

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

PRINTED: 08/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185470	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/31/2015
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NAME OF PROVIDER OR SUPPLIER THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
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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
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{F 000}	INITIAL COMMENTS Based on the acceptable Plan of Correction received on 08/20/15, the facility was deemed to be in compliance as alleged on 08/28/14.	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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NAME OF PROVIDER OR SUPPLIER THE WILLOWS AT HAMBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509	
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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 07/14/15 and concluded on 07/16/15 with deficient practice identified at the highest Scope and Severity of an "E".	F 000	On 7-16-15 the LED began attempting to contact family as res. refused to answer questions regarding activity preferences and goals. These attempts continued until preferences and goals were obtained on 8-7-15. At that time	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. 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 an ongoing program of activities designed to meet residents' interests and psychosocial wellbeing for one (1) of fifteen (15) sampled residents (Resident #1). Observation revealed no participation or provision of activities for Resident #1 either individually or through group activities. Record review revealed Resident #1's activity care plan had no activity preferences listed, or goal or individual activities identified. Continued record review revealed no documented evidence of Activity Progress Notes during the resident's admission period, and review of the facility's activity log revealed Resident #1 attended no group activities and had only five (5) observations from activity staff with no 1:1 activities noted.	F 248.1	Resident (res.) 1 activity preferences were obtained, care plan updated to include goals and approaches, and progress note written by Life Enrichment Director on 8-7-15 to reflect residents current plan of care and activity participation. Res. #1 was observed by LED on 7/16/15, 7/27/15 participating in one on one activities with LEA 2. Other res. activity records were audited by the Activity Director/MDS/Director of Health Services(DHS) by August 27, 2015 to assure activity preferences were obtained, progress note written, and care plans updated with goals and approaches to reflect current plan of care. Other res. were observed by the DHS/ED on date participating in activities 3. Activity Director and activity staff was re-educated by the Executive Director(ED) on 8-6-2015 on the activity policy and procedure with an emphasis on collecting res. preferences, updating of care plans with goals and approaches to assure the psychosocial well being of each res. is met. 4. The ED/ Activity Director/DHS will audit ten percent of activities care plans, activity logs and observe residents participating in activities to assure compliance weekly x 30 days then monthly x three months.	

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Beth Blair

TITLE

Executive Director

(X6) DATE

8/19/15

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

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F 248	Continued From page 1 The findings include: Review of the facility's policy titled, "Participation in Activities", undated, revealed residents had the right to attend and participate in activities of their choice. Further policy review revealed residents were encouraged to attend and participate in activities. Interview, on 07/16/15 at 5:43 PM, with the Administrator revealed the purpose of resident activities was to enhance the lives of the facility's residents. Review of Resident #1's medical record revealed the facility admitted the resident on 11/04/14, with diagnoses which included Glaucoma, Hypertension, Debility and Alzheimer's Disease. Review of the Admission Minimum Data Set (MDS), dated 11/11/14, revealed the facility assessed Resident #1 to make self understood, to usually understand others, to have moderate difficulty hearing, as moderately impaired with daily decision making and to have long term memory problems. Further review of the MDS revealed staff assessed Resident #1 to prefer to choose his/her own clothing, family or significant other involvement in care discussion, as to prefer keeping up with the news. Review of the MDS Care Area Assessment (CAA) Summary revealed Activities triggered and the decision was made to care plan this area. Review of the CAA for Activities revealed the description of the problem, causes and contributing factors and risk factors related to the care area included Resident #1 had a diagnosis of Alzheimer's Disease and was unable to communicate needs. Continued review of the Activities CAA revealed staff would provide social visits and activities.	F 248	The QA committee will review results of all audits. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action to be carried out as indicated. 5. Date: August 28,2015	

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F 248	<p>Continued From page 2</p> <p>Review of Resident #1's Comprehensive Care Plan revealed a care plan titled, "Activities of Interest", which noted the resident would attend activities of choice and would have a palliative care consult. However, further review revealed no documented evidence of a goal for Resident #1 or of interventions which included his/her activities of choice.</p> <p>Observation of Resident #1 on 07/14/15 at 1:11 PM, 2:36 PM, 4:15 PM, 5:24 PM, 6:11 PM and on 07/15/15 at 8:21 AM, 10:28 AM and 11:31 AM revealed the resident was in his/her room with no activities provided and no attendance of group activities observed.</p> <p>Continued record review revealed no documented evidence of Activity Progress Notes for Resident #1 since the resident was admitted to the facility on 11/04/14. Review of the facility's Life Enrichment Log, for the time period of 05/15/15 to 07/14/15, revealed activity staff documented comments in the facility's computerized medical record system on the following dates for "self-initiated" activities for Resident #1 as follows: 05/25/15 at 4:37 PM family visiting, on 06/07/15 at 4:26 PM watching TV, on 06/26/15 at 4:46 PM watching TV, and on 06/29/15 had four (4) entries timed 7:34 PM which included friend, "campus peer" and "other" with no specific activity interventions included. Continued review revealed nursing staff documented "other" sixty-eight (68) times on the Log, watching TV twenty-nine (29) times, and family visiting twenty-three (23) times. However, further review of the Log revealed no documented evidence of Resident #1 having participated in any group activities during this timeframe.</p>	F 248	

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F 248	Continued From page 3 Interview, on 07/15/15 at 2:47 PM, with the Life Enrichment Director (LED) revealed the purpose of Activity Progress Notes was to verify what activities a resident had completed or participated in during the past quarter. She revealed for Resident #1 however, there were no Activity Progress Notes completed since admission. After reviewing the facility's Life Enrichment Log for Resident #1, the LED reported activity staff had not checked on the resident much during the time period reviewed, and she did not know what the documented "other" meant. Further interview revealed the facility's activity program was not meeting Resident #1's activity needs. Record review of the facility's July 2015 Activity Calendar revealed the activities scheduled for 07/14/15 included: at 10:00 AM Mental Workout; at 10:30 AM Chair Yoga; at 11:00 AM Morning Devotions; at 2:30 PM July Birthday Celebration; and Family Night at 5:00 PM. Further review of the Activity Calendar revealed activities on 07/15/15 included: at 10:30 AM Mental Workout and at 11:00 AM Morning Devotions. Interview, on 07/16/15 at 5:07 PM, with the Director of Nursing (DON) revealed activities were an important part of a resident's socialization and the facility's activity staff and other staff were to assure residents had activities offered which they liked. The DON revealed for Resident #1 the activities should have been more involved. Per interview, if staff had not documented Activity Progress Notes for Resident #1, the facility couldn't determine if they had assessed whether the activities were meeting the resident's needs or whether the resident had participated or completed the activities.	F 248		

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F 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure medically-related Social Services (SS) were provided to ensure residents attained or maintained the highest practicable mental and psychosocial well-being for one (1) of fifteen (15) sampled residents (Resident #1).</p> <p>Resident #1 had a verbal order, dated 06/23/15, to receive a Psychiatric (Psych) Consult related to statements made by the resident of feeling anxious and depressed. However, record review revealed no documented evidence the Psych Consult was provided. Interview with SS revealed the facility faxed Psych referrals to a outpatient mental health services provider, but the facility's fax machine did not provide a confirmation of whether faxes made it through or not. SS stated no one had followed up to see if the outpatient mental health provider had received the referral. SS revealed if she was aware of Resident #1's behavior symptoms, she should have assessed the resident's mental/psychosocial needs; however, had not done so. Interview with the mental health provider's Outpatient Nurse revealed the provider had not received a Psych referral for Resident #1 and had just made their routine visits to the</p>	F 250	<p>1. Res. #1 order for psychological(psych) evaluation was re-faxed by Social Services (SS) on 7-16-15 and Res. #1 received evaluation by psych services on 7-21-15</p> <p>2. The DHS/SS/ED completed a chart review for all res. to assure psych orders were completed, faxed and resident's have received psych evaluation as ordered. Audits were started on 7-16-15 and completed with any discrepancies corrected before Aug. 27,2015.</p> <p>3. On 7-16-15 the SS Director was educated by the Administrator/DHS and again on 8-7-15 by the ED on the importance of following procedure for psych evaluation orders to assure psych consults were completed as ordered. Starting on 7-16-15 and completed by Aug. 27,2015 all nurses were re-educated to place a copy of all orders for psych consults in the clinical care binder so that the SS director would be made aware of all new psych orders. The nurses were also reeducated on checking for confirmation when faxing orders. The clinical care binder will be reviewed by the SS director each morning for psych orders, check orders against the fax confirmation and f/u with psych services with a phone call to assure all faxes are received.</p>		

