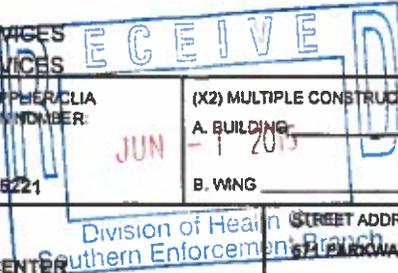


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/12/2015  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/28/2015
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NAME OF PROVIDER OR SUPPLIER  SALYERSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 621 PARKWAY DRIVE SALYERSVILLE, KY 41465
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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 000	INITIAL COMMENTS	F 000	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because the provisions of federal and state laws require it. The provider maintains that the alleged deficiencies do no jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care. neither an admission to nor an agreement with the Deficient Practices noted below, but provided as required under the Condition of Participation	
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure services provided met professional standards of care for one (1) unsampled resident (Resident A). The nurse left Resident A's medications in his/her room to self-administer.</p> <p>The findings include:</p> <p>Review of the Medication Administration Procedure, not dated, revealed staff was to remain with the resident until all medications were taken.</p> <p>Review of Resident A's clinical record revealed a readmission date of 02/25/15. The resident's diagnoses included Schizophrenia, Depressive Disorder, Muscle Weakness, Hypertension, Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease (COPD). Continued review revealed the facility assessed Resident A with a Brief Interview for Mental Status score of 12, indicating the resident was interviewable. Record</p>	F 281	<p>F2814820(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>1. LPN #3 received a coaching and counseling on 4/24/2015 for not ensuring that Resident A had taken all of her medication during her morning medication pass on 4/24/2015. LPN #3 was re-educated on 4/24/2015 by the Administrator and the green wing unit manager on ensuring that the residents take all of their medication and not leaving medication in a residents room. LPN #3 stated that Resident A took her medication before she got back to her room.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elaine Jones, Administrator TITLE: Administrator (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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F 281	Continued From page 1 review revealed Resident A had not been assessed to be able to self-administer medications.  Observations during the initial tour on 04/24/15 at 8:30 AM, revealed Resident A sitting in his/her room holding a medication cup with four (4) pills in the cup. During the interview, Resident A stated he/she takes so many medications and the nurses frequently leave the medications for him/her to take. The resident stated that the nurses trust him/her to take all the medications. Resident A stated if he/she was in the bathroom, the nurses would leave the medication on his/her table. Observation of the hallway revealed no nurse or medication cart on the hall.  Interview with Licensed Practical Nurse (LPN) #3 on 04/24/15 at 8:45 AM revealed she was the nurse who left the medication with Resident A. She stated she thought the resident had taken all of his/her medications. Continued interview with LPN #3 on 04/28/15 at 9:40 AM revealed she was also a medication nurse. She stated it was the expectation of the facility that the nurse stay with the resident until all the medications were taken. She stated if medications were left in a room a confused resident could wander into the room and ingest the medication.  Interview with the Administrator and Director of Nursing on 04/28/15 at 4:00 PM revealed it was their expectation that the nurse stay with the resident until the medications were taken.	F 281	2. In house residents taking medication prescribed, unless deemed appropriate by self-medication assessment to take medications themselves, are at risk for the alleged deficient practice. An audit of interviewable residents will be completed by the DON and or nursing administration to ensure licensed nurses stay with them while their medication is being taken. Any resident identifying that nurses are leaving medications for them to take without staying for observation will be immediately investigated by the DON and/or nursing administration for resolution with the licensed nurse(s). 3. Reducation will be completed by the Staff Development nurse for licensed nursing staff on medication administration including ensuring that residents take all of their medication and not leaving medication in a resident's room by 5/25/2015. New hires will be educated during general orientation by the Staff Development Nurse on medication pass including ensuring that residents take all of their medication and not leaving medication in a resident's room. The Staff Development nurse or Nursing Administration will re-educate nursing staff as needed for continued compliance.  The DON and/or Unit Managers will randomly observe medication pass once per week times 4 weeks beginning week of 5/25/2015 to ensure professional standards are followed for medication pass including ensuring that residents take all of their medication and that no medication is left in the residents room.		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility	F 282	4 Results will be brought to the Quality Assurance Committee and will be reviewed on a monthly basis for three months for further recommendation.	6/4/2015	

