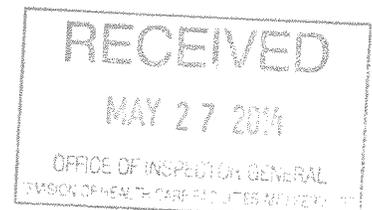
F 441

Criteria #2 Care observations were performed weekly X 2 weeks, monthly X 2 months, and then quarterly on 5 alternately chosen residents receiving care, including wound care, blood glucose finger sticks and isolation care, as completed by the Clinical Educator.

Criteria #3 Facility licensed nurses will have received inservice education by the SDC on the provision of all care in accordance with infection control standards of practice including but not limited to wound care and blood glucose finger sticks as provided by 05/30/14.

All nursing staff will have received inservice education on the provision of all care in accordance with infection control standards of practice, including but not limited to hand hygiene after removal of PPE, as provided by 05/30/14 by the SDC.

Criteria #4 The CQI indicator for the monitoring of Infection Control Standards of Practice will be utilized monthly X 2 months, and then quarterly thereafter under the supervision of the DON.



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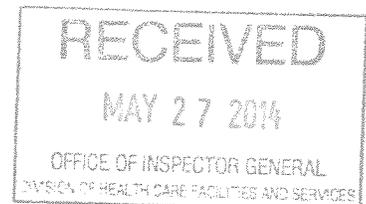
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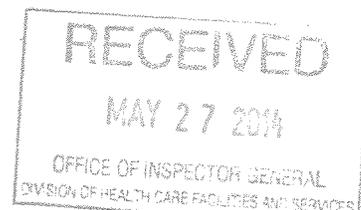
F 441	<p>Continued From page 26</p> <p>was observed to cross contaminate two (2) tubes of wound treatment medications and placed a dirty writing utensil after use on the top of the treatment cart without sanitation. In addition, the nursing staff failed to wash hands after glove changes during a blood glucose stick from Resident #5 in Contact isolation and wore the PPE outside the room.</p> <p>The findings include:</p> <p>Review of the Infection Control-Standard Precautions, undated, revealed hands should be washed after removal of gloves, between resident contact, and when otherwise indicated to avoid transfer of microorganisms to other residents or environment. Gloves should be removed promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident, and wash hands immediately to avoid transfer of microorganisms to other residents or environment. Staff was to ensure that reusable equipment was not used for the care of another resident until it had been appropriately cleaned and reprocessed and single use items were properly discarded.</p> <p>Review of the Center for Disease Control (CDC) guidelines, dated 12/11/13, revealed gloves should be changed: when soiled (e.g., with blood, or other body fluids); and when going from a dirty area or task to a clean area or task. The CDC defined a dirty area as an area where there was a potential for contamination with blood or body fluids and areas where contaminated or used supplies, equipment, blood supplies or biohazard containers are stored or handled. A clean area was an area designated only for clean and</p>	F 441	Criteria #5 05/31/14	05/31/14
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F 441	Continued From page 27 unused equipment and supplies and medications; when moving from a contaminated body site to a clean body site of the same patient; and after touching one patient or their machine and before arriving to care for another patient or touch another patient's machine. According to the CDC, even with glove use, hand hygiene was necessary after glove removal because hands could become contaminated through small defects in the gloves and from the outer surface of the gloves during glove removal. 1. Observation of wound care treatment for Resident #6, on 04/23/14 at 10:30 AM, with LPN #3 with the Director of Nursing (DON) observing, and Registered Nurse (RN) #1 assisting, revealed during the wound care treatment, LPN #3 washed his hands and turned the faucet off with bare hands before putting on clean gloves. Resident #6 had three (3) wound care treatments. The first wound treatment was the right buttock; the nurse cleaned and patted the wound dry, then discarded his dirty gloves. The nurse placed cleaned gloves on his hands without performing hand hygiene. Then LPN #3 applied the wound treatment and covered the wound with a hydrocolloid dressing. The nurse picked up a marker and dated the dressing with the same gloves, re-capped the marker and placed the marker back on the table with other clean dressing supplies. The LPN then removed the soiled gloves and left the room. He reached into his shirt pocket for the treatment cart keys and opened the cart to get more supplies without washing his hands. The DON was observed speaking to LPN #3 at the door while getting into the treatment cart, LPN #3 was observed nodding his head. LPN #3 re-entered the resident's room and washed his hands and placed clean gloves	F 441			