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F 250	Continued From page 5 facility on 07/07/15 and 07/10/15. The findings include: Review of the facility's policy titled, "Role of Social Services", undated, revealed the facility was to provide medically-related SS and the facility's SS program was designed to assist each resident to attain or maintain the highest practical physical, mental and psychosocial well-being. Further review of the policy revealed the facility's SS was to arrange for options which met a resident's emotional needs. Review of the facility's document for the outpatient mental health services provider, undated, revealed to make a request for a patient to have a Psych Consult during the next scheduled outpatient Psych visit the facility was to initiate a consult form which was to be faxed to the outpatient mental health services provider's fax number. Further review revealed no documented evidence of a follow-up procedure for ensuring confirmation the outpatient mental health services provider received the fax. Record review revealed the facility admitted the resident on 11/04/14, with diagnoses which included Debility and Alzheimer's Disease. Review of the Admission Minimum Data Set (MDS), dated 11/11/14, revealed the facility assessed Resident #1 to make self understood, to usually be understood others. Continued review revealed the facility was unable to complete the Brief Interview for Mental Status (BIMS); however, did assess the resident to have long term memory problems and to be moderately impaired in daily decision making. MDS review, under the Behavioral Symptoms	F 250	4. Ten percent of all psych orders will be audited by the DHS/SS weekly x 30 days then monthly x3 months. This audit will include auditing of psych orders, against faxed confirmation notice as well as follow up phone call to verify fax received. The QA committee will review results of all audits. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action to be carried out as indicated. 5. Date: August 28,2015		

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F 250 Continued From page 6

Assessment, revealed every one (1) to three (3) days Resident #1 displayed physical/verbal behaviors directed towards others and other behavior symptoms not directed toward others. Further review revealed the facility assessed the behaviors displayed to have impacted Resident #1's care, put the resident at risk for physical illness/injury, and interfered with the resident's participation in activities or social interactions.

Review of Resident #1's Physician's Orders revealed an order, dated 11/04/14, for Seroquel (an antipsychotic medication) to be given at the following doses: 12.5 milligrams (mgs) at "rising" time and 25 mgs at bedtime for Alzheimer's, Anxiety and Behaviors. Further record review revealed an attempted gradual dose reduction for the bedtime Seroquel dose with an order dated 06/12/15, to decrease the bedtime dose to 12.5 mg. Continued review of the Physician's Orders revealed an order dated 06/19/15, to increase the Seroquel back to the original bedtime dose of 25 mgs due to the resident's yelling and agitation. Further review of the Physician's Orders revealed an order dated 06/23/15, for a Psych Consult related to the resident's feelings of anxiousness and being depressed.

Further record review of the facility's symptom assessments completed each shift on 06/12/15 10:00 PM to 06/26/15 10:00 PM, for the gradual dose reduction attempt, revealed Resident #1 displayed signs of increased behaviors of yelling and or cussing on 06/16/15 the 2:00 PM to 10:00 PM shift and the 10:00 PM to 6:00 AM shift, and on 06/17/15 for the 2:00 PM to 10:00 PM shift. Continued review revealed Resident #1's symptoms of increased anxiety and/or irritability were displayed on 06/18/15 during the 2:00 PM to

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F 250 Continued From page 7
10:00 PM shift and the 10:00 PM to 6:00 AM shifts. Review revealed, after the Seroquel was returned to the 25 mg bedtime dose, Resident #1 displayed behaviors of cursing/yelling at staff and increased anxiety on 06/23/15 on the 10:00 PM to 6:00 AM shift; on 06/24/15 on all shifts the resident displayed verbal aggression, anger, and agitation. Further review revealed on 06/25/14 on the 2:00 PM to 10:00 PM, Resident #1 displayed agitation and on the 10:00 PM to 6:00 AM shift displayed cussing at staff and agitation.

F 250

Interview, on 07/16/15 at 10:59 AM, with LPN #4/Unit Manager (UM) revealed Resident #1 was feeling anxious and depressed on 06/23/15, and an order was received to refer the resident for a Psych Consult. Per interview, when a referral order was written the facility staff faxed a copy of the order and the resident's face sheet to the outpatient mental health services provider. LPN #4/UM stated in addition, staff filled out the top of the consult form, attached the resident's face sheet and put the completed the form in the outpatient mental health services provider's binder. She reported the nurse who received and wrote the order for Resident #1's Psych Consult had said it was faxed to the outpatient mental health services provider; however, the facility's fax machine had no confirmation process to know it was received by the outpatient provider. She stated there was no Nursing Note documentation noting the Psych referral was made. LPN #4/UM revealed she was not sure if staff were supposed to contact the outpatient mental health services provider to see if the fax had been received by them. Further interview revealed a SS evaluation should have been done and the floor nurses were supposed to follow-up regarding Resident #1's feelings of Anxiety and

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F 250	<p>Continued From page 8 Depression.</p> <p>Interview, on 07/16/15 at 3:50 PM, with the outpatient mental health services provider's Outpatient Nurse revealed the outpatient provider was unaware the resident (Resident #1) needed to be seen for a Psych Consult, and had just made routine visits to the facility on 07/07/15 and 07/10/15. Per interview, the outpatient provider was not informed Resident #1 needed to be seen for a Psych Consult. In addition, the Outpatient Nurse stated if the outpatient mental health services provider had never seen a resident and a consult was sent related to a resident displaying or reporting symptoms of Anxiety or Depression, they would attempt to see the resident within the week of receiving the consult to evaluate.</p> <p>Interview, on 07/15/15 at 4:17 PM, with the SS Director (SSD) revealed the facility discussed new Physician's Orders received in the past twenty-four (24) hours and reviewed the facility "24 Hour Report" at the morning clinical meetings. The SSD revealed SS had no Note they were to contact the outpatient mental health services provider regarding the referral and was unaware a Psych Consult referral order had been received in order for SS to follow up on. Continued interview with the SSD, on 07/16/15 at 10:00 AM, revealed she had contacted the outpatient mental health services provider and had spoken to the person there who took referrals. The SSD stated that person reported the outpatient mental health services provider's records had no evidence of a Psych Consult referral received for Resident #1. Further interview on 07/16/15 at 11:50 AM, with the SSD, after she had reviewed the facility's "24 Hour Report" and saw the 06/23/15 Psych Consult</p>	F 250	

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F 250	Continued From page 9 Order noted, revealed the Psych Consult Order was listed on the Report which she had reviewed at the morning clinical meeting. The SSD revealed she was unable to recall why she had not written the Psych Consult Order down to ensure follow up on the referral was done. The SSD reported it was SS's responsibility to follow-up on the referral. Per interview, the SSD should also have assessed Resident #1 related to the behaviors displayed. Interview, on 07/16/15 at 5:07 PM, with the Director of Nursing (DON) revealed there was a breakdown in the facility's system to ensure Resident #1's Psych Consult referral was sent and received by the outpatient mental health provider. Per interview, there should have been documentation and follow-up regarding Resident #1's Psych Consult Order. The DON revealed SS also should have evaluated Resident #1's behaviors and investigated what might have triggered the behaviors. Further interview revealed because Resident #1 had displayed behaviors of Anxiety and Depression there had been a risk of increased behaviors by not following up on the Psych Consult Order in a timely fashion; however, the resident had not experienced a bad outcome.	F 250			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS Interview, on 07/16/15 at 5:43 PM, with the Administrator revealed referrals were to be followed-up on. Per interview, the outpatient mental health services provider was to be contacted regarding referrals and the facility ensured a Psych visit took place for residents' mental health needs.	F 279			