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F 282	<p>Continued From page 2</p> <p>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 interview, record review, and review of the facility's policy, it was determined the facility failed to provide care and services in accordance with the written plan of care for one (1) of four (4) sampled residents (Resident #1). According to nursing staff, Resident #1 had signs and symptoms of pain throughout the night on 04/10/15 into the AM of 04/11/15. Registered Nurse #1 failed to assess and treat Resident #1's pain per the plan of care. On 04/11/15, an x-ray of Resident #1's left leg showed a fractured Tibial Plateau (knee).</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Care Plans - Comprehensive," with a revision date of 10/2010, revealed the care plan should reflect currently recognized standards of practice for problem areas and conditions.</p> <p>Review of the clinical record revealed the facility admitted Resident #1 on 07/01/12 with diagnoses that included Cerebrovascular Accident (stroke), Hypertension, Alzheimer's Disease, Contractures to Extremities, and Dysphagia. Review of the Quarterly Minimum Data Set (MDS) assessment dated 04/23/15, revealed the facility assessed Resident #1 as unable to make self understood and unable to understand others. In addition, the resident was assessed as requiring total assistance of two with bed mobility and transfers.</p>	F 282	<p>F282 483.20(k) (3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>1. Resident # 1 has a Care Plan for alteration in comfort related to pain which stated to report to provider any signs/symptoms of distress or pain unrelieved by ordered treatments/medications and assessing for non-verbal signs/symptoms of pain. RN#1 completed a pain assessment on Resident #1 on 4/11/2015 and there was no indication of pain vocalized or non-verbal. (A copy of the pain assessment was submitted to the state) Resident #1 continued to receive her routine pain medication per physician orders.</p> <p>2. In-house residents will have care plans reviewed by the DON and/or nursing administrator to determine by interview, observation and/or assessment if indicated to ensure, if they have a pain care plan, that it is being followed. Any resident identified with a pain concern will have the physician contacted and an update to the plan of care as indicated by the Inner disciplinary team.. If it is determined by the DON and/or nursing administration that the plan of care for pain is not being followed immediate action will be taken by the nursing administration team for resolution with the nursing staff and updating the plan of care and notifying the physician if indicated.</p>	

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F 282	<p>Continued From page 3</p> <p>Review of the Comprehensive Care Plan, dated 02/17/14, revealed a problem of potential for alteration in comfort related to pain. Further review revealed interventions that included reporting to provider any signs/symptoms of distress or pain unrelieved by ordered treatments/medications, observing during rest and during movement for pain, and assessing for nonverbal signs/symptoms of pain.</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on 04/28/15 at 2:30 PM revealed she had been one of the CNAs taking care of Resident #1 on 04/10/15 on the night shift. She stated she routinely took care of Resident #1. CNA #1 stated around 12:00 AM, she and CNA #2 went in to turn and change Resident #1 when they noticed his/her leg was different than usual, it had a strange movement, and it was swollen. She stated she could tell Resident #1 was in pain; when the nurse touched the resident's knee he/she grunted. CNA #1 stated she filled out a communication form for the Unit Coordinator and slipped it under her door.</p> <p>Interview with CNA #2 on 04/28/15 at 3:05 PM via telephone revealed she and CNA #1 went in to turn and change Resident #1 at 12:00 AM on 04/10/15. She stated she routinely took care of Resident #1. CNA #2 stated Resident #1's left leg had strange movement; she stated the left leg was usually stiff and would not bend, but that night it was bending and the resident's leg was swollen. According to CNA #2, the change in Resident #1's condition was reported to Registered Nurse (RN) #1. CNA #2 said RN #1 was new and had not taken care of Resident #1 before. CNA #2 stated the nurse looked at</p>	F 282	<p>3. Licensed Nursing Staff will be in serviced by the Staff Development Nurse regarding changes in condition, assessing pain, verbal and non-verbal, notification of physician if pain is indicated for further follow up, and on the Comprehensive Care Plan use in directing resident care by 5/25/2015. The staff development nurse will re-educate the CMA's and CNA's to notify the nurse for any resident exhibiting signs/symptoms or complaints of pain for further assessment by 5/25/2015. New licensed nursing staff hires will be educated during general orientation by the Staff Development Nurse regarding changes in condition, assessing pain, verbal and non-verbal, notification of physician if pain is indicated for further follow up, and on the Comprehensive Care Plan use in directing resident care the Comprehensive Care Plans use in directing resident care. The staff development nurse will educate new hire CMA's and CNA's to notify the nurse for any resident exhibiting signs/symptoms or complaints of pain for further assessment during orientation. The Staff Development nurse or Nursing Administration will re-educate nursing staff as needed for continued compliance.</p> <p>Residents exhibiting a change in condition will be reported to Nursing Administration. Beginning the week of 5/25/2015 Nursing Administration will review in clinical meeting to ensure that assessment of pain was completed and further follow up from physician was done if needed.</p> <p>4. Results will be brought to the Quality Assurance Committee and will be reviewed on a monthly basis for three months for further recommendation.</p>	6/4/2015

