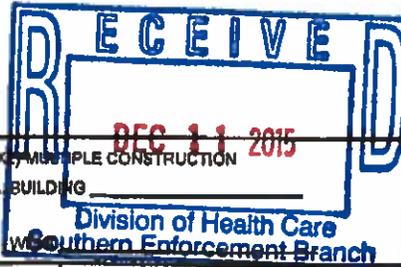


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CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 12/01/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ Division of Health Care Southern Enforcement Branch	(X3) DATE SURVEY COMPLETED 11/13/2015
NAME OF PROVIDER OR SUPPLIER LORETTO MOTHERHOUSE INFIRMARY			STREET ADDRESS, CITY, STATE, ZIP CODE 516 NERINX ROAD NERINX, KY 40049	
(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 000	INITIAL COMMENTS	F 000		
F 282 SS=D	<p>A standard health survey was conducted on 11/11-13/15. Deficient practice was identified with the highest scope and severity at "D" level.</p> <p>483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policies, it was determined the facility failed to implement care plan interventions related to pain management for one (1) of fifteen (15) sampled residents (Resident #3). Facility staff failed to provide care plan interventions during wound care for Resident #3 regarding pain management.</p> <p>The findings include: Review of the facility policy, "Resident Assessment and Care Plan Policy and Procedure," with a revision date of 11/11/14, revealed that the care plan development process included selecting interventions and planning care to identify and implement interventions and treatment to address the resident's physical, functional, and psychosocial needs, concerns, problems, and risks. It further directs "Interdisciplinary Team Staff completing the MDS (Minimum Data Set) and CAA (Care Area Assessment) process are responsible for care</p>	F 282	<p>Corrective action accomplished for residents found to be affected by deficient practice: On 11/14/15, Nurses were notified of the deficient practice of failure to follow the care plan related to assessment and treatment of pain. The current Pain Management policy and procedure was reviewed by nursing staff working and their understanding verified by signature. The Director of Nursing instructed Nurse Supervisors to assess Resident #3 for signs or symptoms of pain through observation and verbal report as stated in the care plan. Nurses were also instructed to pre-medicate Resident #3 prior to wound care treatment if routine pain medication was not recently given.</p> <p>Identify other residents having potential to be affected by deficient practice: Licensed Nurse and Medication Aide Quality Assurance Audits will be conducted to identify other residents having potential to be affected by deficient practice. The QA Audit tool (see Attachment A) is designed to ensure Pain Management Policy is followed appropriately and in compliance with the Resident Care Plan. These QA Audits will be overseen by the Director of</p>	12/23/15

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

TITLE

(X6) DATE

Michelle Essex, Administrator

12/10/15

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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NAME OF PROVIDER OR SUPPLIER LORETTO MOTHERHOUSE INFIRMARY			STREET ADDRESS, CITY, STATE, ZIP CODE 515 NERINX ROAD NERINX, KY 40049		
(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 282	<p>Continued From page 1</p> <p>planning problems, goals and interventions for their assigned areas."</p> <p>Review of the medical record revealed the facility admitted Resident #3 on 09/21/07 with diagnoses of Chronic Obstructive Pulmonary Disease, Borderline Diabetes Mellitus, Parkinson's Disease, Osteoarthritis, and Osteoporosis. Review of the Significant Change Comprehensive Assessment dated 09/23/15, revealed the facility assessed Resident #3 to not be interviewable. According to the Minimum Data Set (MDS), the facility assessed Resident #3 to have no skin breakdown; however, the resident was assessed to be at risk for the development of pressure ulcers. In addition, the MDS revealed Resident #3 received scheduled pain medication and as needed (PRN) medication for pain management.</p> <p>Further medical record review revealed Resident #3 was placed on palliative care related to diagnosis of End Stage Lung Disease on 09/03/15. Review of the Weekly Skin Assessment Record revealed the resident was also noted to have developed a Stage I pressure ulcer on 10/06/15.</p> <p>Review of the Comprehensive Care Plan dated 09/03/15 revealed the facility had developed a care plan to address the provision of palliative care including interventions to assess for signs and symptoms of pain through observation and verbal report and to administer pain medications as ordered by the physician.</p> <p>Review of the Medical Record revealed the physician had prescribed Roxanol (narcotic pain medication) twice daily and Oxycodone (narcotic pain medication) every six hours routinely for</p>	F 282	<p>Nursing and the Quality Assurance Coordinator. The Director of Nursing will schedule the Audits to monitor compliance with the Resident Care Plan, pain management, and infection control procedures. The QA Audits will observe various resident treatments and procedures, including wound care, to assess staff compliance with the Resident Care Plan and to identify if other residents are affected by this deficit practice. QA Audits will be conducted on at least 50% of Licensed Nurse and Medication Aide staff by 12/23/15 and the remaining staff by 1/23/16. Failed compliance will result in re-training and future QA Audits.</p> <p>Measures put into place or systemic changes made to ensure deficient practice will not recur: Resident Assessment and Care Plan Policy and Procedure (see Attachment B) updated to add the Nurse Supervisor to participate in the Resident Care Plan meeting along with the Interdisciplinary Team, resident, and health care surrogate or family member. The Nurse Supervisor will actively participate in the assessment process and the development of the Resident Care Plan. The Administrator notified the Nurse Supervisors of the policy update and the expectation of their attendance and participation in the Resident Care Plan meeting. The Administrator will monitor for compliance beginning on 12/1/15.</p>		