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PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185470	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
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NAME OF PROVIDER OR SUPPLIER THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
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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
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F 279	Continued From page 10 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 failed to ensure an individualized Comprehensive Care Plan was developed to meet each resident's medical, physical, mental, and psychosocial well-being for three (3) of fifteen (15) sampled residents (Residents #1, #9 and #10). Review of the Admission Minimum Data Set (MDS) Assessment revealed the facility assessed Resident #1 to have triggered under the Care Area Assessment (CAA) related to activities and behaviors and the facility had determined activity and care plans were to be	F 279	1. Res. # 1, care plan was update by MDS/LED on 8-7-15 to include goals and approaches to reflect current plan of care for behaviors and activities. Res. # 9 care plan was revised computer updated by MDS on 8-7-15 to include activity goals and approaches to reflect current plan of care. Res. # 10 was discharged from facility on 8-5-15. 2. All other res. activity plan of care was audited and updated by MDS/LED before August 27,2015 to include goals and approaches to reflect current plan of care. 3. The LED/SS/MDS was re-inserviced which was started on 7-16-15 and completed before August 27,2015 by the DHS/Clinical support/ED on the care plan policy with an emphasis on complete and thorough care plans that include goals and approaches. 4. The DHS/ADHS/unit manager will audit ten percent of care plans, Minimum Data Set and Care Area Assessment(CAA) weekly x 30 days then 10 % x 3 months to assure compliance. These audits will ensure that any items triggered on the MDS are care planned with appropriate goals and interventions. The QA committee will review results of all audits. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action to be carried out as indicated. 5. Date: August 28,2015	
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F 279	Continued From page 11 created. However, review of Resident #1's Comprehensive Care Plans revealed the Activity Care Plan created was not individualized with a goal and interventions which included individualized interventions, and there was no documented evidence a care plan was developed to address the resident's behaviors. In addition, Resident's #9 and #10 had activities care plans which had not been thoroughly developed to include goals and interventions necessary to meet the needs of each resident. The findings include: Review of the facility's policy titled, "Care Planning-Interdisciplinary Team", undated, revealed the facility's Care Planning/Interdisciplinary Team (IDT) was responsible for the development of an individualized Comprehensive Care Plan, which incorporated goals and objectives to lead to each resident's highest obtainable level of independence. The Policy noted the care plan was based on each resident's comprehensive assessment. 1. Review of Resident #1's medical record revealed the resident was admitted by the facility on 11/04/14, with diagnoses which included Debility and Alzheimer's Disease. Review of the 11/11/14, Admission Minimum Data Set (MDS) Assessment revealed the facility assessed Resident to have moderate difficulty hearing, to make self understood and to usually understood others. Continued review revealed the facility was unable to assessing Resident #1 utilizing the Brief Interview for Mental Status (BIMS) assessment; however, assessed the resident to	F 279			

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F 279	<p>Continued From page 12</p> <p>have moderate impairment in daily decision making and to have long term memory problems. Continued MDS review revealed under the Behavioral Symptoms assessment section the facility assessed Resident #1 to have displayed physical/verbal behaviors directed towards other every one (1) to three (3) days and to have "Other" behavior symptoms not directed toward others. Per the MDS Assessment, the facility assessed Resident #1's behaviors to have impacted the resident's care, put the resident at risk for physical illness/injury, interfered with the resident's participation in activities or social interactions and put other residents at risk for physical injury, intruded on other resident's privacy or activities and disrupted other residents' care or living environment.</p> <p>Review of the MDS Care Area Assessments (CAA's) Summary revealed the facility assessed Resident #1 to have triggered for Behavioral Symptoms and to have determined the resident needed a care plan developed related to his/her behaviors.</p> <p>However, review of Resident #1's Comprehensive Care Plan, undated, revealed the facility care planned the resident for "Moods and Behaviors" on 06/22/15, related to a gradual dose reduction (GDR) which had been attempted and was ineffective. Continued review of the care plan revealed no documented evidence it was developed with a goal or individualized interventions, other than one (1) intervention which stated to administer the resident's antipsychotic as ordered for his/her diagnosis of Alzheimer's Disease.</p> <p>Interview, on 07/16/15 at 4:07 PM, with the MDS</p>	F 279	

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F 279	Continued From page 13 Coordinator revealed residents' Mood and Behavior assessments and care plans were performed and completed by Social Services (SS). The MDS Coordinator stated however, MDS was ultimately responsible for all residents' care plans and they should have identified there was no Mood and Behavior care plan developed at the time of the resident's admission assessment. Interview, on 07/16/15 at 4:15 PM, with the SS Director (SSD) revealed SS completed the Mood/Behavior section of each resident's MDS Assessment. Per interview, based on the MDS Assessment a Comprehensive Care Plan related to Mood and Behavior was to be developed for residents as indicated. The SSD revealed the care plan was the foundation to manage a resident's behaviors and provide the best care possible for him/her. Interview, on 07/16/15 at 5:07 PM, with the Director of Nursing (DON) revealed it was the facility's expectation care plans were developed to meet each resident's needs and if the resident was assessed to have behaviors it was discussed and a Behavior Care Plan was created. The DON revealed based on the facility's assessment of Resident #1 a Behavior Care plan should have been developed for the resident with interventions which met his/her behavior needs. Further MDS Assessment review revealed the facility was unable to complete the Customary Routine and Activities assessment section with Resident #1 or his/her family and/or significant other. Continued review revealed staff assessed Resident #1 to prefer to keep up with the news.	F 279			

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F 279	<p>Continued From page 14</p> <p>Continued review of the MDS CAA's Summary revealed the facility assessed Resident #1 to have triggered under Activities and determined the resident needed a related care plan. Review of Resident #1's Comprehensive Care Plan revealed the facility had care planned the resident for "Activities of Interest" which noted the resident would attend activities of choice and would have a palliative care consult. However, further review revealed no documented evidence the facility had developed the care plan to have a goal and individualized interventions related to his/her activities of interest.</p> <p>Interview, on 07/15/15 at 2:57 PM, with the Activities Director (AD) revealed Activities assessed Resident #1 and had created the activity care plan; however, she was not the AD at that time. The AD revealed Resident #1's Activities care plan was not appropriate because it only included attending activities of choice and noted a palliative consult which had nothing to do with activities. Continued interview revealed an activity assessment needed to go into more depth regarding a resident's activities of interest. Per interview, Resident #1's Activity care plan was not individualized with his/her interests or related interventions and had no goal. She reported Resident #1 was social if visited 1:1, was easy to talk to, and the care plan should have at minimum included a 1:1 intervention.</p> <p>Continued interview, on 07/16/15 at 4:28 PM, with the MDS Coordinator there was no documentation of an Activities initial assessment. The MDS Coordinator stated however, the Activity CAA's had triggered and Resident #1's care plan should have included the resident's activities of interest and how often staff were to offer</p>	F 279		

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F 279 | Continued From page 15

activities. Further interview with the MDS Coordinator revealed something fell through the cracks in terms of Resident #1's Comprehensive Care Plan, as it was not thoroughly developed.

Continued interview with the DON on 07/16/15 at 5:07 PM, revealed Resident #1's Activities Care Plan had no documentation of the resident's activity preferences or related interventions which it should have included. Per interview, the care plan was not developed and individualized to meet Resident #1's activity needs.

2. Review of Resident #9's medical record revealed the facility admitted the resident on 01/02/15, with diagnoses which included Alzheimer's Disease, Anxiety and Depression. Review of the Quarterly MDS Assessment dated 4/08/15, revealed the facility assessed Resident #9 as cognitively intact. Review of Resident #9's Comprehensive Care Plan revealed an "Activities of Interest" care plan which noted on 07/14/15, the facility staff was to provide diversional activities as needed. Continued review revealed however, there was no documented evidence Resident #9's activity care plan was developed to include a goal, the resident's activities of interest, and individualized interventions regarding activities.

Review of Resident #9's Activities Progress Notes dated 04/13/15 revealed the Notes were based on the 04/08/15 Quarterly MDS Assessment. Continued review revealed Activity staff noted Resident #9 had continued interactions with staff when approached, continued to enjoy independent leisure in his/her room, and watched game shows. Further review of the Notes revealed Resident #9 participated in socials,

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F 279	<p>Continued From page 16</p> <p>happy hours and other facility entertainment for which he/she needed encouragement to interact with peers and pursue group programs.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 07/15/15 at 3:04 PM, revealed Resident #9's behavior and participation in activities depended on the time of the day. She also stated Resident #9 would not participate in activities unless it was 1:1 (one on one) and the 1:1 had to be performed in the resident's room.</p> <p>Interview with Registered Nurse (RN) #4/Unit Manager (UM), on 07/15/15 at 3:56 PM, revealed she was unable to locate an Activities Care Plan for Resident #9 which included goals or interventions. She stated the activities care plan should have been developed to include interventions which should have been in place.</p> <p>Interview with the Life Enrichment Director on 07/16/15 at 4:51 PM, revealed Resident #9's Comprehensive Care Plan needed to be developed to be individualized.</p> <p>Interview with the RN #5/MDS Coordinator on 07/16/15 at 5:06 PM, revealed the activities for Resident #9 were insufficiently care planned and the care plan needed to be developed better and individualized. She stated the Activity Director was responsible for initial and annual updates regarding activities.</p> <p>Interview with the DON on 07/16/15 at 6:29 PM, after review of Resident #9's Comprehensive Care Plan, revealed the resident's care plan had not been developed to include his/her activities of choice or diversional activities. She stated it was her expectation the care plan be developed to</p>	F 279	

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F 279 Continued From page 17
include those interventions.

