

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

PRINTED: 04/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/06/2015
NAME OF PROVIDER OR SUPPLIER FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042		
(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 Based on the facility's acceptable plan of correction, the facility is deemed to be in compliance on 04/06/15 as alleged.	{F 000}			

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

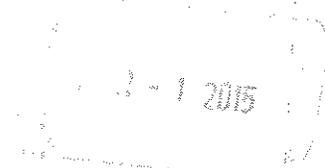
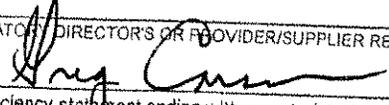
TITLE

(X6) DATE

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

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NAME OF PROVIDER OR SUPPLIER FLORENCE PARK CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042	
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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 02/24/15 and concluded on 02/26/15. Deficiencies were cited with the highest Scope and Severity of an "E". F 157 483.10(b)(11) NOTIFY OF CHANGES SS=D (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 000 F 157	 F157 Notify of Changes (Injury/Decline/Room, EXT) A Facility must immediately inform the resident consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to discontinue an existing form of treatment significantly (i.e., a need to discontinue an
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	
		Administrator	
		(X5) DATE 3/31/15	

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NAME OF PROVIDER OR SUPPLIER FLORENCE PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6976 BURLINGTON PIKE FLORENCE, KY 41042
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F 157 Continued From page 1

This REQUIREMENT is not met as evidenced by:
Based on record review, interview and review of the facility's policy it was determined the facility failed to ensure the responsible party was notified of an accident for one (1) of twenty-four (24) sampled residents (Resident #11). Resident #11's Power of Attorney (POA) was not notified of a fall experienced by Resident #11.

The findings include:

Review of the facility's policy titled, "Family/Resident Notification of Physician Order Changes", undated, revealed residents and/or their responsible party and/or designee had the right to be informed and to be involved in all plan of care issues.

Record review for Resident #11 revealed the facility admitted the resident on 10/11/11, with diagnoses which included Urinary Tract Infections (UTIs), Osteoporosis, Debility, Anxiety, Affective Psychosis, Expressive Language Disorder, Dementia with Behaviors, Chronic Pain, Alzheimer's Disease and Contracture of the Lower Leg Joint. Review of the 11/24/14 Minimum Data Set (MDS) Assessment revealed the facility assessed Resident #11 to have short term and long term memory problems. Review of Resident #11's Comprehensive Care Plan revealed the facility care planned the resident to be at risk for falls.

Review of a Nurse's Note dated 12/16/14 lmed 8:19 AM, revealed Licensed Practical Nurse (LPN) #9 documented Resident #11 experienced

F 157

existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified 483.12(a).

- 1) Resident # 11 showed not no ill effects from the alleged deficient practice. Evidence by resident #11 did not have any change in status nor physician intervention.
- 2) Resident #11's son was immediately notified regarding fall (12/16/14) on 2/26/15 and documented in resident's medical record by Director of Nursing.
- 3) A house wide audit was conducted on 2/26/15, 3/2/15, and 3/3/15 by Director of Nursing and Unit Managers to identify any other residents who would be affected by the alleged

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F 157	<p>Continued From page 2</p> <p>a fall, and the oncoming nurse was to notify the POA. However, further record review revealed no documented evidence Resident #11's POA was notified of the resident's fall on 12/16/14.</p> <p>Interview with LPN #9 on 02/26/15 at 6:30 PM, revealed the Unit Manager (UM), Supervisor, Director of Nursing (DON) and family were to be notified when a resident had a fall. Per interview, Resident #11's fall occurred on 12/16/14 at 5:00 AM, and she had done the initial fall packet at the time of fall. According to LPN #9, documentation of the POA should have been indicated in the progress notes if the POA was notified after the fall. Further interview revealed communication between off-going and on-coming shift was done daily and she had communicated Resident #11's fall to the on-coming nurse (LPN #1).</p> <p>Interview with LPN #1 on 02/25/14 at 5:00 PM, revealed she was the "on-coming nurse" on 12/16/14, and was "pretty sure" the notification of Resident #11's POA was done. Per interview, she should have documented the notification in the progress notes; however, after reviewing the resident's record, the POA's notification was not documented. LPN #1 stated she always documented in the progress notes and on the fall sheet hard copy when a POA was notified, along with verbally giving report to the oncoming nurse, but could not find any documentation of the POA having been notified in Resident #11's medical record.</p> <p>Interview with UM #7 on 02/26/15 at 6:00 PM, revealed when a fall occurred the notification process included notifying the Charge Nurse who would notify the resident's POA.</p>	F 157	<p>deficient practice. This audit involved auditing every resident's medical record for any changes in condition including new physician's orders and incidents, to ensure that family notification was in place. No other residents were identified as being affected.</p> <p>4) All nursing staff were in-serviced on the Policy: Change in a resident's condition or status conducted by DON, UM, and MDS on 3/2/15, 3/3/15, and 3/4/15.</p> <p>5) A QA audit will be conducted by Director of Nursing or designee (Unit Managers, or Clinical Coordinator) on 5 residents a week for 12 weeks to ensure all staff are following the Policy: Change in resident's condition or status. This audit will include identifying all new orders, incidents or other changes and ensuring that family notification has taken place.</p> <p>6) At the end of the 12 weeks, the Director of Nursing will present the audit results to the Quality Assurance Committee, which consists of the Director of Nursing, Administrator, medical director, and unit managers. The QA Committee will review the results of the audits and</p>	

