

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

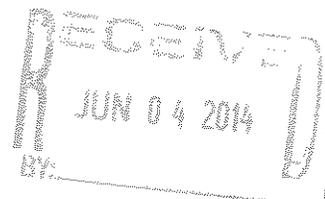
PRINTED: 05/15/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185380	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/01/2014
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NAME OF PROVIDER OR SUPPLIER  EDGEMONT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031
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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	F 000		
F 279 SS=D	<p>A Recertification Survey was initiated 04/29/14 and concluded on 05/01/14. Deficiencies were cited with the highest Scope and Severity of a "F".</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</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 a Comprehensive Care Plan was developed to meet a resident's medical needs which were identified in the comprehensive assessment for one (1) of fifteen (15) sampled residents (Resident #1).</p>	F 279	SEE ATTACHED	5/8/2014



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Deborah Zeck* TITLE: *Administrator* (X6) DATE: *6-4-14*

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

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F 279

Resident #1's Comprehensive Care Plan was not developed to include a problem and goal related to vision, although vision triggered as a problem on the Care Area Assessments (CAAs) and Care Area Assessment Summary (CAAS) dated 03/04/14.

The findings include:

Review of the facility's policy titled, "Care Plans-Comprehensive", undated, revealed the facility was to develop a Comprehensive Care Plan for each resident which included measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs. The Policy stated the Comprehensive Care Plan was designed to: incorporate identified problem areas; incorporate risk factors associated with identified problems; reflect treatment goals and objectives in measurable outcomes; and prevent decline in the resident's functional status.

Review of Resident #1's medical record revealed diagnoses which included Nuclear Sclerosis (also known as a type of cataract), Non-Alzheimer's Dementia, Traumatic Brain Injury, and Schizophrenia. Review of the Significant Change Minimum Data Set (MDS) Assessment dated 03/11/14, revealed the facility assessed the resident as having both short and long term memory loss and as having impaired vision. Review of the CAAS dated 03/04/14, revealed visual function triggered related to the Significant Change MDS Assessment. Review of the CAAs, dated 03/14/14, revealed visual function had triggered related to Resident #1 having impaired vision, was able to see only large print and not regular print in newspapers or books. Continued

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F 279 Continued From page 2  
review of the CAAs revealed Resident #1 was seen on 11/20/13, by the eye Physician, who made visits to the facility, with plans to follow up in six (6) to nine (9) months. Further review revealed the CAAs stated, to proceed to care planning Resident #1's visual impairment under the Activities of Daily Living (ADL's) care plan to monitor for any changes in condition, and ensure follow up appointments or referrals of the appropriate health care professional were provided as needed.

F 279

Review of the Comprehensive Plan of Care dated 03/14/14, revealed a care plan for Resident #1 for alteration in ADL function related to being dependent on staff for all ADL's. The ADL care plan goal stated the resident would be clean and well groomed daily, would maintain the highest level of functional ability, and/or prevent decline unless clinically unavoidable. Further review of the ADL care plan revealed the interventions included: to monitor Resident #1's eyes for redness, drainage, complaints of changes in vision; and, schedule eye exams as needed. In addition, ADL care plan review revealed only interventions related to vision; however, there was no problem related to vision and no goal in regards to Resident #1's vision.

Interview on 05/01/14 with MDS Nurse #1, revealed she had completed Resident #1's MDS Assessment dated 03/11/14, and had also developed the Comprehensive Care Plan from the MDS Assessment. She stated vision had triggered and she had included vision on the ADL Care Plan as indicated on the CAAs. However, she further stated she should have included a problem and a goal for vision and indicated she had just addressed the interventions for vision.