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F 282	<p>Continued From page 4</p> <p>Resident #1's leg and stated it was fluid and that she did not think anything was broken, and that she would check the chart. CNA #2 said they were very careful with Resident #1 the rest of the night because Resident #1 acted as if he/she was in pain during care, his/her eyes would get big, and he/she would moan. According to CNA #2, when the first shift nurse arrived, they reported the resident's condition to her. Further interview with CNA #2 on 04/29/15 at 4:50 PM, revealed that prior to the fractured leg, Resident #1 did have some pain with transfers and repositioning, but not to the extent he/she had that night. She stated she and CNA #1 tried again during the shift to explain to RN #1 that something was wrong with Resident #1's leg.</p> <p>Interview with CNA #3 on 04/28/15 at 8:30 AM revealed she had cared for Resident #1 for years. She stated she had made rounds with CNAs #1 and #2 for the oncoming day shift on 04/11/15. She stated that you could tell Resident #1 was in pain, his/her face was red, and he/she would grunt.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 04/28/15 at 1:25 PM revealed when she arrived at work on 04/11/15, the CNAs asked her to look at Resident #1's left leg because it was moving funny and it was swollen. The LPN stated there was no bruising but the leg was swollen. LPN #1 stated Resident #1 could not speak but she could tell by Resident #1's face he/she was in pain. The LPN stated Resident #1's face had a different look and it was flushed. According to LPN #1, the CNAs had been taking care of Resident #1 for a long time and they knew when Resident #1 was in pain. LPN #1 stated Resident #1 appeared more comfortable after she had</p>	F 282			

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F 282	Continued From page 5 given him/her pain medication. She stated she called Resident #1's Primary Care Physician and received an order for an x-ray. LPN #1 stated the x-ray revealed a fracture. The resident was transferred to the local hospital for an evaluation.  Interview with RN #1 via telephone on 04/28/15 at 9:15 AM revealed she had been the nurse assigned to Resident #1 on 04/10/15 on the third shift. She stated she had examined the resident's leg and there was no bruising or redness. RN #1 stated she had supported the resident's left leg and it had normal range of motion (ROM). RN #1 stated she checked on Resident #1 several times during the night and Resident #1 did not appear to be in pain. RN #1 stated she did not remember if she documented her pain assessment. The RN said she chose not to call Resident #1's physician because it did not appear to be an emergency. RN #1 stated she determined there was no injury or pain and passed the information to the day shift nurse.	F 282			
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 interview, record review, and facility	F 309	F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  1. RN #1 was re-educated on the facilities policy "Pain-Clinical protocol" which includes signs and symptoms of pain for non-verbal residents and changes in a resident's normal/routine behavior which may be non-verbal for indications of pain (swelling, erythema, staff reporting resident's changes in behaviors with care, etc) and to notify the attending physician who will consider adjusting interventions accordingly at that time on 5/6/2015. RN #1 did complete a pain assessment during the shift on 4/10/15 which was submitted to the surveyor supervisor via fax by the Director of Nursing. Resident #1 went to the ER on 4/11/2015 and received her pain medication as ordered by the physician.		