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F 157 Continued From page 3
Interview with the DON on 02/26/15 at 5:35 PM, revealed her expectation was for staff to notify a resident's family and/or POA for any fall or incident as per the facility policy.

Interview with the Administrator on 02/26/15 at 6:58 PM, revealed residents' families or responsible parties were to be notified after each incident or fall or a change in a resident's condition.

F 157

determine a schedule for ongoing monitoring and to determine if any other interventions are needed to ensure compliance.

7) The Administrator will ensure compliance.

Alleged Date of Compliance: 04/06/15

F 164 483.10(e), 483.75(l)(4) PERSONAL
SS=E PRIVACY/CONFIDENTIALITY OF RECORDS

F 164

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another

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F 164	Continued From page 4 healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's "Resident Rights", it was determined the facility failed to maintain each resident's personal privacy during bathing and/or toileting. The facility failed to ensure curtain enclosures were of an appropriate size to prevent unnecessary exposure of body parts during the provision of personal care services in the shower and toilet areas of one (1) of two (2) community bathrooms. The findings include: Review of the facility's policy titled, "Resident Rights", undated, revealed all residents had the right to be treated with dignity and respect. Review of the facility's resident handbook titled, "Your Rights as a Resident in a Long Term Care Facility", undated, revealed the residents would be assured of at least visual privacy in multi-bed rooms and in tub, shower and toilet rooms. Observation, on 02/24/15 at 5:55 PM, during the environmental tour of the Memory Care Unit community shower room, revealed the privacy curtain at the entrance door was not wide enough to cover the entrance to the shower room, and would not prevent unnecessary exposure of body parts during the provision of personal care and services. Continued observation revealed the toilet area had a privacy curtain not wide enough	F 164	F 164 483.10(e), 483.75(l) Personal Privacy/Confidentiality of Records. There were no negative outcomes to Any resident because of the shower Curtain not being long enough or wide Enough to prevent their privacy. 1. A new longer shower curtain was switched with the present curtain. Another shower curtain was added to the toilet area to insure complete privacy; this was completed on February 25 th , 2015. 2. To ensure that no other residents were affected, the director of environmental services audited all shower rooms on February 27th for compliance with privacy curtains to maintain privacy for all residents in the building. 3. All nursing staff and environmental services staff will be educated by the Administrator and/or the Director of Environmental Services by April 6, 2015 on reporting any issues with privacy curtains to the Director of Environmental Services. 4. The director of environmental services will audit all shower rooms weekly to ensure compliance with the longer shower curtain being utilized and to make sure there are enough shower curtains around the toilet area to insure complete privacy and dignity. The shower room will be monitored weekly for six weeks by the environmental services director and/or by his designee, the Administrator. 5. After the six weeks of monitoring, the Administrator will present the results of the audits to the QA	

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F 164

Continued From page 5

to cover the opening of the toilet cubicle. Observation revealed the toilet area privacy curtain was also short in length, as the curtain hung from the ceiling to approximately eighteen (18) inches above the toilet seat which would prevent it providing privacy.