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F 322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure a resident who received medications through a Gastrostomy Tube (g-tube) received appropriate treatment and services to prevent Aspiration Pneumonia for one (1) of fifteen (15) sampled residents (Resident #1).</p> <p>Observation during medication pass revealed the nurse failed to check for g-tube residual prior to the administration of medication via the g-tube for Resident #1.</p>	F 322	SEE ATTACHED	5/8/2014
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F 322 Continued From page 4

F 322

The findings include:

Review of the facility's policy titled, "Enteral Tube Medication Administration", revised 12/07/12, revealed in order to safely and accurately administer oral medication through an enteral (specialized artificial tubes inserted into various parts of the gastrointestinal tract for non-oral feeding purposes) tube: verify tube placement by inserting a small amount of air into the tube with the syringe and listening to stomach with a stethoscope for gurgling sounds, or aspirating stomach contents with the syringe; prepare medications for administration which should be crushed to a powder, and dissolved in at least five (5) milliliters (ml's) of warm water; check gastric contents for residual tube feeding; flush the tube with thirty (30) ml's of water prior to medication administration; allow the medication to flow down the tube via gravity; and flush the tube with 30 ml's of water after medication were administered.

Review of Resident #1's medical record revealed diagnoses which included Traumatic Brain Injury and placement of a g-tube. Review of the Significant Change Minimum Data Set (MDS) Assessment dated 03/11/14, revealed the facility assessed the resident to have short term and long term memory problems, and to have a feeding tube.

Observation on 04/30/14 at 12:40 PM, of a medication pass for Resident #1 revealed Registered Nurse (RN) #2 crushed Tylenol 500 milligrams (mg's), a pain reliever, and dissolved the medication in water. She proceeded to check for placement by inserting air into the g-tube with

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F 322	Continued From page 5 the syringe and listening to the stomach with a stethoscope. Continued observation revealed RN #2 then administered thirty (30) ml's of water, and administered the Tylenol through the g-tube. However, observation revealed RN #2 did not check the g-tube for residual tube feeding as per the policy, prior to the administration of the medication through the g-tube.  Interview on 04/30/14 at 12:50 PM with RN #2, revealed she should have checked the g-tube for residual tube feeding as per the policy, prior to the administration of the medication.  Interview on 05/01/14 at 1:20 PM with the Director of Nursing (DON) revealed it was her expectation for nurses to check g-tubes for placement and residuals, prior to administration of medication as per the policy.	F 322			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  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 residents were free of significant medication errors for one (1) of fifteen (15) sampled residents (Resident #1).  During initial observation on 04/29/14 at 4:00 PM, of Resident #1 it was observed there was a bag	F 333	SEE ATTACHED	5/8/2014	

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F 333 Continued From page 6  
of intravenous (IV) Vancomycin (an antibiotic medication) 1750 milligrams (mg's)/500 milliliters (ml's) of Normal Saline (N/S) hanging with no time or date indicating when the IV bag was hung and a there was 375 milliliters (ml's) of fluid observed to be left in the IV bag. Observation revealed the IV medication was infusing by a Dial a Flow (an IV flow regulator with a dial set to deliver the correct drip rate) which was set for 125 ml's per hour. Interview at the time of the observation with the nurse, who hung the IV medication, revealed the IV medication bag was hung at 11:00 AM, and should have been administered by 3:00 PM.

F 333

The findings include:

Review of the facility's policy titled, "Med Care-IV Monitoring", dated 06/01/99, revealed the purpose of the policy was to enable the nurse administering infusion therapy to recognize and utilize appropriate intervention for infusion related problems or complications. Further review revealed residents receiving infusion therapy were to be monitored at established intervals based on prescribed therapy, and age and condition. According to review of the policy, the nurse administering IV fluids or medications was to recognize and utilize appropriate intervention for any IV related problems or complications. Further review of the policy revealed the nurse was to document any IV related problems or complications according to policies and procedures.

