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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185196		06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-BASHFORD	3535 BARDSTOWN ROAD LOUISVILLE, KY 40218

(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 314	Continued From page 32 and caused a blister and skin breakdown. However, she did not stage the area. The ARNP stated the area on the left thigh was avoidable, by keeping the resident's indwelling catheter tubing position secured and not under the resident. Review of the weekly skin assessment dated 06/15/15 revealed there were no new areas identified. Interview with Certified Nurse Aide (CNA) #2, on 06/17/15 at 3:30 PM, revealed indwelling catheter tubing was suppose to be secured with an anchor type system so the tubing did not get under the residents legs. She stated the catheter tubing could cause blisters and skin sores. Interview with Licensed Practical Nurse (LPN) #7, on 06/17/15 at 3:00 PM, revealed he was not aware of the area of skin breakdown on Resident #8's thigh until it was identified with the ARNP. He stated the catheter tubing should not be under the resident's extremities. The tubing was suppose to be anchored to keep the tubing out from under the resident. Anchored tubing prevented the resident from laying on the tubing. Interview with LPN #6, on 06/17/15 at 3:15 PM, stated indwelling catheter tubing should be anchored to secure the tubing and the position of the tubing. Interview with Resident #8, on 06/17/15 at 3:05 PM, stated the indwelling catheter tubing was anchored at times and other times was not anchored. Interview with the Director of Nursing, on 06/17/15 at 4:00 PM, revealed the facility policy	F 314	Compliance will be maintained by continued Unit Directors performing walking rounds on their units. SDC will also have staff complete annual competencies and as indicated by ongoing monitoring.	

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-BASHFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 3535 BARDSTOWN ROAD LOUISVILLE, KY 40218	

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F 314	Continued From page 33 included the indwelling catheter tubing should be anchored to maintain positioning to keep the tubing from under the resident. She stated the ARNP gave the facility a new order to anchor the catheter with paper tape. She reported tape was also a method to secure the indwelling catheter tubing. She stated a resident laying on the catheter tubing had the potential of blistering of the skin and skin breakdown. She reported the resident's break in the skin integrity could have been prevented by the catheter tubing not being left under the resident leg.	F 314		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record and policy review, it was determined the facility failed to ensure three (3) of twenty-two (22) sampled residents (Residents #4, #7, and #15) with indwelling urinary catheters, received appropriate care and treatment associated with management of indwelling urinary catheters. The indwelling catheters for Resident's #4, #7, and #15, were not anchored to prevent dislodgement, trauma	F 315	F315 Immediate Action Taken: - The indwelling catheter tubing was immediately repositioned and anchored on Resident #4, #7, and #15 by the Director of Nursing. A Skin Assessment was completed by the Director of –Nursing on Resident #4, #7, and #15 to reflect any areas of skin breakdown related to catheter tubing. There were no findings of skin breakdown. Potential to Affect Others: All residents with indwelling catheters have the potential to be effected.	7/15/15

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	185196	A. BUILDING ____ B. WING ____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-BASHFORD	3535 BARDSTOWN ROAD LOUISVILLE, KY 40218

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F 315	Continued From page 34 and/or infection. The findings include: Review, of the facility's policy titled Indwelling Catheters, dated 08/31/12, revealed several guidelines for the care and treatment for prevention of Catheter Associated Urinary Tract Infections. Among those guidelines, catheter tubing was to be secured using an anchoring device to prevent movement and urethral traction. 1. Review of Resident #4's clinical record revealed the facility admitted the resident on 06/10/13, with the diagnoses of Quadriplegia, Osteoporosis, Insomnia, Generalized pain, Edema, Unspecified Spinal Cord Injury, and Spasm of Muscle. Review of Resident #4's Quarterly MDS assessment, completed on 05/02/15, revealed the facility assessed the resident during a Brief Interview for Mental Status (BIMS) as eleven (11) of fifteen (15) and interviewable. Review of the Comprehensive Care Plan for Resident #4 revealed the facility developed a care plan on 03/31/15, with goal revisions on 05/20/15 and the target date of 08/27/15, for an indwelling catheter. Interventions listed included ensuring the catheter tubing was positioned properly; observe urine for changes in characteristics, foul odor, and pain; and, provide catheter care every shift. Observation, on 06/17/15 at 3:40 PM, with Certified Nursing Assistant (CNA) #3 present, revealed Resident #4's indwelling catheter bedside drainage bag was placed in a dignity bag	F 315	All residents with indwelling catheters were assessed by the Director of Nursing on 6/17/15 for any areas of skin breakdown related to improper positioning of the catheter tubing. There were no negative findings. Action Taken to Prevent Reoccurrence: The Nursing Staff were re-educated beginning on 6/17/15 by the Staff Development Coordinator regarding proper placement and positioning of indwelling catheter tubing, including anchoring. This will be completed by 7/14/15. With all education provided the SDC did implement a post test for the staff to complete to validate understanding. This was completed by 7/14/15 after all education sessions. Competencies will be completed by any staff needing further education. SDC will also have staff complete annual competencies and as indicated by ongoing monitoring.	

