

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

PRINTED: 05/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185328	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/26/2012
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NAME OF PROVIDER OR SUPPLIER ST ELIZABETH FT THOMAS SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 86 NORTH GRAND AVENUE FORT THOMAS, KY 41075
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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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>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.</p> <p>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.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the</p>	F 156	<p>Please accept this Plan of Correction as the St. Elizabeth Ft. Thomas Skilled Nursing Facility's credible allegation of substantial compliance effective May 1, 2012 noted from the survey completed April 25, 2012. It is our intent that we have substantially corrected our deficiencies per requirements in 42 CR Part 483 subpart B.</p> <p>F156 Notice of rights, rules, Services, Charges</p> <p>St. Elizabeth Skilled Nursing Facility Ft. Thomas maintains a resident bulletin board, which displays necessary information on Medicare and Ky. Medicaid, including benefits and eligibility.</p> <p>On 4/26/12 the Administrator, when asked by the surveyor to see the posting for Medicare and Medicaid information noted that the information had been removed from the board. The Elder Abuse and Ombudsman information was remained posted on the board.</p> <p>The Administrator immediately replaced the missing information. On 4/30/12 to ensure that the information would remain on the board it was placed in frames and anchored to the wall. See Attachment 2: Frames/Information.</p>	5/1/12

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Wendy Bauer Administrator</i>	TITLE	(X8) DATE <i>5/16/12</i>
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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 156	<p>Continued From page 1</p> <p>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 comply with the requirements specified in subpart 1 of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These</p>	F 156	<p>The Administrator or designee will monitor 3X weekly for two weeks and weekly for four weeks to ensure compliance. See Attachment: 2A "Notice of Rights, Rules, Services, Changes"</p>	

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F 156	<p>Continued From page 2</p> <p>requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</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> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to prominently display information regarding how to apply for and use Medicare and Medicaid benefits.</p> <p>The findings include:</p> <p>Observation, on 04/25/12 at 3:15 PM, revealed there was no signage posted for Medicare and Medicaid and how to apply for these services and benefits.</p> <p>Interview, on 04/26/12 at 9:25 AM, with the Administrator, revealed the signage used to be on</p>	F 156		

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F 156 F 323 SS=D	<p>Continued From page 3</p> <p>the bulletin board in the hall. She indicated she was unaware the signage had been removed.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</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 ensure the resident environment remains as free of accident hazards as is possible for one (1) of eight (8) sampled residents (Resident #2).</p> <p>Observation during the initial tour on 04/24/12 revealed an electric heater, which was close to a wooden chair leg, was turned on and being utilized in Resident #2's room .</p> <p>The findings include:</p> <p>Review of the facility's "Safety Policy/Procedure", dated 01/24/12, revealed space heaters carry a much greater risk of causing fire than central heating, and present a greater potential for human error such as leaving them too close to combustible materials. The policy further stated that space heaters were not permitted in areas</p>	F 156 F 323	<p>F323 Free of Accident Hazards/ Supervision/Devices</p> <p>St. Elizabeth Skilled Nursing Facility Ft. Thomas ensures the safety of the residents through its policies, procedures and practices.</p> <p>On 4/24/12, at the beginning of the Survey process, the facility's Accreditation manager noted that a portable heater was being used in a resident room. She immediately notified the Administrator and recommended it be removed and disposed of. The heater was immediately removed from the room and disposed of. The staff was notified that the space heater had been disposed of as the facility's policy prohibited the use of such heaters in resident rooms. See Attachment K3: "Space Heater Use" Policy.</p> <p>On 4/25/12 during the Life Safety Survey the surveyors inquired about the use of the heater. The facility informed them that the heater had been removed per the recommendation of the Accreditation manager on 4/24/12 and disposed of in the trash compactor. The facility also informed them that there were no additional heaters for use on the unit as they were prohibited by</p>	5/1/12