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NAME OF PROVIDER OR SUPPLIER LORETTO MOTHERHOUSE INFIRMARY			STREET ADDRESS, CITY, STATE, ZIP CODE 515 NERINX ROAD NERINX, KY 40049		
(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 282	<p>Continued From page 2</p> <p>pain. In addition, the physician had also prescribed Roxanol every four hours as needed for pain and Oxycodone every six hours as needed for pain. Review of the Medication Administration Record (MAR) revealed the resident had received the scheduled Roxanol and Oxycodone at 8:00 AM on 11/12/15.</p> <p>Observation of wound care on 11/12/15 at 9:50 AM revealed Resident #3 had a Stage II pressure ulcer to the right heel. Further observation revealed Licensed Practical Nurse (LPN) #1 attempted to remove the soiled dressing from the right heel; however, the dressing had adhered to the wound due to drainage. LPN #1 proceeded to soak the wound with normal saline and gauze and to pull the dressing from the resident's right heel. Resident #3 was observed to moan and to make facial grimaces during this procedure. The surveyor asked Resident #3 if this caused pain and the resident replied, "Yes." LPN #1 continued to pull at the soiled dressing in an attempt to remove the dressing from the resident's foot. However, there was no evidence the LPN identified or assessed Resident #3 for evidence of pain prior to or during the dressing change. Review of the Medication Administration Record (MAR) indicated the resident had not received PRN pain medication since 8:00 PM on 11/11/15.</p> <p>Interview with LPN #1 on 11/12/15 at 4:30 PM revealed she was unaware of a policy regarding the assessment of pain. When asked how she assessed pain prior to wound care, LPN #1 stated she usually attempted to plan wound care within an hour of Resident #3 receiving his/her regular morning dose of pain medication. LPN #1 further stated she should have stopped and asked the medication nurse about pain</p>	F 282	<p>Pain Management Policy and Procedure (see Attachment C) updated to include routine assessment of pain, addressing pain on the resident care plan when indicated, daily assessment of pain, verbal and non-verbal indicators of pain, non-pharmacologic options, monitoring the effectiveness of pain medication or treatment, and documentation. The implementation of a PRN Pain Management Flow Chart (see Attachment D) will assist KMAs and Nurses to assess pain appropriately with numeric rating scale, which is considered a best practice for long term care, to monitor the effectiveness of PRN and scheduled pain medications. The Director of Nursing provided education and training to Licensed Nursing Staff and Medication Aides on the updated Pain Management Policy, best practices in pain assessment, use of the Numeric Rating Scale, and implementation of the PRN Pain Management Flow Chart. Education and Training will be completed on 12/12/15 and the Director of Nursing will monitor for compliance with the QA Audit tool.</p> <p>Plans to monitor performance to ensure solutions are sustained: Licensed Nurse and Medication Aide Quality Assurance Audits will be utilized to monitor performance and compliance with the Resident Care Plan and that Pain Management interventions are followed appropriately. These QA Audits will be overseen by the Director of Nursing and the Quality Assurance Coordinator. The Director of Nursing will review the QA</p>		