Interview with State Registered Nursing Assistant (SRNA) #4, on 02/24/15 at 5:55 PM, revealed the curtain at the entrance to the shower room was not wide enough to provide privacy to the residents in the shower room. SRNA #4 revealed the privacy curtain at the toilet was also not wide or long enough to provide privacy. Per interview, the privacy curtains had been "that way" for approximately three (3) years, and the lack of privacy was a an issue for residents.

Interview with Licensed Practical Nurse (LPN) #5, on 02/24/15 at 6:00 PM, revealed the privacy curtain around the toilet did not reach from wall to wall. Per interview, the privacy curtain was probably too short to provide complete visual privacy; however, she did not care about privacy and modesty since she had given birth to her children.

Interview with the Memory Care Unit Manger, on 02/24/15 at 6:15 PM, revealed residents should be provided complete visual privacy during the provision of any personal care. Per interview, the privacy curtain around the toilet and the privacy curtain at the entrance of the shower rooms did not provide complete visual privacy; however, should have.

Interview with the Director of Nursing (DON), on 02/26/15 at 5:35 PM, revealed the residents should have visual privacy to maintain their rights.

F 164

Committee, consisting of the DON, unit managers, Medical Director and Administrator. Those results will be evaluated to determine a schedule for ongoing monitoring.

Alleged Date of Compliance: April 6th, 2015

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F 164 Continued From page 6
The DON stated her expectation was the privacy curtain would be wide enough to cover the complete area at the entrance to the shower room to provide visual privacy for residents. Further interview revealed the privacy curtain at the toilet area should be long and wide enough to cover the entire toilet area to provide privacy for residents.

F 164

Interview with the Administrator, on 02/26/15 at 6:58 PM, revealed residents did have a right to complete visual privacy during provision of care. Further interview revealed a privacy curtain of inadequate size could be a privacy issue.

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO
SS=D PARTICIPATE PLANNING CARE-REVISE CP

F 280

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

F280 Right to Participate Planning Care-Revise CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment of changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

1) Resident #6 showed no ill effects from the alleged deficient practice. Evidence by resident had no s/s of hypo/hyperglycemia since 10/6/14.

2) Resident #6 CP was immediately updated on 2/26/15 by Director of Nursing.

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F 280	Continued From page 7 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 revise the Comprehensive Care Plan for one (1) of twenty-four (24) sampled residents (Resident #6). The facility care planned Resident #6 for a potential for Hyperglycemia and Hypoglycemia related to a diagnosis of Diabetes Mellitus. On 10/06/14, Resident #6 had a Physician's Order to discontinue his/her sliding scale insulin; however, there was no documented evidence the care plan was revised with this information. The findings include: Review of the facility's policy titled "Care Plans--Comprehensive", undated, revealed care plans were revised as changes in the resident's condition dictated. Review of Resident #6's medical record revealed that facility admitted the resident on 06/14/13 with readmission date on 02/15/2014 with diagnoses which included Diabetes Mellitus Type II, Osteoarthritis, Hypertension, Chronic Obstructive Pulmonary Disease and Altered Mental Status. Review of the Annual Minimum Data Set (MDS) Assessment dated 11/27/2014, revealed the facility assessed Resident #6 as having a Brief Interview for Mental Status (BIMS) score of eleven (11) out of fifteen (15), which indicated moderate cognitive impairment. Continued record review revealed a Physician's	F 280	3) A facility wide audit was conducted on 3/2/15, 3/3/15 and 3/4/15 by Director of Nursing and Unit Mangers to ensure no other residents were affected by the alleged deficient practice. This audit included reviewing the comprehensive plan of care for all residents with diabetes mellitus and verifying that medication orders are up-to-date. 4) MDS, Unit Mangers and Clinical Care Coordinator were In-serviced by Director of Nursing on Policy: Care Plans-Comprehensive on 2/26/15. 5) A QA audit will be conducted by Director of Nursing or designee (Unit Manger/Clinical Care Coordinator) on 5 resident a week for 12 weeks. This audit will involve reviewing comprehensive care plans and verifying that they are updated with new physician's orders.		