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F 323	<p>Continued From page 4 where patients were housed or treated.</p> <p>Observation, on 04/24/12 at 1:15 PM, revealed there was an electric heater plugged in and turned on in Resident #2's room and the heater was positioned close to a wooden chair leg.</p> <p>Further observation, on 04/24/12 at 4:00 PM, revealed the electric heater was not observed to be in the room.</p> <p>Interview, on 04/25/12 at 9:45 AM, with Resident #2 revealed she/he had an electric heater in the room; however, staff had removed it.</p> <p>Interview, on 04/25/12 at 2:00 PM, with the Administrator revealed the electric heater was given to the unit by maintenance and it had been approved for use. She stated it had been removed from the resident's room on 04/24/12 because there was some concern with the style of the electric heater. She indicated she was unaware portable electric heaters were not to be utilized in residents' rooms.</p> <p>Interview, on 04/25/12 at 2:05 PM, with the Director of Plant Engineering, revealed "per policy, heaters were not to be used in patient rooms".</p>	F 323	<p>policy [K3].</p> <p>On 4/27/12 the staff was in-serviced on the policy. See Attachment 1: In-service Sign In Sheet and Attachment 3 and 3A: In-Service.</p> <p>No additional action was taken as there were no heaters within the facility to be inadvertently used that would require ongoing monitoring.</p>	
F 371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p>	F 371		

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F 371	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policies, it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions.</p> <p>Observation during initial tour revealed food items were stored on a shelf, open and unsealed, including a bag of corn meal, a bag of cinnamon sugar, a bag of almonds, a bag of brown sugar, and a bag of dry yeast. In addition, spices were stored on a shelf with the bottle lids open including rosemary leaves, cinnamon, nutmeg, ground ginger, white powder, and black pepper. Also, a bottle of Dawn dishwashing detergent was noted to be sitting on top of the food prep table.</p> <p>Additionally, observation during tray line revealed the cook obtained food temperatures and was using the same alcohol pad to clean the thermometer probe for each food item.</p> <p>The findings include:</p> <p>Review of the facility's "Storage of Foodstuffs Policy", dated 10/11/11, revealed all supplies were to be stored properly to maintain quality and ensure food safety. Cleaning materials were to be stored separately from food and paper products.</p> <p>Review of the facility's "Nutrition Services</p>	F 371	<p>F371 Dietary</p> <p>St. Elizabeth Skilled Nursing Facility Ft. Thomas ensures the safety of the residents through its policies, procedures and practices.</p> <p>On 4/24/12 during the dietary survey the surveyor noted the following:</p> <ul style="list-style-type: none"> • Improper storage of dry products • Improper storage of dishwashing liquid in food area • Food thermometer cleaned between food checks cleaned with the same pad <p>The dry products were immediately [4/24] sealed and all spice container lids replaced and checked for snug fit. The dishwashing liquid was moved to a non-food area for storage.</p> <p>On 4/26/12 the staff was in-serviced on the Above issues. See Attachment D1: Meeting Minutes.</p> <p>The dietary manager or designee will monitor for compliance daily for two weeks, weekly for two weeks and then monthly. See Attachment D2.</p> <p>While the facility understood the surveyor's concern with food allergens, the local and federal protocols do not clearly define the process for cleaning thermometers while checking temperatures. Therefore,</p>	5/1/12

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F 371	<p>Continued From page 6</p> <p>Infection Control Guidelines", undated, revealed thermometers used for testing food temperatures were to be cleaned and sanitized prior to use.</p> <p>Observation during initial tour of the kitchen, on 04/24/12 at 12:45 PM, revealed items on the dry goods shelf which were open and unsealed including a bag of corn meal, a bag of cinnamon sugar, a bag of almonds, a bag of brown sugar, and a bag of dry yeast. Also, a shelf in the kitchen contained spices with the lids flipped open including rosemary leaves, cinnamon, nutmeg, ground ginger, white powder, and black pepper.</p> <p>Interview with the Dietary Manager at the time of the observations revealed the corn meal should have been wrapped with plastic wrap after opening, and the cinnamon sugar, almonds, brown sugar, and dry yeast should have been closed and sealed after opening. She further stated the spice lids should have been closed and she would need to re-educate staff.</p> <p>Further observation, on 04/24/12 at 12:50 PM, during initial tour, revealed a bottle of Dawn dishwashing detergent was on top of the food prep table. Interview with the Dietary Manager at the time of the observation revealed cleaning supplies were not to be stored where food was being prepared.</p> <p>Observation on 04/24/12 at 4:45 PM, revealed Cook #1 wiped the thermometer probe with an alcohol swab and temped the tomato soup. He then used the same alcohol swab to clean the thermometer probe and then dry the probe with a dry dish cloth prior to temping the vegetable soup.</p>	F 371	<p>the dietary department has determined that they will focus on foods containing wheat, egg, fish, soy, shellfish and dairy and has drafted a policy and implemented a practice to ensure that these foods are checked with new "<u>freshly sanitized probe</u>" for each food tested. See Attachment D3: Policy.</p> <p>The dietary manager or designee will monitor for compliance daily for two weeks, weekly for two weeks and then monthly. See Attachment D2.</p>	