Review of Resident #1's medical record revealed diagnoses which included Clostridium Difficile, Osteomyelitis of the Right Heel with Staph Epidermis (a bacteria) infection which was

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F 333	<p>Continued From page 7</p> <p>sensitive to Vancomycin, Pneumonia, and a Urinary Tract Infection with the Kocuria Rosea (a bacteria causing infections in immunocompromised persons). Continued record review of the Significant Change MDS dated 03/11/14, revealed the facility assessed Resident #1 to have memory problems with short and long term memory.</p> <p>Review of the Hospital Discharge Summary dated 04/19/14, revealed Resident #1 was admitted to the hospital on 04/14/14, and started on antibiotic medications which included Vancomycin IV, Levaquin IV, Cefepime IV. Continued review of the Discharge Summary revealed Resident #1 had a Right Heel Ulcer for which a bone scan was been performed and showed early Osteomyelitis (infection of the bone caused by bacteria). Orthopedic surgery was consulted and felt long term IV therapy would be prudent before surgical intervention. Review of the Discharge Summary revealed the ulcer to the Right Heel showed staph epidermis (a bacteria) and Resident #1 was being discharged to the facility with IV Vancomycin orders pending follow up with orthopedic surgery. According to the Summary, Resident #1's diagnosed Sepsis (severe blood infection which could lead to organ failure and death) was presumed to be more likely due to a Urinary Tract Infection (UTI). Further review of the Discharge Summary revealed the urine culture performed at the hospital showed Kocuria Rosea which was to be treated with Vancomycin.</p> <p>Review of the Re-Admission Physician's Orders dated 04/19/14, revealed orders for Vancomycin 1750 mgs in 500 ml's of N/S via IV at 125 ml's per hour at 10:00 AM and 10:00 PM for twenty-one (21) days.</p>	F 333		

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F 333

Observation of Resident #1 initially, on 04/29/14 at 4:00 PM, revealed a bag of IV Vancomycin 1750 mgs per 500 ml's of N/S hanging with no documented evidence of a time or date for when the IV bag was hung. Observation revealed 375 ml's of IV fluid left in the bag. The IV medication was infusing by a Dial a Flow which was set for 125 ml's per hour. Interview at the time of the observation with Licensed Practical Nurse (LPN) #2 revealed she had hung the IV medication at 11:00 AM. LPN #2 stated there was 375 ml's of medication left in the IV bag; however, the medication should have been infused by 3:00 PM. LPN #2 reported she had initially tried infusing the IV medication per IV pump; however, the IV pump kept shutting off so she placed the IV tubing on a Dial a Flow. She stated she was aware there was a new IV pump in the medication room, but had not tried that IV pump.

Additional interviews with LPN #2 on 04/29/14 at 4:30 PM and 5:30 PM, revealed she had checked the IV medication periodically that day, and had last checked it at 3:30 PM. She stated she had noted the IV medication was infusing slowly; however, did not check by her watch to assess how many drips were infusing a minute. LPN #2 stated at 3:30 PM, she had re-adjusted Resident #1's arm to ensure the IV medication was infusing; but, did not realize it was infusing "that slow". She reported she had not taken action to try the new IV pump which was in the medication room and had not notified the Physician of the IV antibiotics not infusing at 125 ml's per hour as ordered.

Interviews on 04/29/14 at 4:30 PM and 05/01/14 at 6:45 PM, with the Director of Nursing (DON),

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F 333 Continued From page 9

revealed the IV Vancomycin medication should have been administered within four (4) hours for a 500 ml bag at 125 ml's per hour. The DON stated if the IV antibiotic was hung at 11:00 AM, it should have infused by 3:00 PM. She stated her expectation was for the nurse to monitor the IV medication closely, at least hourly by visualizing how much medication had infused and estimating the time the medication was expected to be infused. The DON revealed it could effect the "trough" (a lab test, used to monitor the lowest levels of the antibiotic Vancomycin in the blood, obtained just before the next dose of the antibiotic) if the medication was not infused at the times scheduled. She stated this would be considered a medication error because the medication was not infusing at 125 ml per hours as ordered. The DON stated she would have to confer with the Physician in regards to the medication not having been infused as ordered. Continued interview revealed she randomly observed medication pass and monitored IV medications and was unaware there was a concern until now.

Interview on 04/29/14 at 6:00 PM with the Consultant Pharmacist, revealed she had conferred with the IV Pharmacist and the Physician and there was no need to change the IV therapy schedule for the next dose or to change the next time for the trough to be drawn. She stated the IV medication was good for twenty-four (24) hours at room temperature. Continued interview revealed although this did not alter the course of the IV therapy, the nurse should have monitored the resident more closely in order to ensure the IV antibiotic medication was flowing at the correct rate.