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F 280	<p>Continued From page 8</p> <p>Order dated 10/06/14, to discontinue Resident #6's sliding scale insulin.</p> <p>Review of Resident #6's Comprehensive Plan of Care dated 11/06/13, revealed the facility care planned the resident for the potential for Hyperglycemia and Hypoglycemia related to the diagnosis of Diabetes Mellitus. Continued review of the care plan revealed interventions which included to "administer insulin per sliding scale per Physician's Orders". However, further review of the care plan revealed no documented evidence the care plan was revised with the 10/06/14 Physician's Order to discontinue the resident's sliding scale insulin.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 02/25/2015 at 3:40 PM, revealed the order to discontinue Resident #6's sliding scale insulin was on the facility's computerized system. Further interview revealed Resident #6's care plan should have been updated/revised to reflect the order to discontinue the sliding scale insulin.</p> <p>Interview with LPN #2 on 2/26/15 at 4:30 PM, revealed the process for care plan revision the day shift supervisor should revise residents' care plans when orders were received. LPN #2 stated when the order to discontinue Resident #6's sliding scale insulin was received the day shift supervisor should have revised the resident's care plan by removing the intervention to administer sliding scale insulin. Per interview, a process called "red lining" occurred which was for the night shift nurse to look at all orders written and ensure residents' care plans were updated/revised with the order.</p> <p>Interview with MDS Nurse #3, on 02/26/2015 at</p>	F 280	<p>6) At the end of the 12 weeks, the Director of Nursing will present the audit results to the Quality Assurance Committee, which consists of the Director of Nursing, Administrator, medical director, and unit managers. The QA Committee will review the results of the audits and determine a schedule for ongoing monitoring and to determine if any other interventions are needed to ensure compliance. The Administrator will ensure compliance.</p> <p>Alleged Date of Compliance: 04/06/15</p>

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F 280 Continued From page 9
4:15 PM, revealed the Unit Managers (UM) were responsible for updating and revising residents' care plans for daily Physician Orders. Further interview revealed the MDS nurse was responsible for updating and revising residents' care plans on the Quarterly, Annual and Significant Change MDS Assessments.

F 280

Interview with UM #7, on 02/26/2015 at 4:25 PM, revealed the facility's process for updating/revising care plans when a new Physician's Order was received was for the Charge Nurse to enter the order in the computer and medical records staff to make a copy of the order and send the copy to the UM. Per interview, Resident #6's care plan should have been revised to discontinue the sliding scale insulin when the order was received.

Interview with the Director of Nursing (DON) on 2/26/15 at 6:07 PM, revealed her expectation regarding care plan revision/updates was for her staff to revise/update residents' care plans when new orders were received. Per interview, then the night supervisors were to check new orders and ensure the information was reflected on the resident's care plan. Further interview revealed Resident #6's care plan should have been revised after the order was received to discontinue his/her sliding scale insulin.

F 323 483.25(h) FREE OF ACCIDENT
SS=E HAZARDS/SUPERVISION/DEVICES

F 323

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

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F 323 Continued From page 10

F 323

F 323 Free of Accidents Hazards/Supervision/Devices

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 the facility provided an environment as free from accident hazards as possible as evidenced by observation revealed chemicals accessible to cognitively impaired and mobile residents.

The findings include:

Review of the facility's policy titled, "Chemical Hazard Communication", undated, revealed a hazardous chemical was any chemical which was a physical hazard or health hazard. Per the Policy, staff with supervision and oversight were required to ensure all hazardous chemicals in their department contained proper labeling and had a Material Safety Data Sheet (MSDS) available. Further review revealed all chemicals should be stored according to the chemical's MSDS sheet.

Review of the facility's policy titled, "Personal Care Items", undated, revealed residents might retain and use preferred personal care items and a reasonable amount of personal possessions. Continued review revealed residents had might do this, unless to do so would not be medically advisable as documented in his/her medical record by the attending Physician's assessment.

Review of the facility's Census and Condition, dated 02/24/15, revealed the facility had one

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents

1) Residents in room 220 as well as other residents who are cognitively impaired and wander showed no ill effects to the alleged deficient practice. Evidence by no s/s of adverse effects from chemicals (n/v/d, irritated eyes/death).

2) Hazards chemicals were immediately removed on 2/24/15 by Director of Nursing, however resident became very anxious and demanded that staff return her personal belongings. Items were stored in a non-see through bag on top shelf in bathroom until locked cabinet/box arrives by 4/6/15.

3) A letter will be mailed out to all families to educate on what is considered to be a hazards chemical and OTC medications and to refrain from bringing into facility by 4/6/15 by the Administrator.

4) During the care conference, the SW will address personal care items

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F 323 Continued From page 11
hundred and thirty-five (135) total residents. Per the Census and Condition the facility assessed ninety-seven (97) of the residents to be diagnosed with Dementia or Alzheimer's Disease, and fourteen (14) residents to be independently mobile.