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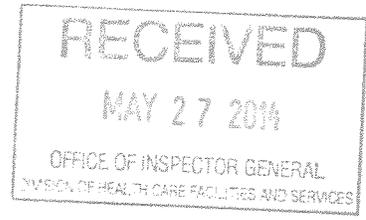
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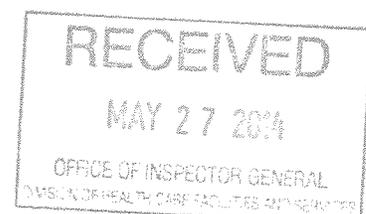
F 441	<p>Continued From page 28</p> <p>on for the second treatment to the left great toe. The nurse went back to the treatment cart with gloved hands, reached into his pocket to get treatment cart keys with his right gloved hand; the nurse reentered the resident room with no gloves on his hands and more gauze, no hand washing was observed. LPN #3 exited the room again, opened the treatment cart and retrieved a measuring device, he reentered the room and placed clean gloves on without hand washing. LPN #3 applied the prescribed medication (mupirocin & collagenase) for the left toe wound with a gloved finger then secured with gauze and paper tape, dirty gloves removed and marker was used to date dressing without hand washing. The last and third wound for Resident #6 was the fourth right toe; the nurse was observed washing his hands and turned the faucet off with bare hands. The nurse was going to exit the room to get a tool to measure and the DON stated "I will get it", and left the resident's room. The nurse applied the medications to the resident's right fourth toe with a gloved finger, he secured and dated the same way for the left great toe wound treatment. The nurse removed his gloves without hand washing. The two tubes of medication were left uncapped on the barrier towel; LPN #3 recapped the tubes of medication with the wrong caps and with bare hands. The tubes were placed back into the medication boxes.</p> <p>Interview with LPN #3 and RN #1, on 04/23/14 at 11:10 AM, revealed the caps for the two tubes of medications were placed on the wrong tube.</p> <p>Continued observation of the wound care treatment, on 04/23/14 at 11:10 AM, revealed LPN #3 used bare hands to place supplies back in the cart which included paper tape and the</p>	F 441		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 29</p> <p>cross contaminated tubes of medication. The marker was picked up and tossed on top of the treatment cart with the treatment book. The nurse was observed signing off completion of the wound care treatment and placing his pen back into his shirt pocket. The treatment cart contained Sanitation Wipes which were not observed to be used before, during or after the wound care treatments were finished at 11:15 AM.</p> <p>Interview with LPN #3 and RN #1, on 04/23/14 at 11:15 AM, revealed sanitation wipes were used to clean up spills, glucometer, and before and after use of the treatment cart.</p> <p>Review of the clinical record revealed the facility admitted Resident #6 on 06/09/77 with history of Cerebral Palsy and pressure ulcer on the right buttock, left great toe, and the right fourth toe.</p> <p>Interview with LPN #3, on 04/24/14 at 11:45 AM to 12:00 PM, revealed he did not remember turning the faucet off with his bare hands. LPN #3 denied reaching into his shirt pocket to retrieve keys to open the treatment cart with a dirty gloved hand and he thought he washed his hands each time he changed his gloves. The nurse stated he dated Resident #6's applied buttock dressing with dirty gloved hands and should have changed his gloves before using the marker, then later stated he should have cleaned the marker as he had another resident treatment to do. He acknowledged the caps were on the wrong tubes of medication and it was an accident and the medication could have been contaminated. He further stated the facility policy was to wash hands after changing gloves and when leaving a resident room after care because gloves were</p>	F 441			