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F 315	Continued From page 35 hanging on the left side of the resident's bed. The indwelling catheter tubing was not anchored to the resident's leg. The catheter tubing was laying loose on top of the resident's left thigh, no skin breakdown was noted. Interview with CNA#3, on 06/17/15 at 3:40 PM, revealed indwelling catheter tubing was supposed to be anchored to the resident's leg to prevent the catheter tubing from moving. Interview with Resident #4, on 06/17/15 at 3:40 PM, revealed the indwelling catheter tubing had been anchored to his/her leg with tape at times. 2. Review of Resident #15's clinical record revealed the facility admitted the resident on 10/08/14, with the diagnoses of Idiopathic Peripheral Neuropathy, Benign Prostatic Hypertrophy with Urinary Obstruction, Muscle Disorder, Pressure Ulcers, Obesity and Diabetes. Review of Resident #15's Quarterly MDS assessment, completed on 04/02/15, revealed the facility assessed the resident during a Brief Interview for Mental Status (BIMS) as fifteen (15) of fifteen (15) and interviewable. Review of the Comprehensive Care Plan for Resident #15 revealed the facility developed a care plan on 10/28/14, with a target date of 07/23/15, for an indwelling catheter. Interventions listed included: ensuring the catheter tubing was positioned properly; observe for urinary tract infection; monitor intake and output; and, monitor for pain and discomfort. Observation, on 06/17/15 at 3:45 PM, with Registered Nurse (RN) #1 present, revealed	F 315	The Nurse Aide Assignment Sheets were updated to include the identification of those residents needing anchoring of his/her indwelling catheter tubing. This will be completed by 7/14/15 by the Unit Directors. Monitoring: The Unit Directors will audit placement of indwelling catheter tubing 3 times per week. Findings will be reviewed by DNS. The DNS will track and trend audit results and these results will be reviewed by Performance Improvement Committee on a monthly basis. Overall compliance will be monitored by the Performance Improvement Committee monthly x 3 or until substantial compliance is achieved. Compliance will be maintained by continued Unit Directors performing walking rounds on their units. SDC will also have staff complete annual competencies and as indicated by ongoing monitoring.	

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F 315	Continued From page 36 Resident #15's indwelling catheter drainage bag was in a dignity bag hanging on the left side of the resident's bed. The indwelling catheter tubing was not anchored to the resident's leg. The catheter tubing was laying loose on top of the resident's left thigh, no skin breakdown noted. Interview with RN #1, on 06/17/15 at 3:45 PM, revealed the indwelling catheter tubing was usually anchored to the resident's leg to keep the catheter tubing in place and to keep the resident from laying on the tubing. Interview with Resident #15, on 06/17/15 at 3:45 PM, revealed the indwelling catheter tubing was usually anchored to his/her leg with tape. 3. Review of Resident #7's clinical record revealed the facility admitted the resident on 08/22/14, with diagnoses of Dementia, Pressure Ulcer of Buttock, Hypertension, Atrial Fibrillation and Anemia. Review of Resident #7's Quarterly MDS assessment, completed on 05/11/2015, revealed the facility assessed the resident during a Brief Interview for Mental Status (BIMS) as (2) two of (15) fifteen, which meant the resident was not interviewable. Review of the Comprehensive Care Plan for Resident #7 revealed the facility developed a care plan on 08/26/14. Problems on the care plan included the resident was at risk for falls related to increased fall risk score, poor cognition, poor safety awareness and past attempts to get out of bed unassisted. In addition, the care plan included the resident was at risk for skin breakdown related to current pressure area,	F 315		