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NAME OF PROVIDER OR SUPPLIER LORETTO MOTHERHOUSE INFIRMARY			STREET ADDRESS, CITY, STATE, ZIP CODE 515 NERINX ROAD NERINX, KY 40049		
(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 282	Continued From page 3 medication for Resident #3 before continuing wound care. During interview with the Director of Nursing (DON) on 11/13/15 at 8:25 PM, she stated pain assessments are done weekly during medication pass and during MDS assessment. The pain management care plan is developed accordingly. She further stated staff had not reported any problems regarding these assessments. The DON stated she was not aware if anyone monitors the MAR to ensure pain is assessed or documented.	F 282	Audits to ensure continued compliance. The Quality Assurance Coordinator will collect data from the QA Audit tool for tracking and monitoring of trends or patterns.		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for one (1) of fifteen (15) sampled residents (Resident #3) related to pain. Observation of wound care on 11/12/15 for Resident #3 revealed facility staff failed to provide	F 309	F309 Corrective action accomplished for residents found to be affected by deficient practice: On 11/14/15, Nurses were notified of the deficient practice of failure to follow the care plan related to assessment and treatment of pain. The current Pain Management policy and procedure was reviewed by nursing staff working and their understanding verified by signature. The Director of Nursing instructed Nurse Supervisors to assess Resident #3 for signs or symptoms of pain through observation and verbal report as stated in the care plan. Nurses were also instructed to pre-medicate Resident #3 prior to wound care treatment if routine pain medication was not recently given. Identify other residents having potential to be affected by deficient practice: Licensed Nurse and Medication Aide Quality Assurance Audits will be conducted to identify other residents having potential to be affected by deficient practice. The QA Audit tool (see	12/23/15	

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NAME OF PROVIDER OR SUPPLIER LORETTO MOTHERHOUSE INFIRMARY			STREET ADDRESS, CITY, STATE, ZIP CODE 616 NERINX ROAD NERINX, KY 40049		
(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 309	<p>Continued From page 4</p> <p>pain management during wound care according to the facility policy and the resident's care plan.</p> <p>The findings include:</p> <p>Review of the facility policy, "Pain Management," undated, revealed the purpose of the policy was to ensure the resident is "monitored and treated to manage and/or alleviate pain." The policy stated "daily resident pain evaluation is completed during the medication pass" and the resident is asked to describe any pain as mild, moderate, or severe. The policy directed that the resident be re-evaluated one to two hours after pain medication is given to determine effectiveness and for staff to document pain severity on the Medication Administration Record (MAR).</p> <p>Review of the medical record revealed the facility admitted Resident #3 on 09/21/07 with diagnoses of Chronic Obstructive Pulmonary Disease, Borderline Diabetes Mellitus, Parkinson's Disease, Osteoarthritis, and Osteoporosis. Further review of the record revealed Resident #3 was placed on palliative care related to a diagnosis of End Stage Lung Disease on 09/03/15. Review of the Significant Change Comprehensive Assessment dated 09/23/15, revealed the facility assessed Resident #3 to not be interviewable. According to the Minimum Data Set (MDS) assessment, the facility assessed Resident #3 to require scheduled pain medication and as needed (PRN) medication for pain management.</p> <p>Review of the Comprehensive Care Plan revealed the facility had developed a care plan to address the provision of palliative care including interventions to assess for signs and symptoms</p>	F 309	<p>Attachment A) is designed to ensure Pain Management Policy is followed appropriately and in compliance with the Resident Care Plan. These QA Audits will be overseen by the Director of Nursing and the Quality Assurance Coordinator. The Director of Nursing will schedule the Audits to monitor compliance with the Resident Care Plan, pain management, and infection control procedures. The QA Audits will observe various resident treatments and procedures, including wound care, to monitor pain assessment, management, and reassessment to monitor effectiveness of intervention. QA Audits will be conducted on at least 50% of Licensed Nurse and Medication Aide staff by 12/23/15 and the remaining staff by 1/23/16. Failed compliance will result in re-training and future QA Audits.</p> <p>Measures put into place or systemic changes made to ensure deficient practice will not recur: Pain Management Policy and Procedure (see Attachment C) updated to include routine assessment of pain, addressing pain on the resident care plan when indicated, daily assessment of pain, verbal and non-verbal indicators of pain, non-pharmacologic options, monitoring the effectiveness of pain medication or treatment, and documentation. The implementation of a PRN Pain Management Flow Chart (see Attachment D) and the Weekly Focused Assessment (see Attachment E) will assist KMAs and Nurses to assess pain appropriately with</p>		