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F 309	<p>Continued From page 6</p> <p>policy it was determined the facility failed to ensure one (1) of four (4) sampled residents (Resident #1) received the necessary care and services related to pain management. Nursing staff reported to Resident #1's nurse on 04/10/15 that Resident #1's leg was swollen and the resident was in pain. The nurse failed to assess and treat the resident's pain per facility policy and per the resident's plan of care. An x-ray of the resident's leg on 04/11/15 revealed a fracture to the left Tibial Plateau (knee).</p> <p>The findings include:</p> <p>Review of the facility's policy, "Pain-Clinical Protocol," with a revision date of 04/2013, revealed staff would observe the resident (during rest and movement) for pain; for example, grimacing while being repositioned or having a wound dressing changed. The staff will discuss significant changes in levels of comfort with the Attending Physician who will consider adjusting interventions accordingly.</p> <p>Record review revealed the facility admitted Resident #1 on 07/01/12 with diagnoses that included Cerebrovascular Accident, Hypertension, Alzheimer's disease, Contractures to Extremities, and Dysphagia. Review of the Quarterly Minimum Data Set (MDS) assessment dated 04/23/15, revealed the facility assessed Resident #1 as unable to make self understood and unable to understand others. In addition, the resident was assessed as requiring total assistance of two with bed mobility and transfers.</p> <p>Interview with Certified Nursing Assistant (CNA) #2 on 04/28/15 at 3:05 PM via telephone revealed she and CNA #1 went in to turn and change</p>	F 309	<p>2. In house residents not able to verbally express pain are at risk for the alleged deficient practice. In house residents who can't express pain verbally or cognitively unable to verbally express pain will be assessed by the DON and/or nursing administrator to determine if they are having pain. Resident's identified as having signs and symptoms of pain will have the pain plan of care reviewed by the DON/licensed nurses) and/or Interdisciplinary team to determine if changes need to be made and will have the physician contacted and an update to the plan of care as indicated by the Interdisciplinary team and licensed nurses(s).</p> <p>3. Licensed Nursing Staff will be in serviced by the Staff Development Nurse regarding changes in condition, assessing pain, verbal and non-verbal, notification of physician if pain is indicated for further follow up, and on the Comprehensive Care Plan use in directing resident care by 5/25/2015. The staff development nurse will re-educate the CMA's and CNA's to notify the nurse for any resident exhibiting signs/symptoms or complaints of pain for further assessment by 5/25/2015. New licensed nursing staff will be educated during general orientation by the Staff Development Nurse regarding changes in condition, assessing pain, verbal and non-verbal, notification of physician if pain is indicated for further follow up, and on the Comprehensive Care Plan use in directing resident care the Comprehensive Care</p>		

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F 309	<p>Continued From page 7</p> <p>Resident #1 at about 12:00 AM on 04/10/15. According to CNA #2, she routinely took care of Resident #1. CNA #2 stated Resident #1's leg was usually stiff and would not bend, but that night it was bending and it was swollen. According to CNA #2, the change in Resident #1's condition was reported to Registered Nurse #1 who was new and had not taken care of Resident #1 before. The nurse said she did not think anything was broken and that she would check the chart. CNA #2 said they were very careful with Resident #1 the rest of the night because Resident #1 acted as if he/she was in pain during care, his/her eyes would get big, and he/she would moan. According to CNA #2, when the first shift nurse arrived they reported the resident's condition to her. Further interview with CNA #2 on 04/29/15 at 4:50 PM, revealed that prior to the fractured leg Resident #1 did have some pain with transfers and repositioning, but not to the extent he/she had that night. She stated she and CNA #1 tried again during the shift to explain to RN #1 that something was wrong with Resident #1's leg.</p> <p>Interview with CNA #1 on 04/28/15 at 2:30 PM revealed she had been one of the CNAs taking care of Resident #1 on 04/10/15 on the night shift. According to the CNA, she routinely took care of Resident #1. CNA #1 stated at about 12:00 AM, she and CNA #2 went in to turn and change Resident #1 when they noticed her leg was different than usual; it had a strange movement, and it was swollen. She stated you could tell Resident #1 was in pain and when the nurse touched his/her knee he/she grunted. CNA #1 stated she filled out a communication form for the Unit Coordinator and slipped it under her door.</p>	F 309	<p>Plans use in directing resident care. The staff development nurse will educate new hire CMA's and CNA's to notify the nurse for any resident exhibiting signs/symptoms or complaints of pain for further assessment during orientation. The Staff Development nurse or Nursing Administration will re-educate nursing staff as needed for continued compliance.</p> <p>Residents exhibiting a change in condition will be reported to Nursing Administration. Beginning the week of 5/25/2015 Nursing Administration will review in clinical meeting to ensure that assessment of pain was completed and further follow up from physician was done if needed</p> <p>4 Results will be brought to the Quality Assurance Committee and will be reviewed on a monthly basis for three months for further recommendation.</p>	6/4/2015	