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F 315	Continued From page 37 decreased mobility and history of decreased nutritional intake. The care plan also stated that Resident #7 could not meet his/her own daily care needs without assistance from staff. The care plan also had an intervention of an indwelling catheter to bedside drainage. Observation, on 06/16/15 at 3:20 PM, revealed Resident #7 was laying in the bed with a drainage bag placed on the resident's left side of the bed. Observation of a skin assessment, on 06/15/15 at 1:50 PM, with LPN #6, revealed no new skin areas related to the indwelling catheter. Continued Interview with the Director of Nursing, on 06/17/15 at 4:15 PM, revealed the facility practice was to anchor indwelling catheter tubing to the resident leg with an anchoring device, unless the physician orders a different method such as paper tape or another source. She stated the anchoring of the indwelling catheter ensures the tubing does not get under the residents legs, mispositioned or tugged on. The facility practice is to use an anchoring device on each resident with a catheter. She stated it was the facility policy was to anchor the indwelling catheter; however, that was not the case during this time.	F 315		
F 441 SS=E	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.	F 441	F441E Immediate Action Taken: The staff responsible for providing care and housekeeping services for Resident #11 and #14 were re-educated on the proper infection	7/15/15

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F 441	Continued From page 38 (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 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to consistently implement and follow their infection control practices for two (2) of	F 441	control techniques required upon entrance to the room, while providing care or performing duties, and when exiting the room. This included proper disposal of protective gear, proper placement of the food cart, the need for appropriate receptacles with lids, and possible cross-contamination situations. Potential to Affect Others: All residents have the potential to be affected. Action Taken to Prevent Recurrence: An audit of all isolation rooms were completed by the SDC on 6/18/15 to ensure all PPE, stop signs and visitor education were in place for current isolation residents. The facility staff was educated on the appropriate infection control techniques regarding the isolation policy and procedure, including isolation PPE (Personal Protective Equipment), altered hand hygiene and implementation of specialized environmental disinfectant agents	

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-BASHFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 3535 BARDSTOWN ROAD LOUISVILLE, KY 40218	

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F 441	Continued From page 39 twenty-two (22) sampled residents (Residents #11 and #14). The facility failed to ensure Nursing, Housekeeping and Rehabilitative staff consistently used personal protective equipment (PPE), isolation protocol and environmental disinfection. The findings include: Review of the facility's policy regarding Clostridium Difficile Infection-Associated Diarrhea, dated 06/01/15, revealed known or suspected Clostridium Difficile (C-Diff or C. Diff) infection, in any resident, indicated implementation of isolation PPE, altered hand hygiene to include washing of hands with soap and water and implementation of specialized environmental disinfectant agents and practices. Due to the degree to which the environment becomes contaminated with spores of C. Diff and the potential for soiling and contamination of clothing and hands, put on a gown and gloves before entering the resident's room when caring for the resident. Wash hands with soap and water. 1. Review of Resident #11's clinical record revealed the facility admitted him/her on 10/31/14 with diagnoses of Multiple Sclerosis, Post-Laminectomy of the Lumbar Region, Diabetes, C-Diff, End Stage Renal Deficiency and Hypertension. Further review of the clinical record revealed Resident #11 had chronic C-Diff and the facility placed the resident in Contact Isolation on 01/06/15. Review of Resident #11's Quarterly Minimum Data Set (MDS) assessment, completed by the facility on 03/13/15, revealed a Brief Interview for	F 441	and practices. This education included demonstration by the Staff Development Coordinator of use of PPE, disinfection, and hand hygiene. A visual reference guide of use of PPE, disinfection and hand hygiene was given to all staff. This was completed 7/14/15 by the Staff Development Coordinator. With all education provided the SDC did implement a post test for the staff to complete to validate understanding. This was completed by 7/14/15 after all education sessions. Competencies will be completed by any staff needing further education. SDC will also have staff complete annual competencies and as indicated by ongoing monitoring. Monitoring: The Staff Development Coordinator will audit compliance during walking rounds utilizing the Infection Control Checklist 3 times a week for 3 months.	