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F 371	<p>Continued From page 7</p> <p>The cook continued the same process using the same alcohol wipe and the same dry cloth to clean the same thermometer probe to temp the potato soup, green beans, macaroni an cheese, mashed potatoes, corn, pasta noodles, and carrots. Interview at the time of the observation with the Dietary Manager, who was also watching tray line, revealed it was polioy to use a different alcohol wipe to clean the thermometer probe after each food item and she had not noticed the cook using the same alcohol wipe.</p> <p>Interview, on 04/24/12 at 5:30 PM with Cook #1, revealed he was unaware of the need to use a different alcohol pad to clean the thermometer probe between each food item, and was unaware he was not to use a dish cloth to dry the probe after each use. After further questioning, he stated he could see how this could be a problem if residents had food allergies and also for the possible contamination of food items.</p> <p>Further interview, on 04/26/12 at 11:30 AM, with the Dietary Manager when requesting a policy related to temping food items, revealed there was nothing in the facility policy related to using a different alcohol swab prior to temp each food item, and she had never instructed the cooks to do this.</p>	F 371		
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system 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</p>	F 431		

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F 431	<p>Continued From page 8</p> <p>controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure all medication vials were labeled in accordance with current professional standards. The facility failed to ensure a multi-dose vial of Tuberculin skin test serum was dated upon opening.</p>	F 431	<p>F431 Label/Store Drugs</p> <p>St. Elizabeth Skilled Nursing Facility Ft. Thomas ensures the safety of the residents through its policies, procedures and practices.</p> <p>On 4/26/12 the surveyor noted an open, unlabeled multi-dose PPD vial in medication refrigerator. Per facility policy it should have been labeled with date opened and discarded on the 28th day. See Attachment 3D: "Use of Multi-dose Vials"</p> <p>The vial was immediately discarded. On 4/27/12 the nurses were in-serviced on the labeling and discarding of multi-dose vials. See Attachments 1, 3 and 3D: In-service Sign In Sheet, In-Service and Policy.</p> <p>Vials are now placed in plastic bag with label that nurse can enter discard date – See Photo Attached to 3D</p> <p>The Administrator or designee will monitor the labeling of multi-dose vials 3X a week for two weeks and weekly for four weeks. See Attachment 4: Label Monitoring.</p>	5/1/12

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F 431	<p>Continued From page 9</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Medication Storage - Single and Multi Dose Vials", (undated), revealed the maximum expiration date for any properly stored, opened multiple-dose containers was twenty-eight (28) days.</p> <p>Observation, on 04/26/12 at 11:50 AM, revealed an opened (uncapped) vial of Tuberculin skin test serum was stored in the refrigerator in the medication room. Interview with Registered Nurse #8, at that time, revealed multidose medication vials should be dated when opened and expired twenty-eight (28) days after opening. She confirmed the vial had not been dated when opened and stated there was no way to determine when the medication had or would, expire.</p> <p>Interview with the Administrator, on 04/26/12 at 12:30 PM, revealed all multi-dose medication vials were to be dated upon opening. She stated she was not sure when the medication would expire, but thought it was twenty-eight (28) days after opening.</p>	F 431		
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p>	F 441		