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F 309	Continued From page 8  Interview with Registered Nurse (RN) #1 via telephone on 04/28/15 at 9:15 AM revealed she had been the nurse assigned to Resident #1 on 04/10/15 on the third shift. She stated the CNAs told her she needed to look at Resident #1's leg. She stated she immediately went in and examined the left leg and it was swollen from the knee down. She stated the leg had no bruising or redness. RN #1 stated she supported the left leg and it had normal range of motion (ROM). RN #1 stated she checked on Resident #1 several times during the night and Resident #1 did not appear to be in pain. RN #1 stated she did not remember if she had documented her pain assessment. The RN said she chose not to call Resident #1's physician because it did not appear to be an emergency. RN #1 stated she determined there was no injury or pain and passed the information to the day shift nurse.  Review of the nurse's note dated 04/11/15 at 2:20 AM revealed no assessment of the swelling in the left lower leg or a pain assessment. The 2:20 AM nurse's note stated, "Resting quietly in bed, HOB elevated. Respirations even and unlabored. Lungs diminished bilaterally. GT patent and intact. Placement checked. Flushes as ordered. Receiving Jevity 1.5 @ 50cc/hour and water flushes as ordered. Tolerated well. Total assist provided with Activities of Daily Living. Turn and reposition every two hours and as needed. Bed in low position. Call light within reach." The 7:14 AM nurse's note written by RN #1 stated, "Edema noted to left lower extremity positive range of motion noted to left leg and left knee." Review of the Medication Administration Record revealed no pain medication was administered to Resident #1 on the night shift.	F 309			

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NAME OF PROVIDER OR SUPPLIER  SALYERSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41466		
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F 309	<p>Continued From page 9</p> <p>During a post survey interview with the Director of Nursing on 05/07/15 at 3:00 PM, she stated the facility had found an uncompleted pain assessment in the system dated 04/11/15. She stated it was not determined who had initiated the pain assessment or the time it was initiated. She stated the facility had the Information Technology Department looking into it. Documentation received via fax from the DON revealed a pain assessment dated 04/11/15 with the time of 2:39 AM signed by RN #1.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 04/28/15 at 1:25 PM revealed when she arrived at work on 04/11/15 at 6:00 AM, the CNAs asked her to look at Resident #1's left leg because it was moving funny. The LPN stated there was no bruising but the leg was swollen. LPN #1 stated Resident #1 could not speak but she could tell by Resident #1's face he/she was in pain. The LPN stated Resident #1's face had a different look and it was flushed. According to LPN #1, the CNAs had been taking care of Resident #1 for a long time and they knew when Resident #1 was in pain. LPN #1 stated Resident #1 appeared more comfortable after she had given him/her pain medication. She stated she called Resident #1's Primary Care Physician and received an order for x-ray. LPN #1 stated the x-ray revealed a fracture and the resident was transferred to the local hospital for an evaluation.</p> <p>Interview with RN #2 on 04/28/15 at 10:45 AM, who was the Unit Manager at the time it was discovered Resident #1 had a fractured left lower extremity, revealed she had an issue with the situation because the CNAs reported a change and nothing was done for Resident #1 all night.</p>	F 309			

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F 309	Continued From page 10 She stated RN #1 had not completed a pain assessment, called the physician, nor filled out an incident report. According to RN #2, Resident #1's leg was normally fixed straight, but after the fracture, Resident #1 had full ROM. RN #2 stated RN #1 even documented that Resident #1 had full ROM in the nurse's note.  During an interview with the Administrator and Director of Nursing on 04/28/15 at 4:00 PM, the Administrator stated the night nurse had determined the swelling was edema and was not aware the leg was fractured. The Administrator said the day shift nurse immediately notified the Physician who ordered an x-ray and since the facility did not know how the fracture had happened, they started the investigation. The Administrator stated she did not know whether Resident #1 had been in pain that night or not, even though CNAs #1 and #2 both wrote in their statements that Resident #1 appeared to be in pain.	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	F 441	F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  1. The Staff Development Nurse re-educated CNA #5 on handwashing on 5/2/2015. A new bedpan was given to resident B labeled with their name and placed in a garbage bag on 4/29/2015.  2. The DON and/or Nursing Administration will complete a one time audit of handwashing on 6/1/2015 to identify any issues with infection control and any issue noted will be immediately resolved.  The HR Director and Medical Records Clerk completed an audit of bedpans on 5/13/2015 to ensure that they were properly bagged and labeled and stored properly any issues identified were immediately corrected.		