F 279

3. Review of Resident #10's medical record revealed the facility admitted the resident on 04/21/15, with diagnoses which included Spinal Stenosis, Chronic Kidney Disease and Suprapubic Catheter. Review of the Admission MDS dated 04/09/15, revealed the facility assessed Resident #10 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating the resident was cognitively intact.

Review of Resident #10's Comprehensive Care Plan revealed the facility had care planned the resident for "Activities of Interest"; however, the care plan included one (1) intervention which stated "activities of my choice".

Interview, on 07/16/15 at 4:52 PM, with the Life Enrichment Director revealed having no activities care plan developed or an activities care plan which was vague, was not sufficient in ensuring a resident's activity needs were being addressed. She revealed she had been working on updating care plans as she realized they were insufficient and not thoroughly developed. The Life Enrichment Director stated Resident #10 was very vocal about his/her interests and could express which activities were of interest.

Interview, on 07/16/15 at 5:43 PM and at 6:09 PM, with the Administrator revealed the facility had a new MDS Coordinator now who she didn't think was present when the facility provided inservices regarding development of care plans. Per interview, she was not sure why the care plans slipped through the cracks. She reported Activities were important to enhance the quality of

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F 279	Continued From page 18 life of residents. The Administrator stated she expected the facility staff to discuss with a resident his/her wants and needs, and then that information should be identified on the resident's Comprehensive Care Plan.	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	1. Res. #1 care plan was revised and updated to reflect her current plan of care to include her hearing aid. Res. #4 plan of care was updated to reflect her biting of deodorant. Res. #9 care plan was revised to include her fall on 7/8/15. These care plans were updated on 7-16-15 and the computer care plan was updated and printed by MDS/Unit managers on 8-7-15 to reflect res. current plan of care to include goals and approaches. 2. Other res. plan of care was audited and updated. These audits began on 7-16-15 and completed by August 27, 2015 by MDS/ Unit managers/DHS/ADHS to assure they have been revised and updated to reflect current plan of care with goals and approaches. 3. The LED/SS/MDS nurses were re-inserviced starting on 7-16-15 and completed before August 27, 2015 by the DHS/Clinical support on the care plan policy with an emphasis on updating and revising care plans to reflect res. current plan of care to include goals and approaches.		
	This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Care Plan was updated and revised for three (3) of fifteen (15) sampled residents (Residents #1, #4 and				

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F 280 Continued From page 19 #9).

Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 05/08/15, revealed the facility had assessed the resident to have moderate difficulty hearing and to have a hearing aid. However, Resident #1's Comprehensive Care Plan had not been updated and revised to include the information related to the hearing aids.

Resident #4 displayed a behavior of eating deodorant; however, his/her Comprehensive Care Plan was not updated and revised to include the behavior.

Resident #9 experienced a fall on 07/08/15; however, the resident's Comprehensive Care Plan was not updated and revised to include information regarding the fall or with any related interventions.

The findings include:

Review of the facility's policy titled, "Interdisciplinary Team Care Plan Guideline", undated, revealed the purpose was to ensure the appropriateness of services provided met the resident's needs. The Policy noted the resident's Comprehensive Care Plan was reviewed and revised as needed with each MDS Assessment to reflect any change in condition updates. Further review revealed any new problem areas were added to the existing care plans.

1. Review of the medical record for Resident #1 revealed the resident was admitted by the facility on 11/04/14, with diagnoses which included Glaucoma, Alzheimer's Disease, Hypertension

F 280 4. The DHS/ADHS/Medical Records Nurse will audit ten percent of care plans to assure care plans are revised and updated with current physician orders and or changes in condition. These audits will be weekly x 30 days then 10 % x 3 months to assure compliance. The QA committee will review results of all audits. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action to be carried out as indicated.

5. Date: August 28,2015

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F 280	Continued From page 20 and Debility. Review of the Admission MDS, dated 11/11/14, revealed the resident was assessed with moderate difficulty hearing but had no hearing aids and usually understood others. Continued review of the Admission MDS Assessment revealed the facility assessed Resident #1 to have moderate impairment with daily decision making and to have long term memory problems. Review of the Quarterly MDS, dated 05/08/15, revealed the facility assessed Resident #1 to have hearing aids, and as always understanding others. However, review of Resident #1's Comprehensive Care Plan revealed no documented evidence the care plan was updated and revised to include the assessed hearing aids after the 05/08/15 Quarterly MDS Assessment. Interview, on 07/16/15 at 4:07 PM, with the MDS Coordinator and MDS Float nurse revealed the Admission MDS Assessment, dated 11/14/15, noted Resident #1 had moderate difficulty hearing, but no hearing aids. They stated therefore, hearing aids were not included on the initial Comprehensive Care Plan. Continued interview revealed the Quarterly MDS Assessment identified Resident #1 now had hearing aid devices, which the Comprehensive Care Plan regarding Activities of Daily Living (ADL) should have been updated and revised to include. Per interview, the care plan should have been updated and revised with hearing aid interventions, such as, taking the hearing aids out at night and placing them in a container or on the nursing cart, and offering the hearing aids to the resident in the mornings. Interview, on 07/16/15 at 6:55 PM, with the	F 280		
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F 280	Continued From page 21 Director of Nursing (DON) revealed residents' Comprehensive Care Plans were used to communicate interventions necessary for residents to staff. The DON revealed the ADL care plan interventions should have been updated and revised when the facility assessed Resident #1 had hearing aid devices in place on the Quarterly MDS Assessement. Continued interview revealed possible interventions the care plan should have been revised to include were to secure the hearing aids for the resident when they were not in use and offer the hearing aids to the resident in the mornings. 2. Review of Resident #4's medical record revealed the facility admitted the resident on 08/15/14, with diagnoses which included Depressive Disorder, Senile Dementia and Anxiety Disorder. Review of the Quarterly MDS Assessment dated 05/16/15, revealed the facility assessed Resident #4 as moderately cognitively impaired. Review of Resident #4's Comprehensive Care Plan dated 07/14/15, revealed the resident was care planned for "Cognition" due to altered cognition related to the diagnosis of Alzheimer's Disease. Continued review of the Comprehensive Care Plan revealed the facility also had care planned the resident for "Moods and Behaviors" due to diagnoses of Depression and Anxiety. Continued record review revealed a Social Service (SS) Progress Note, dated 05/29/15, which stated Resident #4 had taken a bite out of his/her deodorant while in his/her room. The Note revealed two (2) Certified Resident Care Associates (CRCAs) removed all items which could be ingested by the resident and those items were placed in the nurse's office. Per the Note,	F 280			

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F 280 Continued From page 22

the resident's family was notified the items were removed from the room and why.

However, further review of Resident #4's Comprehensive Care Plan revealed no documented evidence the Comprehensive Care Plan was updated and revised to include the behavior displayed on 05/29/15, or with interventions, such as, keeping those items out of the resident's room.

Interview with Registered Nurse (RN) #4/Unit Manager (UM), on 07/15/15 at 3:56 PM, revealed after reviewing Resident #4's record, there was no documented evidence the resident's Comprehensive Care Plan was updated and revised to include the information regarding the resident taking a bite of deodorant. Per interview, due to the facility's failure to revise the care plan the resident's safety was at risk and his/her care needs were not being addressed. She stated the incident on 05/29/15, should have been shared with the Interdisciplinary Team (IDT), and the appropriate care plans should have been revised with any necessary interventions.