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NAME OF PROVIDER OR SUPPLIER LORETTO MOTHERHOUSE INFIRMARY			STREET ADDRESS, CITY, STATE, ZIP CODE 616 NERINX ROAD NERINX, KY 40049	
(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 309	<p>Continued From page 5</p> <p>of pain through observation and verbal report and to administer pain medications as ordered by the physician.</p> <p>Review of the Medical Record revealed the physician had prescribed Roxanol (narcotic pain medication) twice daily and Oxycodone (narcotic pain medication) every six hours routinely for pain. In addition, the physician had also prescribed Roxanol every four hours as needed for pain and Oxycodone every six hours as needed for pain. Review of the Medication Administration Record (MAR) revealed the resident had received the scheduled Roxanol and Oxycodone at 8:00 AM on 11/12/15.</p> <p>Observation of wound care on 11/12/15 at 9:50 AM revealed Resident #3 had a Stage II pressure ulcer to the right heel. Further observation revealed Licensed Practical Nurse (LPN) #1 attempted to remove the soiled dressing from the right heel; however, the dressing had adhered to the wound due to drainage. LPN #1 proceeded to soak the wound with normal saline and gauze and to pull the dressing from the resident's right heel. Resident #3 was observed to moan and to make facial grimaces during this procedure. The surveyor asked Resident #3 if this caused pain and the resident replied, "Yes." LPN #1 continued to pull at the soiled dressing in an attempt to remove the dressing from the resident's foot. However, there was no evidence the LPN identified or assessed Resident #3 for evidence of pain prior to or during the dressing change. Review of the Medication Administration Record (MAR) indicated the resident had not received PRN pain medication since 8:00 PM on 11/11/15.</p> <p>Interview with LPN #1 on 11/12/15 at 4:30 PM</p>	F 309	<p>numeric rating scale, which is considered a best practice for long term care, to monitor the effectiveness of PRN and scheduled pain medications. The Director of Nursing provided education and training to Licensed Nursing Staff and Medication Aides on the updated Pain Management Policy, best practices in pain assessment, use of the Numeric Rating Scale, and implementation of the PRN Pain Management Flow Chart. Education and Training will be completed on 12/12/15 and the Director of Nursing will monitor for compliance with the QA Audit tool.</p> <p>Plans to monitor performance to ensure solutions are sustained: Licensed Nurse and Medication Aide Quality Assurance Audits will be utilized to monitor performance and compliance with the Resident Care Plan and that Pain Management interventions are followed appropriately. These QA Audits will be overseen by the Director of Nursing and the Quality Assurance Coordinator. The Director of Nursing will review the QA Audits to ensure continued compliance. The Quality Assurance Coordinator will collect data from the QA Audit tool for tracking and monitoring of trends or patterns.</p>	

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NAME OF PROVIDER OR SUPPLIER LORETTO MOTHERHOUSE INFIRMARY			STREET ADDRESS, CITY, STATE, ZIP CODE 815 NERINX ROAD NERINX, KY 40049	
(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 309	Continued From page 6 revealed she was unaware of a policy regarding the assessment of pain. When asked how she assessed pain prior to wound care, LPN #1 stated she usually attempted to plan wound care within an hour of Resident #3 receiving his/her regular morning dose of pain medication. LPN #1 further stated she should have stopped during wound care and asked the medication nurse about pain medication for Resident #3 before continuing the wound care. During interview with the Director of Nursing (DON) on 11/13/15 at 6:25 PM, she stated pain assessments are completed weekly with hydration assessment, during medication pass and during MDS assessment, and the pain management care plan is developed accordingly. She further stated staff had not reported any problems regarding these assessments, and that she was not aware if anyone monitors the MAR to ensure pain is assessed or documented.	F 309		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441	F441 Corrective action accomplished for residents found to be affected by deficient practice: On 11/14/15, Nurses were notified of the deficient practice related to infection control. The Infection Control Standard Precaution policy and current Clean Dressing Change procedure was reviewed by nursing staff working and their understanding verified by signature. The Director of Nursing reviewed the importance of good infection control with the nurses performing the treatment for Resident #3.	12/23/15