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F 441	Continued From page 40 Mental Status (BIMS) score was a (15) fifteen of fifteen (15) meaning the resident was interviewable. Review of the Comprehensive Care Plan, dated 12/10/14, for Resident #11, revealed he/she was non-ambulatory and at risk for falls, incontinent of bowel and bladder and at risk for for skin breakdown. Observations, on 06/14/15 at 6:35 PM, of Resident #11's room revealed soiled clothing on the bedside table in an unlined bin spilling over onto the table, which contained boxes of leftover food and open beverage containers. A yellow PPE gown was draped over the bottom of Resident #11's bed. Discarded PPE was observed in an uncovered bedside trash can. The privacy curtain pooled into the trash can co-mingling with used and discarded PPE. Observation, on 06/14/15 at 6:41 PM, revealed the dinner meal cart arrived to the East Hall and was placed outside of Room 102, identified as an isolation room. The door to Room 102 had a door hanging container for Personal Protective Equipment (PPE) hung on the door on the hall side of door. The door to Room 102 was open to corridor with staff were present. The food cart door was opened and released to swing back into the isolation room and rested against the open isolation room door. Observation, on 06/14/15 at 6:50 PM, revealed Room 102's door was open to the corridor. A door hanging container for Personal Protective Equipment (PPE) was hung on the door. A garbage can without a lid was located just inside the door. The open garbage can contained PPE	F 441	The completed Infection Control Checklists will be reviewed by the Director of Nursing on a weekly basis x 4 weeks and then monthly x 2. Overall compliance will be monitored by the Performance Improvement Committee on a monthly basis x 3 or until substantial compliance is achieved. Compliance will be maintained by SDC to continue to use infection control checklist weekly with her walking rounds. SDC will also have staff complete annual competencies and as indicated by ongoing monitoring.	

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F 441	Continued From page 41 (yellow gown and gloves) with the resident's privacy curtain inside the garbage can touching the PPE. Interview with Licensed Practical Nurse (LPN) #6, on 06/14/15 at 6:51 PM, revealed the meal tray cart door open to the inside of an isolation room had the potential for cross contamination with other residents and the spread of the infection. Observation, on 06/14/15 at 6:45 PM, revealed CNA #11 entered the room walking past Resident #11's bed to deliver a meal tray to bed 2 without donning PPE. Observation, on 06/14/15 at 6:45 PM, revealed Resident #11's visitor entered the room and donned the PPE gown from the foot of bed, but the resident's visitor did not don gloves. Interview with Resident #11's visitor, on 06/17/15 at 2:00 PM, revealed Resident #11's visitor had been educated regarding the importance of PPE, but stated it was too hot to wear the gear as recommended. Observations, on 06/14/15 at 6:45 PM, revealed CNAs #5, #12 and #13 stopped with the meal cart in front of Resident #11's opened door. When they opened the meal cart, the cart door fully swung into Resident #11's room and rested against the PPE caddy on the door. When CNA #12 began to close the meal cart door, LPN #6 came and wiped down the cart door with a bleach wipe after surveyor intervention. Interview, on 06/15/15 at 3:10 PM, with LPN #6 revealed she had been educated on Infection Control on 6/14/15, 6/15/15, annually and during	F 441		

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F 441	Continued From page 42 her original orientation. Interview, on 06/17/15 at 10:40 AM, with CNA #5 revealed that he/she had worked for the facility for one (1) year and had received training multiple times over the course of that year via video and 1:1 education. Observations, on 06/15/15 at 9:45 AM, revealed Housekeeper #1 was cleaning Resident #11's room without PPE. She was observed placing the trash can full of soiled and discarded PPE into her cart trash. She did not use any one-time cleaning tools and she did not head toward the housekeeping cart room to change out the mophead or broom. Housekeeper #1 began down the hallway, in the opposite direction of the cartroom, to clean the next room when interrupted by the Housekeeping Manager who explained to her that room 102 was an isolation room and would need to be recleaned with alcohol. The Housekeeping Manager then walked with Housekeeper #1 toward the housekeeping cart room. The Housekeeping Manager further explained that room 102 would need to be recleaned with alcohol. Observation of Resident #11, on 06/15/15 at 10:40 AM, revealed the resident was in isolation and visitors were in the room without personal protective equipment. Observations, on 06/15/15 at 11:55 AM, of Resident #11's room, revealed soiled clothing on the bedside table in an unlined bin spilling over onto the table, which contained boxes of leftover food and open beverage containers. A new trash can was in the room with a lid that could be operated by a foot pedal. However, soiled and	F 441		