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F 441	<p>Continued From page 10</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to 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 for one (1) of eight (8) sampled.</p>	F 441	<p>F441 Infection Control</p> <p>St. Elizabeth Skilled Nursing Facility Ft. Thomas ensures the safety of the residents through its policies, procedures and practices.</p> <p>On 4/25/12 the surveyor observed the LPN providing care that required a change in gloves. The nurse failed to wash her hands after removing the first and putting on the second pair of gloves. The procedure was not a sterile procedure and the nurse followed the isolation handwashing protocol before exiting room. The nurse was immediately instructed that the facility procedure requires handwashing when changing gloves.</p> <p>On 4/27/12 the nurses were in-serviced on the procedure for "Hand Hygiene" and use of gloves. See Attachment 1: In-Service Sign In Sheet and Attachment 3 and 3C: In-service and Hand Hygiene handout.</p> <p>The Administrator or designee will monitor procedures requiring glove changes times four weeks, including Resident #4 until discontinuation of procedure or discharge from facility. See Attachment 5: Hand Hygiene And Use of Gloves Monitor.</p>	5/1/12
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186328	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/26/2012
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NAME OF PROVIDER OR SUPPLIER ST ELIZABETH FT THOMAS SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 86 NORTH GRAND AVENUE FORT THOMAS, KY 41075
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F 441	<p>Continued From page 11 residents (Resident #4).</p> <p>Resident #4 was in contact isolation related to a penile wound with Methicillin Resistant Staphylococcus Aureus (MRSA) organism. Observation revealed a Licensed Practical Nurse (LPN) examined Resident #4's penile wound site/Foley catheter site, and removed the soiled gloves. The nurse then donned new gloves without washing her hands and applied lotion to the resident's feet.</p> <p>Also, observation revealed a Certified Nursing Assistant (CNA) removed the isolation gown by untying the gown around the neck with soiled gloves.</p> <p>The findings include:</p> <p>1. Review of the "Mosby's Nursing Skills Isolation Precautions Quicksheet", dated 11/09, used by the facility, revealed when leaving the isolation room, the order of removal of protective barriers depends on what the nurse wears in the room. Further review revealed, remove one glove by grasping cuff and pulling glove inside out over hand. Hold removed glove in gloved hand. Slide fingers of ungloved hand under remaining glove at wrist. Peel glove off over first glove. Discard gloved in proper container. Perform hand hygiene. Untie neck strings of gown, and then untie back strings of gown. Allow gown to fall from shoulders; touch inside of gown only. Remove hands from sleeves without touching outside of gown. Hold gown inside at shoulder seams, and fold inside out into a bundle; discard in laundry bag.</p>	F 441	<p>On 4/25/12 the surveyor observed the removal of PPE [gown/gloves] by CNA providing care in an isolation room. The CNA [who was nervous] inadvertently removed her gown before her gloves. She immediately recognized her mistake and reported to the Administrator who reviewed the appropriate process with her.</p> <p>On 4/27/12 the staff was in-serviced on the appropriate sequence for removing gown and gloves. See Attachment 1: In-service Sign In Sheet. The staff was in-service using the CDC procedure for removal of PPE. See Attachment 3 and 3B: In-service and CDC "Sequence for Removal of PPE".</p> <p>The Administrator or designee will monitor compliance with CDC procedure 3 X week for two weeks and weekly times four weeks. See Attachment 6: "Removal of PPE Monitor"</p>	

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F 441	<p>Continued From page 12</p> <p>Review of Resident #4's medical record revealed the resident was admitted to the facility on 04/16/12 with diagnoses which included Urinary Retention, Hematuria, Urinary Tract Infection, and Status Post Transurethral Resection of the Prostate.</p> <p>Review of the laboratory data revealed a wound culture of the penis was collected on 04/16/12. Review of the Physician's Orders dated 04/18/12 revealed orders for Bactrim (antibiotic medication) 400/80 tab by mouth twice a day for ten (10) days. The final report received on 04/20/12 indicated MRSA which the culture and susceptibility showed resistant to Trimethoprim/Sulfamethoxazole (antibiotic medication).</p> <p>Review of the Care Plan, dated 04/23/12, revealed a problem of a chronic indwelling catheter for Benign Prostatic Hyperplasia (BPH-enlarged prostate), status/post TURP with complication of Hematuria. Further review revealed the resident was diagnosed with a Urinary Tract Infection, had MRSA in the wound on the Glans Penis, and was in contact isolation.</p> <p>Observation, on 04/25/12 at 9:30 AM, revealed there was an isolation cart outside the resident's door containing gloves, masks, and gowns and a sign by the resident's door which stated contact precautions.</p> <p>Observation of a skin assessment, on 04/25/12 at 3:00 PM, revealed Licensed Practical Nurse (LPN) #1 touched Resident #4's penile wound and Foley catheter and stated the resident had MRSA in the wound. She then removed the</p>	F 441		
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F 441	<p>Continued From page 13</p> <p>soiled gloves, and donned new gloves without washing her hands. LPN #1 proceeded to touch her glasses, and then lotion the resident's feet.</p> <p>Interview, on 04/25/12 at 3:30 PM, with LPN #1 revealed she should have washed her hands prior to donning new gloves, and she had not realized she touched her own glasses with the gloves on.</p> <p>2. Further observation, on 04/25/12 at 5:00 PM, revealed Certified Nursing Assistant (CNA) #2 repositioned Resident #4 in the bed and then weighed the resident by pushing a button on the side rail of the bed. The CNA then untied the tie at the neck of her gown while still wearing soiled gloves and then removed her gown and placed it in the laundry hamper. She then removed her soiled gloves. Interview with CNA #2 after she exited the resident's room, revealed she should have removed her gloves, and then her gown, however, may have been nervous due to being observed.</p> <p>Interview, on 04/25/12 at 4:20 PM and 5:15 PM, with the Infection Control Nurse, revealed CNA #2 should have removed her soiled gloves prior to removing her gown in order to keep from contaminating her hair and neck area. She stated the proper procedure was to remove the gloves, then gown, roll the gown in a ball, and place the gown in a hamper.</p>	F 441		