Interview with the RN #5/MDS Coordinator on 07/16/15 at 5:06 PM, revealed she had been employed with the facility for one (1) month. She stated Resident #4's Comprehensive Care Plan should have been revised with the incident information from 05/29/15, and with appropriate interventions related to the resident's behavior. Per interview, Resident #4's care plan interventions should have include interventions to ensure the resident's safety, such as, removing items from his/her room which might be harmful if swallowed.

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F 280 Continued From page 23

Interview with the DON, on 07/16/15 at 6:29 PM, revealed her expectations were the information regarding the incident on 05/29/15 would have been shared with the IDT, staff and the Physician. She stated the Social Worker should have been notified in order to ensure Resident #4's Comprehensive Care Plan was updated and revised with the information regarding the resident's behavior of taking a bite of his/her deodorant, and with the necessary interventions. Further interview if a resident's Comprehensive Care Plan was not revised and necessary interventions implemented, there was a concern the resident's safety and needs would not be met.

Interview with the Administrator, on 07/16/15 at 6:09 PM, revealed her expectations regarding Resident #4's behavior of taking a bite of his/her deodorant would have been for staff to have shared the information and for the Social Worker to have been notified of the behavior. Per interview, she further expected Resident #4's Comprehensive Care Plan should have been updated and revised to include the behavior and with any necessary interventions.

3. Review of Resident #9's medical record revealed the facility admitted the resident on 01/02/15, with diagnoses which included Anxiety, Alzheimer's Disease and Depression. Review of the Quarterly MDS Assessment dated 4/08/15, revealed the facility assessed Resident #9 as cognitively intact. However, review of Resident #9's Comprehensive Care Plan dated 07/14/15, revealed the facility had care planned the resident for altered cognition regarding the diagnosis of Alzheimer's Disease.

Continued record review revealed Resident #9

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F 280	Continued From page 24 experienced a fall on 07/08/15 at 2:05 PM, and was found lying on the bathroom floor in his/her room. Review revealed Resident #9 stated he/she had not used the call bell for assistance to the bathroom, lost his/her balance and fell to the floor. Per the Incident Report completed for the fall, Resident #9's Comprehensive Care Plan was to be updated with the fall information. However, further review of the Comprehensive Care Plan revealed no documented evidence it was updated and revised with the fall incident information or with any additional or necessary interventions. Interview with the RN #4/UM on 07/16/15 at 3:56 PM, revealed after reviewing Resident #9's Comprehensive Care Plan she could not locate any information with regard to Resident #9's fall on the Comprehensive Care Plan. She stated however, the fall information should have been on the care plan and the care plan revised with any necessary interventions. Per interview, if Resident #9's was not revised and updated with the fall incident information and necessary interventions, the Certified Nursing Assistants (CNA's) would not be aware of the residents care needs and therefore, he/she would have unmet needs due to that. Interview with RN #5/MDS Coordinator on 07/16/15 at 5:06 PM, revealed Resident #9's Comprehensive Care Plan should have been updated and revised with the fall incident information and with any necessary interventions put into place. She stated omission of the information was her fault and she must have overlooked the Incident Report regarding the resident's fall. Interview with the DON, on 07/16/15 at 6:29 PM	F 280		
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F 280	Continued From page 25 revealed the Fall incident of 07/08/15 for Resident #9 should have been on the Comprehensive Care Plan with revised interventions. She stated the MDS coordinator updated the care plan after the circumstances had been discussed at morning meetings. She stated she planned to print the Incident Reports and compare them to all care plans for the residents. Interview with the Administrator, on 07/16/15 at 5:43 PM, revealed she was uncertain as to how the Fall incident of 07/08/15 was not included on Resident #9's Comprehensive Care Plans. She stated the facility had a new MDS coordinator and that could have been the reason. She was not sure how the information slipped through the cracks; however, it should have been added and interventions in place.	F 280			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. 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 a	F 315			

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F 315 Continued From page 26
diagnosis for an indwelling catheter was documented and a Physician's Order obtained for the indwelling catheter for one (1) of fifteen (15) sampled residents (Resident #8).

The findings include:

Review of the facility's policy titled, "Guidelines for the Use of Indwelling Catheter", dated September 2014, revealed the purpose of the urinary catheterization was to provide urinary drainage when medically necessary and to evaluate its continued use. Continued review revealed the intent was to ensure each resident who was incontinent of urine was identified, assessed and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible. The Policy revealed an indwelling catheter would not be used unless there was a valid medical justification and an indwelling catheter for which continuing use was not medically justified was discontinued as soon as clinically warranted by the attending Physician and/or Urologist. Further review revealed the medical necessity for a catheter would be for conditions deemed valid by the attending Physician and/or Urologist with supporting documentation.

Review of Resident #8's medical record revealed the resident was admitted by the facility on 07/06/15, with diagnosis which included Arthrodesis (surgical immobilization of a joint by fusion of the adjacent bones), High Blood Pressure and Gout. Review of Resident #8's Physician's Orders, dated 07/06/15, revealed the resident had an indwelling catheter with a diagnosis of "indwelling urinary device, must be weight bearing". Continued review of the

F 315

1. Res # 8 was discharged from facility on August 5, 2015.
2. Before Aug. 25, 2015 The DHS/Unit manager/ADHS audited all other res. with Foley Catheter's clinical record to assure appropriate diagnosis for f/c use, orders for f/c care and treatment being signed off to indicate f/c care completed.
3. Nurses were re-inserviced on Foley catheter policy with an emphasis on insuring appropriate diagnosis is present and f/c care is signed off indicating f/c care completed. This re-education was given by DHS/ADHS/MDS/Clinical Support which was started on 7-16-15, and completed by Aug 27, 2015
4. All new admissions will be audited by the DHS/ADHS/Unit Manager/MDS during morning clinical care meeting to assure appropriate diagnosis is present and assure f/c care is being completed as ordered. This audit will be completed weekly x 30 days then monthly x 3 months. The QA committee will review results of all audits. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action to be carried out as indicated.
5. Date: August 28, 2015

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F 315	<p>Continued From page 27</p> <p>resident's medical record revealed the Treatment Orders, dated 07/06/16, revealed Catheter Care every (q) shift; however, review of the Treatment Administration Record (TAR) revealed no signatures of staff showing catheter care had been performed. Review of the facility's "Telephone Nursing Report for New Admission", dated 07/06/15, revealed Resident #8 used a Foley Catheter with documentation noting a diagnosis of "Robotic Urinary Device, must bear weight before Foley Catheter comes out".</p> <p>Observation and interview with Resident #8, on 07/15/15 at approximately 9:00 AM, revealed he/she had a diagnosis of Prostrate Cancer twice (2), had a Foley Catheter and stated, "this is not my first rodeo".</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 07/15/15 at 11:23 AM and 12:01 AM, revealed she did not know what Resident #8's diagnosis was for his/her Foley Catheter. She reported the diagnosis stating the resident "must be weight bearing" was not a clear diagnosis. Continued interview with LPN #2 reported the admission nurse should have obtain a Physician's Order determining the resident's diagnosis for the use of the Foley Catheter. Additionally, LPN #2 reported she was not familiar with the "Robotic Urinary Catheter", but would find out. LPN #2, in a different interview, reported she talked to the resident and he/she reported he/she had Prostrate Cancer, two (2) times, and this was why he needed a catheter. She stated the resident also had a device called the "AMS 800" which was implanted in the resident and he/she would press a button when he/she needed to relieve him/herself. Further interview with LPN #2 revealed the device only worked while the</p>	F 315		
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F 315	Continued From page 28 resident was standing, which was why he needed to be "weight bearing" before the Foley Catheter could be removed. Interview with LPN #5, on 07/06/15 at 10:25 AM, revealed the facility's process for a resident who comes into the facility with a catheter would be to obtain a diagnosis for the catheter from the Physician. She reported staff would check the orders to see when the catheter should be changed and/or for catheter care. LPN #5 reported the nurses were responsible for the catheter care and would sign off in the Treatment book when catheter care was completed. In reviewing of the TAR for Resident #8, LPN #5 reported nursing staff did not sign the book to indicate catheter care was administered. LPN #5 stated staff should have signed the book because it appeared the catheter care was not completed. Interview with the Director of Nursing (DON), on 07/16/15 at 6:30 PM, revealed the resident should have had a Physician's Order to clarify the diagnosis of the Indwelling Catheter. She reported information should have been provided to staff, within the chart, to inform staff about the resident's robotic catheter. She stated it should have been clarified in twenty-four (24) hour report, the initial care plan, and on any new orders. Continued interview with the Director of Health Services revealed it was important to have a medical diagnosis for the catheter so that the facility could provide interventions to the resident if it was needed, adding catheters was not the best option for the residents. She further revealed that staff should have documented catheter care for Resident #8 in the Treatment Book, adding, "if it was not documented then it was not done".	F 315			