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F 333	Continued From page 10 Interview with the Physician on 05/01/14 at 12:00 PM, revealed it was his expectation for the Physician's Orders to be followed. The Physician stated he was aware in this situation there was a problem with the IV pump and the Dial a Flow. He stated he had left it up to the Consultant Pharmacist to decide if there was a need to change the order for the trough schedule or change the IV medication dosing. The Physician indicated Resident #1 had been hospitalized several times recently with Pneumonia and other associated health issues, and the resident was immunocompromised.	F 333			
F 441 SS=F	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 actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	SEE ATTACHED	5/8/2014	

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F 441	<p>Continued From page 11</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policy, and the Centers for Disease Control (CDC) recommendations, it was determined the facility failed to maintain an Infection Control Program to utilize contact precautions, as per CDC recommendations, for residents identified with multi-drug resistant organisms (MDROs) for two (2) of fifteen (15) sampled residents (Residents #1 and #6). Resident #1 and Resident #6 were diagnosed with MDROs; however, observations revealed the residents were not on contact precautions.</p> <p>In addition the facility failed to ensure infection control techniques were utilized when two (2) residents at a time were assisted with meals. Observations in the dining room revealed a State Registered Nursing Assistant (SRNA) was using poor infection control technique when assisting two (2) residents with their meals (Unsampled Resident A and Unsampled Resident B).</p>	F 441		
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F 441	<p>Continued From page 12</p> <p>Also, observations on initial tour revealed the facility failed to ensure residents' items were stored in a manner to maintain infection control as evidenced by: resident urinals noted to be unlabeled and undated; resident wash basins observed to be unbagged lying on bathroom floors; an elevated toilet seat stored on a bathroom floor; and residents' toothbrushes stored together and not labeled with the resident's name.</p> <p>The findings include:</p> <p>Review of the CDC's 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings revealed contact precautions were intended to prevent transmission of infectious agents, such as MDROs, which were spread by direct or indirect contact with the infected individuals or his/her environment. The Guideline revealed specific agents for which the application of contact precautions was appropriate included infectious agents which had been implicated in transmission through environmental contamination such as Clostridium difficile (C-Diff). In addition, the guideline noted healthcare personnel caring for individuals on Contact Precautions were to wear a gown and gloves for interactions which might involve contact with the person or potentially contaminated areas in his/her room.</p> <p>Interview, on 04/30/14 at 5:00 PM, with the Administrator revealed the facility had created a "Contact Precautions" policy that day as the facility did not have adequate policies for Infection Control. She indicated the facility utilized Standard Precautions which were not adequate for all MDROs.</p>	F 441		
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F 441	<p>Continued From page 13</p> <p>Review of the facility's policy titled, "Contact Precautions", undated, revealed contact transmission required the use of contact precautions to prevent infections spread by person-to-person contact. The policy stated staff were to use appropriate personal protective equipment (PPE), which included gown and gloves upon entering a resident's room with contact precautions. Further review of this policy revealed staff were to remove the PPE prior to exiting the room.</p> <p>1. Review of Resident #1's medical record revealed diagnoses which included Non Alzheimer's Dementia, C-Diff Infection (an intestinal bacteria which caused infectious diarrhea that ranged from mild to life-threatening), Osteomyelitis (infection of the bone) of the Right Heel, recent Urinary Tract Infection (UTI) and Pneumonia. Review of the Significant Change Minimum Data Set (MDS) Assessment dated 03/11/14, revealed the facility assessed Resident #1 to have short term and long term memory deficits.</p> <p>Review of the Physician's Orders dated 04/13/14 revealed orders to obtain a stool sample to test for C-diff. Review of the laboratory (lab) report revealed a stool specimen was collected on 04/14/14, and was reported on 04/15/14 as being C-Diff positive. Further review of the lab report revealed no documented evidence a notation on it to confirm a nurse had acknowledged the test results and notified the Physician of the results. Continued record review revealed Resident #1 was sent to the hospital at approximately 6:00 AM on 04/14/14 and returned on 04/19/14.</p>	F 441		
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F 441	<p>Continued From page 14</p> <p>Review of the Hospital Discharge Summary dated 04/19/14 revealed Resident #1 was admitted to the hospital on 04/14/14, and had been started on intravenous (IV) antibiotics which included Vancomycin, Levaquin, Cefepime. Continued review of the Summary revealed the discharge diagnoses included Pneumonia, Right Heel Ulcer, Urinary Tract Infection, Sepsis, and Osteomyelitis; however, there was no documented diagnoses of C-Diff.</p> <p>Review of the Physician's Orders for 04/14/14 revealed no documented evidence of orders related to contact isolation for Resident #1 prior to being sent to the hospital or on the resident's return to the facility on 04/19/14. Review of the Comprehensive Plan of Care revealed there was no indication the resident was in contact isolation for C-diff.</p> <p>Observation on 04/29/14 at 4:00 PM of Resident #1, revealed no PPE present outside the resident's room, on the door or on a cart by the door and no signage to indicate the resident was on contact precautions, on the door. Continued observation revealed Resident #1 was lying on the bed with the head of the bed elevated. Observation revealed Resident #1 was receiving tube feeding and IV antibiotics. Further observation revealed Licensed Practical Nurse (LPN) #2 entered Resident #1's room to adjust the resident's IV and was not wearing PPE.</p> <p>Interview with Registered Nurse (RN) #2 on 04/30/14 at 9:10 AM, revealed she was assigned to Resident #1 and was frequently assigned to his/her care. She stated she was unaware of Resident #1 having any MDRO at this time. She stated in the past, the resident had C-Diff and</p>	F 441		
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F 441	<p>Continued From page 15</p> <p>they used "standard precautions". RN #2 stated she was unaware if there was ever an order for Contact Precautions. She stated in the past she remembered seeing a cart by his/her door with PPE, and she had used the gown and gloves located in it when she took care of the resident. However, she stated she did not remember any signage on the door indicating contact precautions or a biohazard bin being left in the room for the dirty linens and soiled briefs to be placed in. She stated in the past staff would take the soiled linens and briefs to the soiled utility room.</p> <p>Interview with LPN #2 on 04/30/14 at 9:15 AM revealed Resident #1 was not currently on contact isolation precautions; but, had been in the past for C-Diff. She stated there was never any signage on the door indicating contact precautions; however, staff were instructed to wear a gown and gloves when caring for the resident and gowns were kept in the clean utility closet not beside Resident #1's room door.</p> <p>Interview with SRNA #2 on 04/30/14 at 9:20 AM, revealed he was assigned to Resident #1 and the resident did not have C-Diff at that time; but, had it in the past. He stated when Resident #1 had C-Diff he did not remember any signage on the door indicating contact precautions, or any biohazard container in the room for soiled linens and briefs. He stated if a resident had C-Diff, he would "double" glove and use a gown if he had to clean up stool. He stated he would have to retrieve the gowns from the clean linen closet. SRNA #2 stated if he was just cleaning the resident for urinary incontinence he would not need to "double" glove or wear a gown. He stated the linens and the soiled briefs would be</p>	F 441		