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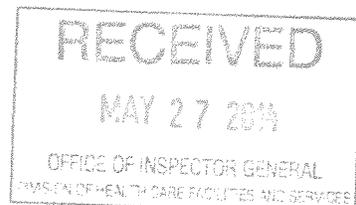
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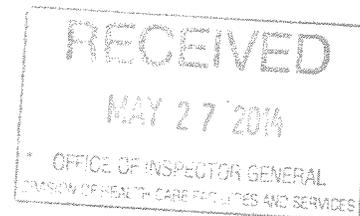
F 441	<p>Continued From page 30</p> <p>porous and not 100% protection for hands. LPN #3 also stated the risk could be the spread of infection to the residents, nurses and visitors.</p> <p>Interview with RN #1, on 04/24/14 at 2:15 PM, revealed she had concerns about LPN #3's nursing skills which included the application of medication to wounds with a gloved finger, using a dirty gloved hand to date a dressing that was already placed on the resident and then placing the marker back into a clean field with supplies. She also observed the nurse left the room several times without washing his hands and not washing his hands after changing his gloves and was aware he exited the bedside with dirty gloves on his hands. RN #1 stated hand washing and infection control was basic standard nursing knowledge and he should have followed those basic principles of nursing. RN #1 acknowledged residents, staff and anybody that comes into the building were at risk for infection, if infection control practices were not followed. The RN further stated Sani-clothes should have been used to sanitize equipment such as pens and markers.</p> <p>2. Observation of blood glucose checks, on 04/24/14 at 11:40 AM, with LPN #3 revealed LPN #3 exited Resident #5's room wearing personal protective equipment (PPE), a yellow gown, and gloves, while carrying a glucometer. Resident #5 had Contact precautions posted on the resident's door related to a positive culture for C-Difficile Infection. LPN #3 placed the glucometer on top of the treatment cart, disposed of the lancet in the sharps container on the treatment cart, documented the blood glucose result on to the Medication Administration Record (MAR), and changed gloves without washing hands or using</p>	F 441		
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F 441	<p>Continued From page 31</p> <p>hand sanitizer. The LPN changed his gloves and then drew up Resident #5's insulin. The nurse re-entered the resident's room to administer the insulin to the resident and then exited the room, and removed the PPE at the treatment cart without washing his hands or using hand sanitizer. LPN #3 then put on new gloves, disinfected the glucometer with a Sani Cloth and removed his gloves without washing hands or using hand sanitizer. No hand sanitizer was observed on the treatment cart.</p> <p>Interview with LPN #3 on 04/24/14 at 5:17 PM, revealed Resident #5 was under contact isolation precautions. The LPN denied that he had exited the resident's room wearing PPE and stated he did not stay outside wearing gown and gloves. He removed it right away. He was inside the door and put his stuff on the cart and removed his gown and gloves. The nurse stated the facility policy for contact isolation was to wear gown and gloves while in the resident's room when care was provided, and to remove the PPE and wash hands before leaving the room. The nurse stated removing gloves and gowns and washing hands prior to exiting the resident's room prevented the spread of germs or infection to other residents.</p> <p>Interview with DON, on 04/24/14 at 3:25 PM to 3:40 PM, revealed she observed LPN #3 apply medication with a gloved hand to Resident #6's wounds, with dirty gloved hands the nurse used a marker and dated a wound dressing after it was applied to the resident, placed the used marker back into a clean field, left the resident room multiple times without washing his hands and expected him to wash his hands before getting into the treatment cart. She further stated placing the used marker on the treatment cart after being</p>	F 441			



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F 441	Continued From page 32 used in the resident room would be contamination of the treatment cart. The DON stated the contaminated medication tubes should have been discarded due to contamination. Interview with Staff Development and Infection Control Nurse (SD/IC), on 04/24/14 at 2:40 to 2:55 PM, revealed facility staff should be washing hands when entering and exiting the resident rooms when providing care and touching personal items of the resident, and to wash hands in-between changing gloves. He further stated faucets were to be turned off with a clean paper towel, markers should be cleaned after use to prevent cross contamination and hands should be washed before getting into the treatment cart. The SD/IC nurse revealed he did not have a surveillance program set up yet. Review of the training records revealed License Practical Nurse (LPN) #3 had been provided facility training on Infection Control/Standard Precautions and completed on 03/18/14. The facility provided the nursing staff with a Wound Care in-service on 03/26/14 in which LPN #3 was not in attendance. The facility utilized a Nurse Orientation Check List for new hires that included skills such as treatments, wound care, and infection control. LPN #3 had no check off list in his education folder, a copy was provided for reference dated 08/21/08.	F 441			
F 497 SS=D	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these	F 497	Criteria 1: SRNA #2 was removed from the schedule until (s)he completed 12 hours of inservice education as provided by the SDC on 4/25/14.		