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F 315	Continued From page 29 Interview with the Administrator, on 07/16/15 at 5:46 AM, revealed she was not familiar with the clinical process related to the use of catheters; however, it would be her expectation that the Facility's policy, Federal and State Regulations were followed.	F 315			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of the facility's policy, it was determined the facility failed to ensure the residents' environment remained free from accident hazards for two (2) of fifteen (15) sampled residents (Residents #1 and #7) and seven (7) of nine (9) Unsampled residents, (Unsampled Residents A, B, C, D, E, H, & I). A medication cart was observed unlocked and unattended by staff on 07/14/15 for a period of ten minutes by surveyors. Additionally, during the course of the survey, medications, clippers, tweezers, and razors were observed in resident rooms. The findings include:	F 323	1. Res. # 1,7,A,B,C,D,E,H, and I rooms were observed and items that could cause hazards such as clippers,tweezers,razors and medications were removed or placed in a locked drawer by the Unit Manager/DHS ADHS/ Medical Records on 7-16-15 Res. # 7and I electric razor,disposable razor, preparation H, clippers and tweezers was removed and stored properly by Unit Manager/DHS/Medical Records on 7-16-15. LPN #2 was counseled for leaving medication cart unlocked and unattended by DHS/Unit Manager on7-15-15 and again on 8-19-15 An order was obtained from the physician on 7-15-15 by the unit manager that res. #1 may keep creams at bedside. The creams were placed in a bedside drawer for res. use out of site of confused residents. 2. All confused residents have the potential to be affected by the deficient practice. All rooms were audited on 7-15-15, 7-16-15 and again on 8-13, and 8-14-15 and on-going by the unit managers/DHS/ADHS and any hazardous items found were removed or secured in a drawer out of site.		

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F 323	<p>Continued From page 30</p> <p>Review of the facility's policy "Medication Storage in the Facility" dated 09/17/12, revealed Medication rooms, carts, and medication supplies are locked or attended by staff with authorized access.</p> <p>1. Review of Unsampled A's medical record revealed the facility admitted the resident on 12/09/14 with diagnoses, which included Dementia, Arthritis, Hypertension, and Hyperlipidemia. Review of the Quarterly MDS assessment, dated 06/15/15, revealed the BIMS score to be 04 revealing resident was severely cognitively impaired and not interviewable.</p> <p>Review of Unsampled B's medical record revealed the facility admitted the resident on 07/17/13 with diagnoses, which included, Coronary Artery Disease, Dementia, Osteoarthritis. Review of the Annual MDS assessment, dated 06/16/15, revealed the BIMS score to be 99 revealing resident was severely cognitively impaired and not interviewable.</p> <p>Review of Unsampled C's medical record revealed the facility admitted the resident on 12/09/14 with diagnoses, which included, Dementia, Depression, Hypertension, Aphasia. Review of the Annual MDS assessment, dated 05/22/15, revealed the BIMS score to be 99 revealing resident was severely cognitively impaired and not interviewable.</p> <p>Review of Unsampled D's medical record revealed the facility admitted the resident on 12/09/14 with diagnoses, which included, Alzheimer's disease, Hypertension, anxiety. Review of the Quarterly MDS assessment, dated 05/19/15, revealed the BIMS score to be 99</p>	F 323	<p>3. Nursing staff to include nurses, Kentucky medication aide and Certified Resident Care Coordinators(nursing assistants) were re-inserviced on keeping he res. environment free of hazards items. This in-servicing started on 7-15-15 and was completed prior to August 27,2015 by the DHS/ADHS/ED/Administrator.</p> <p>4. Twenty percent of rooms will be audited weekly by DHS/ADHS/Unit Managers/MDS x 30 days then monthly x 3 months to assure hazardous items are stored securely. DHS/ADHS/Unit Managers will observe Two medication carts weekly x 30 days and then monthly x 3 months to assure compliance.</p> <p>The QA committee will review results of all audits. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action to be carried out as indicated.</p> <p>5. Date: August 28,2015</p>

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F 323	Continued From page 31 revealing resident was severely cognitively impaired and not interviewable. Review of Unsampled E's medical record revealed the facility admitted the resident on 01/12/13 with diagnoses, which included, Review of the Quarterly MDS assessment, dated 04/26/15, revealed the BIMS score to be 06 revealing resident was severely cognitively impaired and not interviewable. On 07/15/15 at 8:14 AM, observation revealed a medication cart in front of the nurses station unlocked and unattended for ten (10) minutes. Unsampled Resident A, B, C, D, and E, were in sitting area close to the medication cart. Unsampled B and E were reported by facility as being on the wander list. Interview, on 07/15/15 at 11:00 AM, with Kentucky Medication Aide (KMA) #1, revealed Licensed Practical Nurse (LPN) #2, approached her and informed her she needed a glucometer machine from the medication cart. Continued interview revealed the KMA unlocked her cart and informed LPN #2 to lock the cart when she was done. Further interview revealed she should never leave her cart unlocked for anyone and ultimately she was responsible for her medication cart.	F 323			
	Interview, on 07/15/15 at 11:15 AM, with LPN #2, revealed she asked KMA #1 to open her medication cart for her to retrieve a glucometer. The LPN stated, she told the KMA #1 she would lock the medication cart when she was done. Continued interview revealed she pushed the lock in; however, did not check to see if the cart was locked. Further interview revealed she was responsible for leaving the medication cart open				

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Continued From page 32

and could have exposed residents to harm by allowing them access to medication. LPN #2 revealed if a resident had taken medication from the cart, it could have caused them harm.

Interview, on 07/16/15 at 5:07 PM, with the Director of Nursing (DON) revealed medication carts should always to be locked when not in eye view, and all nurses and KMA's were responsible for their own medication carts. Continued interview revealed the residents were at risk, and anyone that wanders could have gotten the medication that could have harmed them.

2. Review of the facility's policy "Bedside Storage of Medications" dated 09/17/12, revealed a written order for the bedside storage of medication was present in the resident's medical record. Lockable drawers or cabinets are required for all medication.

Review of Material Safety Data Sheet (MSDS) for Preparation H products revealed Inhalation may cause mucous membrane and upper respiration tract irritation and artificial respiration and/or oxygen may be necessary.

A review of the facility's policy revealed it did not address procedures pertaining to storage of clippers, tweezers, and razors; however, on 07/15/15 at 2:25 PM, the Director of Health Services (DHS), revealed it was her expectations that razor be properly stored in residents room and clippers and tweezers were to be stored in the locked treatment cart.

Review of Resident #7's medical record revealed the facility admitted the resident on 03/04/15 with diagnoses, which included Diabetes Mellitus,

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F 323	Continued From page 33 Hypertension, Parkinson's Disease and Hyperlipidemia. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 06/01/15, revealed the Brief Interview for Mental status (BIMS) score to be 06 revealing resident was severely cognitively impaired and not interviewable. Review of Unsamped H's medical record revealed the facility admitted the resident on 12/09/14 with diagnoses, which included, Hypertension, Hyperlipidemia, Osteoarthritis, and Asthma. Review of the Admission MDS assessment, dated 07/13/15, revealed the BIMS score to be 14 revealing resident was interviewable. Review of Unsamped I's medical record revealed the facility admitted the resident on 12/09/14 with diagnoses, which included, Dementia, Hypertension, Anemia, and Hyperlipidemia. Review of the Quarterly MDS assessment, dated 05/23/15, revealed the Brief Interview for BIMS score to be 14 revealing resident was interviewable. Observation on 07/14/15 at 10:04 AM, during the initial tour of the facility, revealed an electric razor and disposable razor in the rooms of Resident #7 and Unsamped I. Further observation revealed Preparation H in the room of Resident #7 and Unsamped H and fingernail clippers and tweezers in the room of Resident #7. Interview on 07/14/15 at 11:15 AM, with LPN #6, revealed staff should keep residents items in their drawer. Continued interview revealed the razor should have been put up because someone could get injured.	F 323			

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F 323 Continued From page 34

F 323

Interview, on 07/15/15 at 1:45 PM, with Certified Resident Care Associate (CRCA) #2, revealed all razors should be placed in the residents drawers, and clippers and tweezers should be locked in the treatment cart. Continued interview with CRCA #2 revealed it was a safety problem and should never be left out.