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F 441	<p>Continued From page 7 actions related to infections.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to maintain an effective infection control program to prevent the development and transmission of disease/infection for one (1) of fifteen (15) sampled residents (Resident #3). Observation of wound care for Resident #3 on 11/12/15 revealed LPN #1 failed to change gloves and perform handwashing after removing a soiled dressing and prior to applying a clean dressing to the resident's wound.</p>	F 441	<p>Identify other residents having potential to be affected by deficient practice: Licensed Nurse and Medication Aide Quality Assurance Audits will be conducted to identify other residents having potential to be affected by deficient practice. The QA Audit tool (see Attachment A) is designed to ensure Infection Control Protocols are followed appropriately. These QA Audits will be overseen by the Director of Nursing and the Quality Assurance Coordinator. The Director of Nursing will schedule the Audits to monitor compliance with the Resident Care Plan, pain management, and infection control procedures. The QA Audits will observe various resident treatments and procedures, including wound care, to monitor infection control procedures, appropriate use of PPE, and handwashing. QA Audits will be conducted on at least 50% of Licensed Nurse and Medication Aide staff by 12/23/15 and the remaining staff by 1/23/16. Failed compliance will result in re-training and future QA Audits.</p> <p>Measures put into place or systemic changes made to ensure deficient practice will not recur: Wound Care Policy and Procedure (see Attachment F) updated to include disposal of gloves after removing soiled dressing, handwashing after removal of gloves, and followed by clean gloves before applying a clean dressing. The Director of Nursing provided education and training to Licensed Nursing Staff on</p>		

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NAME OF PROVIDER OR SUPPLIER LORETTO MOTHERHOUSE INFIRMARY			STREET ADDRESS, CITY, STATE, ZIP CODE 516 NERINX ROAD NERINX, KY 40049		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 8</p> <p>The findings include:</p> <p>Review of the facility policy "Standard Precautions," undated, revealed "use of disposable gloves is indicated for procedures where blood, body fluids, secretions, excretions and/or non-intact skin are handled" and that "handwashing/hand antiseptics is necessary when gloves are removed."</p> <p>Review of the medical record revealed the facility admitted Resident #3 on 09/21/07 with diagnoses of Chronic Obstructive Pulmonary Disease, Borderline Diabetes Mellitus, Parkinson's Disease, Osteoarthritis, and Osteoporosis. Review of the Significant Change Comprehensive Assessment dated 09/23/15, revealed the facility assessed Resident #3 to not be interviewable. In addition, the facility assessed Resident #3 to have no skin breakdown; however, the resident was assessed to be at risk for the development of pressure ulcers.</p> <p>Review of the Weekly Pressure Ulcer Record, dated 10/11/15, indicated a Stage I pressure ulcer to Resident #3's right heel which had developed on 10/08/15. The pressure sore was to receive treatment and dressing changes daily and had progressed to a Stage II pressure ulcer on 10/24/15.</p> <p>Observation of wound care on 11/12/15 at 9:50 AM revealed Resident #3 had a Stage II pressure ulcer to the right heel. Further observation revealed Licensed Practical Nurse (LPN) #1 attempted to remove the soiled dressing from the right heel; however, the dressing had adhered to the wound due to drainage. LPN #1 proceeded to soak the soiled gauze attached to the wound with</p>	F 441	<p>Wound Care Policy updates and Infection Control prevention. Education and Training will be completed on 12/12/15 and the Director of Nursing will monitor for compliance with the QA Audit tool.</p> <p>Plans to monitor performance to ensure solutions are sustained: Licensed Nurse and Medication Aide Quality Assurance Audits will be utilized to monitor performance and compliance of Infection Control Policy and Procedure. These QA Audits will be overseen by the Director of Nursing and the Quality Assurance Coordinator. The Director of Nursing will review the QA Audits to ensure continued compliance. The Quality Assurance Coordinator will collect data from the QA Audit tool for tracking and monitoring of trends or patterns.</p>		