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F 441	<p>Continued From page 16</p> <p>placed in the general bathroom in a dirty linen cart and trash cart. He stated he would get information related to the need for isolation precautions in report from the nurses or the SRNA's who were going off shift.</p> <p>Observation on 04/30/14 at 10:05 AM, revealed there was no signage on the door to indicate contact precautions, and no PPE near the door. Further observation revealed RN #2 went into the room without PPE and spiked and hung a bag of IV antibiotics. Further observation on 04/30/14 at 12:40 PM, revealed there continued to be no signage on the door regarding contact precautions, and no PPE near the door. RN #2 was observed at the time to enter Resident #1's room without PPE and administered medication per the gastric tube (g-tube).</p> <p>Further interview with LPN #2 on 05/01/14 at 11:20 AM, revealed she had received the lab report back on 04/15/14 which stated Resident #1 had a C-Diff infection. She stated Resident #1 was in the hospital at that time, and she called the hospital and talked to the nurse assigned to the resident to inform the nurse of the results. LPN #2 stated she left Resident #1's lab report on the clipboard at the nurse's station for when the resident returned to the facility. She stated she did not remember calling the Physician to notify him of the lab results because the resident was in the hospital. She stated normally when she received a lab result from the fax machine, she would: call the Physician; write the new orders on the lab slip and on the Telephone Orders; and sign the lab report before filing it in the resident's record. She stated after Resident #1 returned from the hospital she presumed he/she no longer had the C-diff.</p>	F 441			