Interview, on 07/15/15 at 2:00 PM, with Registered Nurse (RN) #2, revealed razors should be placed in a safe place in the resident's drawer, and clippers and tweezers should not be in a resident's room. Continued interviews revealed this was a safety concern.

3. Record review of Resident #1's medical record revealed the resident was admitted by the facility on 11/04/14 with diagnoses which included Glaucoma, Hypertension, Debility, and Alzheimer's Disease. Review of the initial Minimum Data Set (MDS), dated 11/11/14, revealed the facility was unable to conduct a Brief Interview for Mental Status and assessed the resident was moderately cognitively impaired with long term memory problems.

Observation, on 07/14/15 at 1:11 PM, revealed the resident had topical cream prescription medications, two (2) containers, on the bedside table.

Record review revealed an order for Cetacrm/Men1/2%/Phen1/4% applied topically to the affected area two (2) times to four (4) times a day for itching.

Interview, on 07/14/15 at 1:18 PM, with LPN #4 revealed the prescription topical cream medicine

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F 323 Continued From page 35
was prescribed for itching and was a mixture created by pharmacy. The LPN revealed it was not supposed to be left in the room unless ordered to be kept at bedside and was not supposed to be visible to other residents. Continued interview revealed the resident had no order for the cream be kept at the bedside and it was supposed to be applied by the nurse. Further interview revealed the medication was a safety concern for the other residents.

F 323

Interview, on 07/16/15 at 5:07 PM, with the Director of Nursing (DON) revealed Resident #1's prescription cream was not ordered to be kept at bedside and was not supposed to be on the bedside table. The DON revealed they had two (2) wandering residents and if medications were ordered to be kept at bedside, staff were to secure the medication so it was not visible to other residents.

F 441 483.65 INFECTION CONTROL, PREVENT SS=E SPREAD, LINENS

F 441

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

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(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

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

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to maintain an effective Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Bed pans and a wash basin were observed to be uncovered and on the bathroom floor, oxygen tubing was observed to be uncovered on the floor, and toothbrushes were observed to be unlabeled and uncovered in a shared resident's room. In addition, an aide was observed feeding

F 441
1. Res. G's 02 tubing was replaced and bagged, room 210, 212, and 213's tooth brush, wash basin and bed pans were replaced and stored properly in their Individual drawers. Res. # 11 f/c bag was placed in a dignity bag and stored off the floor by DHS/ADHS/MDS/Unit Manager on 7-15-15.
CRCA # 1 was educated on the proper method of feeding residents and utilizing hand sanitizer when touching residents while assisting with feeding of residents by Unit Manager on 7-14-15.
LPN #1 was educated on the proper cleaning of glucose monitoring device utilizing sani-cloth as per policy by DHS/MDS/Unit Manager on 7-14-15.
The whirlpool tub will not be utilized and a sign was placed on the tub until the tub can be cleaned as per manufactures guidelines, by the Environmental director. The cleaning disinfectant is on back order and should be available prior to August 26,2015
2. All res have the potential to be effected by the deficient practice
3. Nursing staff to include nurses, CRCA, KMA were re-educated by the DHS/ADHS/MDS/Medical Records Nurse on the infection control policy with an emphasis on preventing the spread of infections to include keeping items off the floor, storage of personal items, feeding of res., cleaning of glucose machine and proper sanitation of w/p tubs. This in-service was started on 7-17-15. This in-service included not using the whirlpool until the manufacturer's disinfectant is available. The disinfectant arrived at the campus on

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F 441 Continued From page 37

two residents using the same hand without sanitizing between residents, Resident #11's catheter bag was observed on the floor, and during the medication pass a staff member was observed to disinfect a blood glucose monitoring device with alcohol instead of an approved product. Furthermore, staff were observed to clean a whirlpool improperly.

The findings include:

Review of the facility's policy titled "Infection Control", undated, revealed all employees would be trained on the prevention and control of infections before being assigned to resident care, annually, and anytime it was deemed necessary by the Infection Control Practitioner.

The facility did not provide a policy related storage of oxygen tubing when not in use; however, interview with the Director of Nursing (DON), on 07/15/15 at 2:25 PM, revealed it was her expectation for oxygen tubing to be bagged and off the floor when not in use. She stated it should be changed immediately if it was found to be improperly stored.

1. Observation during the initial tour of the facility, on 07/14/15 at 10:04 AM, revealed uncovered wash basins and bed pans in three toured rooms, and an unbagged oxygen tubing in the floor of Unsampld Resident G's room. Continued observation during the initial tour revealed an uncovered and unlabeled was basin on the floor of the shared bathroom for room 212. In addition, a toothbrush was uncovered and unlabeled with the specific resident's name. In the shared bathroom for room 213, an uncovered and unlabeled toothbrush was lying on the soap dish

F 441 on 8-13-15 and in-servicing with specifics on how to use the disinfectant for cleaning of the whirlpool tub will be completed by Aug. 27, 2015.

4. Twenty percent of rooms will be audited weekly. These audits will include all shifts and weekends, 4 nurses will be observed cleaning glucose machine weekly to include all shifts and weekends, 4 staff members will be observed cleaning w/p tub weekly to include weekends, 4 staff members will be observed feeding residents their meals weekly to include all 3 meals. All audits will be completed by the DHS/ADHS/Unit managers and will be completed weekly x 30 days then monthly x 3 months to assure compliance. The ED will assure that all audits are completed and provided to the QA committee for review. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action to be carried out as indicated.

5. Date: August 28,2015

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F 441	<p>Continued From page 38</p> <p>In the shower. In the bathroom for room 210, an uncovered and unlabeled wash basin was observed on the floor.</p> <p>Interview with Certified Resident Care Associate (CRCA) #2, on 07/15/15 at 1:45 PM, revealed all wash basins and bed pans were to be stored in a plastic bag labeled with the resident's name, and located off the floor. In addition, toothbrushes were to be labeled and put away as well. Continued interview with CRCA #2 revealed these issues and the discovery of uncovered oxygen tubing lying in the floor was a concern for infection control.</p> <p>2. Observation of the evening meal service, 07/14/15 at 5:35 PM, revealed CRCA #1 touched the hand of one resident before handling the resident's flatware. Continued observation revealed the CRCA proceeded to feed Unsampld Resident F and Unsampld Resident G without first sanitizing her hands. Further observation revealed the CRCA fed both residents with the same hand, without performing any hand hygiene between residents.</p> <p>Interview with Certified Resident Care Associate (CRCA) #1, on 07/14/15 at 5:55 PM, revealed she feed both residents at the same time so their food would not get cold. She stated she usually sanitized her hands before feeding the residents and between residents. Continued interview revealed she forgot on this occasion. She further stated proper hand hygiene was important to prevent the spread of germs from resident to resident.</p> <p>Interview with Registered Nurse (RN) #2, on 07/15/15 at 2:00 PM, revealed the aides were to</p>	F 441		

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F 441

Continued From page 39

sanitize their hands between residents, and if feeding two residents, they should use one hand for one resident and the other hand for the second resident. She stated if the aides touched a resident's body they were to sanitize their hands. Further interview with RN #2 revealed staff were to bag and label wash basins and bed pans, and they were to be stored in the bathroom off of the floor. Continued review revealed oxygen tubing should be dated and bagged when not in use, and should not be allowed to fall on the floor. She further stated when the tubing was found on the floor, it was to be discarded and replaced. RN #2 revealed this was an infection control issue, it and should be monitored closely.

3. Review of the facility's "Glucometer Cleaning Guidelines", undated, revealed Glucometers were to be disinfected after each use following the manufacturer's directions using a wipe containing an Environmental Protection Agency (EPA) registered detergent or germicide. Continued review revealed alcohol should not be because it was not an EPA-registered detergent/disinfectant.

Observation during the Medication pass, on 07/14/15 at 4:15 PM, revealed Licensed Practical Nurse (LPN) #1 cleaned the blood glucose monitoring device with an alcohol pad instead of the Sani-Cloth wipes which were readily accessible.