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

PRINTED: 12/01/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/13/2015
NAME OF PROVIDER OR SUPPLIER LORETTO MOTHERHOUSE INFIRMARY			STREET ADDRESS, CITY, STATE, ZIP CODE 616 NERINX ROAD NERINX, KY 40048	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 9</p> <p>normal saline and to pull the dressing from the resident's right heel. LPN #1 discharged the soiled dressing and with the same soiled gloved proceeded to clean the wound. While wearing the same soiled gloves LPN #1 was observed to apply a Calcium Alginate dressing. LPN#1 did not remove her gloves or wash her hands until she had applied the clean dressing.</p> <p>Interview with LPN #1 following dressing change on 11/12/15 revealed she had been trained to change gloves between dirty and clean dressing changes.</p> <p>Interview conducted on 11/13/15 with the Director of Nursing (DON) revealed that she had not done direct observation of wound care. She also stated gloves should be removed and hands washed after removing a soiled dressing and before applying a clean dressing.</p>	F 441		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 185276	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 12/23/2015	Y3
NAME OF FACILITY LORETTO MOTHERHOUSE INFIRMARY			STREET ADDRESS, CITY, STATE, ZIP CODE 515 NERINX ROAD NERINX, KY 40049		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0441	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.65	Completed
LSC	12/23/2015	LSC	12/23/2015	LSC	12/23/2015
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) <i>ad</i>	DATE <i>2/18/16</i>	SIGNATURE OF SURVEYOR <i>Alisia Dunn</i>	DATE <i>2/18/16</i>
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/13/2015		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 100439	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/23/2015
NAME OF FACILITY LORETTO MOTHERHOUSE INFIRMARY		STREET ADDRESS, CITY, STATE, ZIP CODE 515 NERINX ROAD NERINX, KY 40049

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix N0144	Correction	ID Prefix N0194	Correction	ID Prefix N0199	Correction
Reg. # 902 KAR 20:300-6(7) (b)2.a.	Completed	Reg. # 902 KAR 20:300-7(4) (c)2.	Completed	Reg. # 902 KAR 20:300-8	Completed
LSC	12/23/2015	LSC	12/23/2015	LSC	12/23/2015
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) <i>ad</i>	DATE <i>2/18/16</i>	SIGNATURE OF SURVEYOR <i>Alicia Dunn</i>	DATE <i>2/18/16</i>
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/13/2015		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		



CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL

Matthew G. Bevin
Governor

Sandy Goins, Regional Program Manager
Division of Health Care
116 Commerce Avenue
London, Kentucky 40744
(606) 330-2030
Fax: (606) 330-2054
<http://chfs.ky.gov/os/oig>

Vickie Yates Brown Glisson
Secretary

Stephanie Hold
Acting Inspector General

February 18, 2016

Ms. Michelle Essex
Loretto Motherhouse Infirmary
515 Nerinx Road
Nerinx, Kentucky 40049

Dear Ms. Essex:

Thank you for submitting your proposed plan of correction regarding the deficiencies noted during the survey completed on November 13, 2015.

We are accepting your allegation of compliance and presume that substantial compliance was achieved by December 23, 2015, as alleged in your plan of correction. Therefore, we are not recommending the remedies referred to in the initial notice dated December 1, 2015, to the Centers for Medicare and Medicaid Services Regional Office at this time. Based on implementation of your plan of correction, we will recommend that your nursing facility be relicensed and recertified for continued participation in the Title XVIII/XIX program(s) contingent upon approval from the appropriate agencies.

Your cooperation is appreciated. If you should have questions regarding this information, please contact our office.

Sincerely,

A handwritten signature in blue ink that reads "Sandy Goins /ad".

Sandy Goins
Regional Program Manager

SG.md:lk

Enclosure