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-BASHFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 3535 BARDSTOWN ROAD LOUISVILLE, KY 40218	

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F 441	Continued From page 43 discarded PPE were observed in the uncovered bedside trash can. The privacy curtain pooled into the trash can co-mingling with used and discarded PPE. Interview with CNA #9, on 06/15/15 at 4:42 PM, revealed Resident #11 had C. Diff and was on Contact Precautions. She stated the resident's visitors were supposed to be wearing gowns and gloves while in the room. Observations, on 06/16/15 at 8:50 AM, of Resident #11's room revealed soiled clothing on the bedside table in an unlined bin spilling over onto the table, which contained boxes of leftover food and open beverage containers. The foot pedal operated trash can with a lid was now lined with a red biohazard liner. However, soiled and discarded PPE were observed in the uncovered bedside trash can. The privacy curtain continued pooled into the trash can co-mingling with used and discarded PPE. Observations, on 06/16/15 at 2:15 PM, revealed Speech Therapist #20 in Resident #11's room working with his/her roommate without donning PPE. Interview, on 06/17/15 at 1:45 PM, revealed the Speech Therapist entered Resident #11's room on 06/16/15 to work with his/her roommate without donning PPE. She stated that she worked at multiple facilities and the infection protocol differed with each one. She couldn't remember the specifics for this facility, and when she saw the yellow PPE caddy, she chose to ignore it. Interview with the Housekeeper, on 06/17/15 at 9:50 AM, revealed she was unaware that	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185196	A. BUILDING _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-BASHFORD	3535 BARDSTOWN ROAD LOUISVILLE, KY 40218

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F 441	Continued From page 44 Resident #11 had an infection. She didn't have any work experience in healthcare housekeeping and did not know what the yellow PPE caddies on the doors meant. She stated she had not been trained to clean rooms using the infection control protocol, but she now understood she should be cleaning with alcohol in those rooms. Interview with the Housekeeping Manager, on 06/17/15 at 10:00 AM, revealed he had retrained all housekeeping staff on the infection protocol and environmental disinfection. He believed the housekeeper was aware she should use a 10:1 bleach mixture to clean Resident #11's room and that alcohol would be ineffective. Observations, on 06/17/15 at 10:10 AM, of the Housekeeper and the Housekeeping Manager revealed the Housekeeper was unaware alcohol was an ineffective disinfection agent for Resident #11's room. When the Housekeeping Manager attempted to show her the appropriate cleaning mixture, 10:1 bleach, it was observed to be missing from her cart. 2. Review of the clinical record for Resident #14 revealed the facility admitted him/her on 11/05/12, and then readmitted the resident on 11/21/13 with diagnoses of Diabetes Type II, Esophageal Reflux, Unspecified Essential Hypertension, Neurogenic Bladder, Iron Deficiency Anemia, Major Depressive Disorder, and a history of Sepsis. The facility transferred Resident #14 to the hospital on 05/31/15 for evaluation, and the resident was diagnosed with pneumonia and with Extended Spectrum Beta Lactamase (ESBL) in his/her urine. Resident #14 was discharged from	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185196	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 06/17/2015
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-BASHFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 3535 BARDSTOWN ROAD LOUISVILLE, KY 40218	

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F 441	Continued From page 45 the hospital on 06/07/15 and transferred back to the facility with orders for intravenous (IV) antibiotic therapy for five (5) days. Upon Resident #14's return, the facility placed the resident under contact isolation precautions. Observation, on 06/15/15 at 9:45 AM, revealed Licensed Practical Nurse (LPN) #2 donned a disposable gown and gloves, and went into Resident #14's room to take the resident's blood pressure. LPN #2 returned the blood pressure cuff to the hanging storage for isolation equipment on the resident's door, removed her disposable gown and gloves and placed them in a regular trash can in the room, but did not wash or sanitize her hands before exiting the room. Instead, LPN #2 stated she was going to go wash her hands, and walked down the hall and entered the public restroom in the main lobby area of the facility. Observation, on 06/15/15 at 9:50 AM, during a morning medication pass, revealed a visitor (Family #1) entered Resident #14's room, but did not don a disposable gown or gloves. Family #1 went to Resident #14's bedside and put down a plastic grocery bag. After speaking to the resident, Family Member #1 moved over to the empty bed belonging to the other occupant in the room, laid what looked like some photos/papers on that occupant's bed and used his/her phone to take a picture of the photos/papers. Family #1 then returned to Resident #14's side of the room with the phone/camera and the photos/pieces of paper. Shortly thereafter, Family #1 exited Resident #14's room, obtained a tape dispenser from the 100 hallway nurses' station, and carried it into Resident #14's room. Again, Family #1 entered Resident #14's room without donning a	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185196		06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-BASHFORD	3535 BARDSTOWN ROAD LOUISVILLE, KY 40218