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F 441 Continued From page 17

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Interview with the Director of Nursing (DON)/Infection Control (IC) Nurse on 04/30/14 at 8:50 AM, revealed the facility did not use signage for contact precautions due to confidentiality and resident's rights. She stated if a resident had C-Diff she expected staff to go to the clean utility closet and get a gown and use gloves when caring for the resident. She stated there would be no PPE near the resident's door, and staff would only be expected to wear a gown if coming in contact with body fluids. Further interview revealed the need for contact precautions would be passed along to staff in report and would not necessarily be on a resident's care plan. Additional interview with the DON/IC Nurse on 04/30/14 at 3:40 PM, revealed when lab data came in on the fax machine related to C-diff for Resident #1, the nurse should have called the results in to the Physician, and written on the lab slip the date and time the Physician was notified. She stated Resident #1 had been C-Diff positive and staff were unaware and were using only "standard precautions" with no gowns when coming into contact with stool. She further stated until this survey, only "standard precautions" were used for residents with C-Diff, and a gown was used only if staff was expected to come into contact with stool.

Interview on 05/01/14 at 12 :00 PM with the Attending Physician, revealed he was aware the resident had C-Diff because he received lab data from the lab company on his personal fax machine. He further stated the Vancomycin the resident was currently receiving should also cover the C-Diff infection.

2. Review of Resident #6's medical record

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F 441	Continued From page 18  revealed the facility admitted the resident on 04/14/14, from the hospital with diagnoses which included Acute Renal Failure, Right Leg Above the Knee Amputation, Urinary Tract Infection, Septicemia (a bacterial infection in the blood) and Pneumonia. Continued record review revealed a urine culture, dated 04/03/14, which identified a MDRO, Escherichia Coli (E-Coli) which was Extended-Spectrum $\beta$ -lactamase (ESBL) positive (enzymes that mediate resistance to extended-spectrum, third generation, cephalosporin antibiotics). Review of the Physician's Orders revealed orders for Resident #6 to receive the antibiotic Invanz, for three (3) days, with the last day 04/17/14. Additional record review revealed Resident #6 had cultures obtained from wounds on the top and bottom of his/her left foot which were collected on 04/29/14. Further record review revealed the lab results indicated the MDRO Methicillin Resistant Staphylococcus Aureus (MRSA) was cultured from the wounds.  Interview with SRNA #1 on 04/30/14 at 2:32 PM, revealed Resident #6 was currently on contact precautions, and staff was supposed to gown and glove prior to entering the room because of an infection. However, she stated prior to that day Resident #6 had not been on contact precautions and staff had not had to wear a gown when providing care before.  Interview, on 05/01/14 at 7:23 PM with LPN #1, revealed Resident #6 was on contact precautions because he/she currently had an MRSA infection. After reviewing the hospital Discharge Summary, LPN #1 stated when Resident #6 was admitted to the facility, they had a urine culture which identified ESBL, a MDRO; however, they used	F 441			