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Accepted 5/1/12

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Plan approval: 1954, 1965</p> <p>Facility type: SNF</p> <p>Type of structure: Type II protected</p> <p>Smoke Compartment: Three (3)</p> <p>Fire Alarm: Complete fire alarm with smoke detectors installed in corridors</p> <p>Sprinkler System: Complete sprinkler system (wet)</p> <p>Generator: Four (4) type 1 generators installed in 1954 and 1984</p> <p>A standard Life Safety Code survey was conducted on 04/25/12. St Elizabeth Ft Thomas Skilled Nursing Facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was sixteen (16). The facility is licensed for twenty four (24) beds. The Highest Scope and Severity deficiency was an "E" level.</p>	K 000	<p>Please accept this Plan of Correction as the St. Elizabeth Ft. Thomas Skilled Nursing Facility's credible allegation of substantial compliance effective <u>May 1, 2012</u> noted from the survey completed April 25, 2012. It is our intent that we have substantially corrected our deficiencies per requirements in 42 CR Part 483 subpart B.</p> <div data-bbox="925 1191 1236 1377" style="border: 1px solid black; padding: 5px; text-align: center;"> <p>RECEIVED</p> <p>MAY 24 2012</p> <p>BY: _____</p> </div>	
K 029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire</p>	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Wendy Bauer Administrator</i>	TITLE	(X6) DATE <i>5/16/12</i>
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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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K 029	<p>Continued From page 1</p> <p>extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors located in the corridor were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, twelve (12) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation, on 04/25/2012 at 12:28 PM, with the Maintenance Director, revealed the janitor's closet had been used to store combustible materials (toilet tissue rolls), and would not close and latch under the power of its automatic closer. Further observation revealed a room located next to the janitor's closet was being used to store combustible materials (paper boxes) and did not have a self closer.</p> <p>Interview, on 04/25/2012 at 12:28 PM, with the Maintenance Director, indicated the facility was unaware of the doors not functioning according to</p>	K 029	<p>K029 Fire Door</p> <p>St. Elizabeth Healthcare ensures the safety of the patients through it's policies and procedures.</p> <p>On 4/25/12 the Life Safety surveyor identified a problem with the door closer on the Janitor's closet and a storage closet door that did not have a door closer. During the survey both items were completed: the door to the Janitor's closet was fixed and adjusted to ensure complete closure and a door closure was installed on the storage closet. See Attachment K1 and K2: WO #115393 and WO #115394. The job was completed by senior maintenance technician, Don Leisl.</p>	5/1/12

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K 029	<p>Continued From page 2 code.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ul style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. <p>Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.</p>	K 029	<p>K070 Portable Heater</p> <p>St. Elizabeth Healthcare ensures the safety of the patients through it's policies and procedures.</p> <p>On 4/25/12 the Life Safety Surveyor Was notified by the Team Leader that portable heater had been noted in a patient room during the tour on 4/24/12. Per the recommendation of the facility Accreditation manager on 4/24/12, without notification from the State surveyor, the heater was removed from the room, placed in the trash and disposed of.</p> <p>The facility policy prohibits portable heaters in patient rooms. See Attachment K3: "Space heater Use " Policy.</p> <p>The staff was notified on 4/24/12 that the space heater had been disposed of. On 4/27/12 the staff was in-serviced on policy [K3]. See Attachment 1: In-service Sign In Sheet.</p>	5/1/12
K 070	NFPA 101 LIFE SAFETY CODE STANDARD	K 070		

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K 070 SS=D	<p>Continued From page 3</p> <p>Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure portable space heaters were not used in patient sleeping areas, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, one (1) resident, staff and visitors.</p> <p>The findings include:</p> <p>Observation, on 04/24/12 at 1:00 PM by the Health Team, revealed a portable heater in Resident #2's room. Portable heaters cannot be used in resident sleeping areas.</p> <p>Interview, on 04/25/12 at 2:04 PM, with the Administrator, confirmed a portable space heater was removed from Resident #2's room.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies.</p>	K 070		

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K 070	Continued From page 4 Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).	K 070		