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F 441	<p>Continued From page 11</p> <p>(3) Maintains a record of incidents and corrective 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 REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to maintain an effective infection control program designed to provide a safe and sanitary environment to prevent the transmission of disease and infection for one (1) of four (4) sampled residents (Resident #2) and one unsampled resident (Resident B). Facility staff failed to sanitize their hands after providing care to Resident #2, who was in isolation for shingles. A bedpan was observed stored on the floor in</p>	F 441	<p>3. The Staff Development Nurse will inservice nursing staff on hand washing, and proper labeling and storage of bedpans to ensure that infection control is followed by 5/25/2015. The Staff Development Nurse will educate new hires nursing staff during orientation on hand washing, and proper labeling and storage of bedpans to ensure that infection control is followed. The Staff Development nurse or Nursing Administration will re-educate nursing staff as needed for continued compliance.</p> <p>DON and/or unit managers will monitor 5 staff weekly times 8 weeks beginning the week of 5/25/2015 to ensure hand washing is completed correctly.</p> <p>The DON and/or Unit managers will review 6 residents who use bedpans per week to ensure that they are properly stored and labeled for 8 weeks.</p> <p>4. Results will be brought to the Quality Assurance Committee and will be reviewed on a monthly basis for three months for further recommendation.</p>	6/4/2015

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F 441	<p>Continued From page 12</p> <p>Resident B's bathroom on 04/24/15 and 04/28/15.</p> <p>The findings include:</p> <p>Review of the facility's policy, with a revision date of 10/2010, revealed employees must wash their hands for 10 to 15 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: before and after direct contact with resident, and after removing gloves. Alcohol hand rub can be used before and after direct contact with resident and after removing gloves.</p> <p>1. Review of Resident #2's clinical record revealed the facility admitted the resident on 03/29/15 with diagnoses that included Gangrene left and right heel, Urinary Tract Infection, and Shingles (viral infection) left eye. Further review revealed Resident #2 was receiving Valtrex (antiviral medication) as a treatment for the Shingles and that the resident was on contact isolation.</p> <p>After the observation of wound care to Resident #2's bilateral feet, Certified Nursing Assistant (CNA) #5, who had assisted by holding the lower extremities in position, removed his gown and gloves. CNA #5 failed to wash or sanitize his hands. The CNA walked out of the room into the room across the hall.</p> <p>Telephone interview with CNA #5 on 04/28/15 at 1:50 PM, revealed it was facility policy to wash the hands or use hand sanitizer after removal of gloves to prevent cross contamination. He stated he thought he had sanitized his hands.</p> <p>2. Observation on 04/24/15 at 2:0 PM, revealed a</p>	F 441		

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F 441	<p>Continued From page 13</p> <p>mechanical lift transfer of Resident B from the wheelchair to the bed by CNAs #3 and #4. Further observation of Resident B's bathroom revealed a bedpan on the floor without a bag or a name on it. This same observation was made on 04/28/15 at 9:55 AM.</p> <p>Interview with CNA #4 on 04/28/15 at 10:00 AM revealed he was not aware the bedpan was in the bathroom on the floor. He stated the bedpan should have been in a plastic bag with the resident's name on it. He stated it was the CNA's responsibility.</p> <p>Interview with the Infection Control Nurse on 04/28/15 at 3:50 PM revealed the facility had just provided an in-service related to bagging and putting a name on bedpans. The Infection Control Nurse said Resident #2 was in isolation due to having shingles in his/her left eye. According to the Infection Control Nurse, the problem with staff not washing their hands after removing the gloves was the chance of spreading infection to other residents.</p>	F 441			