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F 441	<p>Continued From page 19</p> <p>"standard precautions" when caring for the resident because that was the process at the time.</p> <p>Interview, on 05/01/14 at 7:40 PM with the DON/IC Nurse, revealed Resident #6 was incontinent and had ESBL in his/her urine when admitted to the facility. The DON stated they used "standard precautions" when providing care for the resident; however, had changed the facility's process during the survey. She stated the facility would now use contact precautions to reduce the risk of transmission of MDROs to other residents. The DON further stated after reviewing the federal regulations, the facility had changed the infection control procedures to incorporate contact precautions when appropriate.</p> <p>3. Interview with the DON/IC Nurse on 04/29/14 at 12:00 PM, revealed she was unaware of any facility policy related to the dating or labeling of urinals.</p> <p>Observation on 04/29/14 at 10:45 AM, during the initial tour of the facility, revealed in the resident bathrooms connected to rooms 215, 216, 217 there were unlabeled and unbagged wash basins lying on the floor. Continued observation during the initial tour revealed in the bathroom of room 309 a raised commode seat was lying on the floor, and in the bathroom of room 303 there were two (2) toothbrushes stored in an emesis basin uncovered and not labeled with residents' names. Further observation during the initial tour revealed in room 205 a urinal was observed hanging on a trash can with no resident's name or date. In addition, observation on initial tour revealed a urinal hanging on the bed rail in room 105, bed 2;</p>	F 441		
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F 441 Continued From page 20 and a urinal hanging on the trash can in room 205 which was undated and not labeled with the resident's name.

Interview, on 05/01/14 at 7:23 PM, with LPN #1 revealed nurses made rounds to see if resident items were stored correctly. She stated resident items such as wash basins were not to be stored on the floor, it was an infection control issue.

Interview with the DON/IC Nurse on 04/29/14 at 12:00 PM, revealed she did not think the facility labeled or dated urinals, and just changed them out if they "appeared soiled". She stated she could see how this could be an infection control issue if residents shared rooms and urinals were stored on the trash can. Additional interview, on 04/29/14 at 12:08 PM, with the DON/IC Nurse revealed wash basins were not to be stored on the floor because anything on the floor would be considered dirty. The DON stated toothbrushes should not have been stored in the basin together without identification, in a shared bathroom. She also stated the raised toilet seat should not have been lying on the floor. The DON indicated all these were infection control issues.

4. Observation of the dinner meal on 04/29/14 at 5:40 PM, revealed SRNA #3, wiped Unsampld Resident A's mouth with a napkin and started feeding Unsampld Resident B. SRNA #3 continued to feed both residents with the same hand while repeatedly holding the cup and touching the straw for Unsampld Resident B. Continued observation revealed SNRA #3 did not sanitize or wash her hands at anytime while feeding the two (2) residents.

Interview with SRNA #3 on 04/29/14 at 3:45 PM,

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revealed she had training on hire related to feeding two (2) residents at the same time; and, was not taught to use different hands to feed or to sanitize her hands between residents when feeding two (2) residents. SRNA #3 admitted she touching Unsampld Resident A's face, and not sanitizing her hands prior to feeding Unsampld Resident B. She stated she should have sanitized after touching Unsampld Resident B's straw. She stated the nurses watched her feed the residents; but, had not addressed the potential for cross contamination with her feeding technique.

Interview on 05/01/14 at 1:20 PM with the DON/IC Nurse, revealed when a staff member was feeding two (2) residents at the same time, she would expect them to use one hand for each resident. She further stated the department managers monitored the meals daily and she was unaware of any concerns identified. She indicated there was the potential for cross contamination if the same hand was used when feeding two (2) residents and staff touched the residents and straws.

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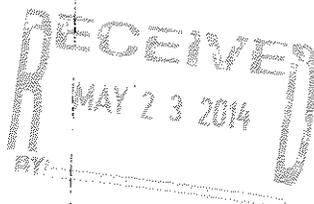
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  Building: 01  Plan Approval: Unknown  Survey under: 2000 Existing  Facility Type: SNF/NF  Type of structure: One (1) story Type V(111) with basement  Smoke Compartments: Three (3)  Fire Alarm: Full fire alarm system  Sprinkler System: Automatic (dry) sprinkler system  Generator: Type II Diesel Generator  A Life Safety Code Survey was initiated and concluded on 04/30/14. The facility was in compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire) with no deficiencies cited.	K 000		5/8/14
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Deborah Zuel* TITLE *Administrator* (X6) DATE *5/15/14*

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