Interview with LPN #1, on 07/14/15 at 5:55 PM, revealed she had always cleaned the device with an alcohol pad. She stated as long as she allowed the alcohol to stay on the surface for fifteen (15) to thirty (30) seconds, she felt it was sufficient. Continued interview with LPN #1 revealed she did see the Sani-Cloth wipes and

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F 441	<p>Continued From page 40</p> <p>after thinking about it, she should have use the wipes. Further interview revealed she did not follow the facility's policy.</p> <p>Further interview with the DON on 07/15/14 at 2:30 PM, revealed she expected all staff to follow the facility's Infection Control policy. She stated LPN #1 did not follow the facility's policy for cleaning the glucose monitoring device, and should never have used an alcohol pad for the procedure. Continued interview revealed the failure to follow proper infection control procedures placed all residents at risk for infection.</p> <p>4. Observation of Resident #11, on 07/16/15 at 7:04 AM, revealed the resident's urinary catheter drainage bag was lying on the floor next to the resident's bed.</p> <p>Interview with CRCA #7, on 07/16/15 at 7:21 AM, revealed the resident's catheter bag should not be on the floor. She stated it was an infection control concern for contamination of the urinary catheter drainage apparatus.</p> <p>Interview with the Unit Manager, RN #4, on 07/16/15 at 7:25 AM, revealed a catheter bag should never be lying on the floor. She stated it was an infection control issue.</p> <p>Interview with the Administrator, on 07/16/15 at 6:09 PM, revealed it was her expectation for catheter bags to be located off the floor to prevent the possibility of contamination.</p> <p>Interview with the Director of Nursing (DON), on 07/16/15 at 6:29 PM, revealed the catheter bag should not be allowed to lie on the floor. She</p>	F 441		

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F 441	Continued From page 41 stated it was an infection control concern for the resident, and it was a safety concern if someone stepped on the bag and the catheter became dislodged. Interview with the Infection Control Nurse (ICN), on 07/16/15 at 6:30 PM, revealed catheter bags were not be on the floor. She stated it increased the risk of contamination and could be stepped on, causing the catheter to be pulled out of the resident. 5. Review of the facility's manufacturer's instructions for the whirlpool (w/p) tubs titled, "Operating Instructions for MasterCare Gen II Entree Bath", dated 06/01/12, revealed to clean and disinfect the w/p tubs the door was to be closed, the drain opened, the inside surfaces of the tub were to be rinsed and the drain closed. Continued review of the instructions revealed the w/p tub's "foot well" was to be filled with a half a gallon of water; one (1) ounce of MasterCare Disinfectant Cleaner was to be added; all inside surfaces of the w/p tub, the pads and belts were to be scrubbed and the drain opened. Further review revealed "Allow standard contact time per label directions on disinfectant container. Rinse with hot water and allow to dry. Open the door".	F 441			
	Review of the facility's Material Safety Data Sheet (MSDS) for the Mastercare Disinfectant Cleaner, dated 02/23/10, revealed the solution was a "quaternary ammonium disinfectant cleaner for use on equipment and environmental hard surfaces". Per review, the products active ingredients included Dimethyl benzyl ammonium chloride, dimethyl ethyl benzyl ammonium chloride which were "listed as germicidal active ingredients".				

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F 441	<p>Continued From page 42</p> <p>Interview with Certified Nursing Assistant (CNA) #9 and observation of her demonstrating the process of cleaning and disinfecting the facility whirlpool, on 07/15/15 at 8:52 AM, revealed she stated she was trained two (2) and a half years ago on the correct process for cleaning and disinfecting the facility's w/p tubs. Per interview and observation, after placing the cleaning solution in the w/p tub she used a sponge or rag to wipe the surfaces, then rinsed the w/p tub out and dried it with a towel. She stated she received the cleaning solution from housekeeping; however, was unsure as what the solution's was.</p> <p>Interview with Certified Resident Care Associate (CRCA) #6 on 07/15/15 at 3:15 PM, revealed he had been employed with the facility for three (3) and a half months, but was never trained on the process for cleaning the w/p tubs. He stated the process he used to clean and disinfect the w/p tub was to use bleach wipes to clean it after he sprayed the tub with water. He stated after using the bleach wipes to disinfect the w/p tub he dried the tub with a towel. Per interview, the bleach wipes were to ensure no feces were left in the w/p tub.</p> <p>Interview with RN #4/Unit Manager (UM) on 07/15/15 at 3:56 PM, revealed she was not aware of any training having been provided regarding cleaning and sanitizing the facility's w/p tubs. She stated the cleaning solution used to clean the whirlpool was Oxivir (a disinfectant cleaner). She stated the Oxivir solution was sprayed into the w/p tub and then the tub was wiped dry.</p> <p>Review of the facility's MSDS for the Oxivir Tb product, dated 12/05/08, revealed the active</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	Continued From page 43 ingredient was Hydrogen Peroxide, not the manufacturer's recommended Dimethyl benzyl ammonium chloride and dimethyl ethyl benzyl ammonium chloride ingredients. Additional interview with the RN #4/UM on 07/16/15 at 4:40 PM, revealed the facility had not had any recent Multiple Drug Resistance Organisms (MDROs) within the last few months. She stated if there had been any residents with MDROs, she would not allow those residents to use the w/p tubs. Interview with CNA #3 on 07/16/15 at 8:35 AM, revealed she had been employed with the facility for two (2) months; however, had never received training on how to clean and disinfect the w/p tubs. She stated she had not used the w/p tub since being employed and was not aware of any residents who used the w/p tubs. Interview with the Infection Control Nurse (ICN) on 07/16/15 at 6:30 PM and at 6:52 PM, revealed staff were to disinfect and clean the w/p tub after each resident use. She stated the Unit Coordinator was supposed to audit the use of the w/p tubs to ensure staff were properly cleaning and disinfecting the tubs. Per interview, residents with known MDROs or wounds should not be allowed to use the w/p tubs, as the risk of staff not properly cleaning and disinfecting the tub after resident use was a potential for cross contamination and infection. The ICN revealed her expectations were for staff to follow the manufacturer's recommendations when they cleaned and disinfected the w/p tubs after each resident use. She stated the Oxivir product staff was using was not the correct chemical for use in disinfecting the tub as per the manufacturer's	F 441			

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

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NAME OF PROVIDER OR SUPPLIER THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
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Continued From page 44

recommendations. Continued interview revealed the Oxivir contained Hydrogen Peroxide which was not an effective cleaner to disinfect the w/p tubs as per the manufacturer's recommendations. She stated the correct disinfecting solution staff should be using was Mastercare Disinfectant which was the product the manufacturer recommended. Further interview revealed RN #4/UM was supposed to educate staff on the process for cleaning and disinfecting the w/p tub per the manufacturer's recommendations. She stated the facility had failed in ensuring staff were trained on the proper disinfecting process for the w/p tubs.

Interview with the Director of Nursing (DON) on 07/16/15 at 6:29 PM, revealed she was uncertain what process the facility used to clean and disinfect the w/p tubs. She stated her expectation however, was for staff to clean and disinfect the w/p tub per the manufacturer's recommendations after each resident. Per interview, staff were also to ensure the individual using the disinfectant cleaner understood and was aware of any safety concerns. She stated to her knowledge no training had ever been provided for staff regarding cleaning and disinfecting the facility's w/p tubs. Further interview revealed a resident having an MDROs should not use the w/p tubs as there was a potential staff might not disinfect the w/p properly. In addition, she stated improper cleaning and disinfecting of the w/p tubs was a potential for transferring infections between residents who utilized the w/p tubs.

Interview with the Administrator on 07/16/15 at 6:09 PM, revealed her expectation was for staff to ensure they used the manufacturer's recommendations when cleaning and disinfecting

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F 441	Continued From page 45 the facility's w/p tubs. She stated she was not sure if training had been provided for staff regarding the proper cleaning and disinfecting of the w/p tubs per the manufacturer's recommendation; however, she expected staff to ensure the w/p tubs were thoroughly cleaned and disinfected between each resident's use. Per interview, she was not sure if residents with MDRO's were able to use the w/p tubs or not. Further interview revealed if facility staff did not clean and disinfect the w/p tubs per the manufacturer's recommendations, the w/p should not be used until this was performed. According to the Administrator, her expectations included staff using the Mastercare Disinfectant cleaner recommended by the manufacturer, and not to use a product not recommended by the manufacturer.	F 441	