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F 441	Continued From page 46 disposable gown and gloves. After using the tape, Family #1 left Resident #14's room and returned the tape dispenser to the 100 hallway nurses' station. LPN #2 was preparing medication for Resident #14 at the medication cart just outside the resident's room while Family #1 was entering and exiting the room, but LPN #2 did not guide Family #1 to don Personal Protective Equipment (PPE) before entering Resident #14's room. Observation, on 06/15/15 at 10:05 AM, revealed LPN #2 donned a disposable gown and gloves and entered Resident #14's room to administer the resident's medication. Upon exiting the room, LPN #2 removed the PPE and then went to the restroom just behind the 100 hall nurses' station to wash her hands. Interview, on 06/15/15 10:10 AM with LPN #2, revealed Resident #14 had ESBL in his/her urine, and was in contact isolation, but she did not like washing her hands in the bathroom in Resident #14's room because the other occupant of the room frequently urinated in that restroom, making a mess. LPN #2 stated housekeeping had to frequently clean that restroom. Interview, on 06/15/15 at 11:10 AM, with Family #1, revealed she was a sitter who stayed with Resident #14 three (3) days each week. Family Member #1 stated during a recent hospitalization, Resident #14's physician, at the hospital, told her it was not necessary to wear Personal Protective Equipment (PPE) while in the resident's hospital room. Family #1 stated since Resident #14's readmission to the long term care facility, no one on staff had told her to wear PPE while in the resident's room.	F 441		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185196		06/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-BASHFORD	3535 BARDSTOWN ROAD LOUISVILLE, KY 40218

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1960, 1962, 1988 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story with a partial basement; Construction Type III, Unprotected. SMOKE COMPARTMENTS: Ten (10) smoke compartments. FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic, dry sprinkler system. GENERATOR: Type II, 350 KW generator. Fuel source is diesel. A Recertification Life Safety Code Survey was conducted on 06/15/15. The facility was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

X Executive Director X 7/10/15

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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K 000	Continued From page 1	K 000		
	Deficiencies were cited with the highest deficiency identified at D level.			
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	K038 Immediate Action Taken: The exit door located in the dining room was corrected on 6-16-15 and now opens within 15 seconds Potential to Affect Others: All exit doors were checked by the Maintenance director on 6-15-15 and were found to open within 15 seconds. Action Taken to Prevent Recurrence: All exit doors will be checked weekly on an ongoing basis by the Maintenance Director and/or Maintenance Assistant to insure exit doors open within 15 seconds. Monitoring: The weekly audits of the exit doors will be reviewed by the Performance Improvement Committee monthly until substantial compliance is achieved.	7/15/15
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit doors equipped with fifteen (15) second delayed egress hardware were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of ten (10) smoke compartments, residents, staff and visitors. The facility has one-hundred and twenty-two (122) certified beds and the census was one-hundred and six (106) on the day of the survey. The findings include: Observation, on 06/15/15 at 11:24 AM, with the Maintenance Director revealed the exit door located in the Dining Area, was equipped with fifteen (15) second delayed egress hardware, but did not open within fifteen (15) seconds when			

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K 038	Continued From page 2 tested. The exit door would open upon activation of the Fire Alarm System. Interview, on 06/15/15 at 11:26 AM, with the Maintenance Director revealed he was not aware of the exit door from the Dining Area, equipped with fifteen (15) second delayed egress hardware was malfunctioning. The census of one-hundred and six (106) was verified by the Administrator on 06/15/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 06/15/15. Reference: NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke	K 038		

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K 038	Continued From page 3 detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS 7.10.8.1* No Exit. Any door, passage, or stairway	K 038		

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K 038	Continued From page 4 that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. 7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.	K 038		

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