Review of a list of provided by the facility of cognitively interviewable residents revealed the facility had assessed forty-nine (49) residents to be interviewable, and the remaining eighty-six (86) as cognitively impaired. Review of the Roster Sample Matrix, provided by the facility on 02/24/15, revealed the facility's 200 and 300 Halls had ninety (90) residents residing on the halls. Further review of the Roster Matrix, revealed thirty-one (31) cognitively impaired residents lived on the 200 or 300 halls.

Observation during initial tour of the facility, on 02/24/15 at 11:35 AM, revealed the resident bathroom in room 220 contained one (1) bottle of Isopropyl Rubbing Alcohol, one (1) bottle of Hydrogen Peroxide, one (1) can of Aussie aerosol hair spray and one (1) can Aqua-Net aerosol hair spray, and two (2) containers of Vicks Vapor Rub.

Review of the facility's Materials Safety Data Sheet (MSDS) for the Isopropyl Rubbing Alcohol revealed the product was harmful if swallowed or inhaled, and caused irritation to eyes and the respiratory tract. Further review of the MSDS revealed if the product was ingested it might cause unconsciousness and death.

Review of the facility's MSDS for Hydrogen Peroxide revealed the product might cause: eye irritation and possible corneal injury; skin irritation and respiratory tract irritation; and lead to

F 323 potentially hazards to all residents. If an item is to be in room an assessment will be conducted by Unit Manager and a locked cabinet/box will be place in resident's room by Maintenance Director.

5) All staff will be educated on monitoring for hazards chemicals in rooms and to report to Unit Manager regarding their findings by 4/6/15.

6) A QA will be conducted by Unit Manager or designee (Supervisor/Clinical Care Coordinator) on 5 rooms a week for 12 weeks to ensure that the rooms are free from hazardous chemicals or an assessment is conducted and locked cabinet/box is placed in resident's room.

7) At the end of the 12 weeks, the Director of Nursing will present the audit results to the Quality Assurance Committee, which consists of the Director of Nursing, Administrator, medical director, and unit managers. The QA Committee will review the results of the audits and determine a schedule for ongoing monitoring and to determine if any other interventions are needed to ensure compliance. The Administrator will ensure compliance.

Alleged Date of Compliance: 04/06/15

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F 323 Continued From page 12

chemical pneumonitis and pulmonary edema. Further review revealed to avoid ingestion and inhalation of the product. Additional review revealed the Hydrogen Peroxide was incompatible with Alcohol.

Review of the facility's MSDS for the Vicks Vapor Rub revealed if ingested the product could cause gastrointestinal irritation. Further review revealed to avoid contact with eyes.

Review of the facility's MSDS for Aqua-net Aerosol Hair Spray revealed the product contained dimethyl ether and alcohol contained in a pressurized container which could explode when exposed to excessive heat. Further review revealed if ingested the contents were toxic and to call a Physician or poison control immediately.

Review of the facility's MSDS for the Aussie Volume Aerosol Hairspray revealed: inhalation caused transient respiratory irritation; ingestion caused gastrointestinal irritation and necessitate medical attention. Additional review revealed the product contained dimethyl ether and alcohol and was an explosive. Further review revealed to keep out of reach of children.

Interview with State Registered Nursing Assistant (SRNA) #2 on 02/26/15 at 11:10 AM, SRNA #2 at 11:25 AM and SRNA #3 at 5:10 PM, revealed personal care items should be labeled and placed in a drawer, not out in the open. Per interview, the Alcohol, Hydrogen Peroxide, hairspray and Vicks Vapor Rub should be locked up at the nurse's station so other residents would not have access to them, and potentially ingest them which could poison the resident. SRNA #3 stated there were wandering residents on the unit.

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F 323 Continued From page 13

F 323

Interview with Licensed Practical Nurse (LPN) #4 on 02/26/15 at 5:20 PM, revealed the Alcohol, Hydrogen Peroxide, Vicks Vapor Rub and hairspray should be stored in a locked cabinet. Per interview, the products could be hazardous or harmful if swallowed and wandering residents were on the unit.

Interview with Unit Manager (UM) #7 on 02/26/15 at 6:00 PM, revealed Alcohol and Hydrogen Peroxide could be harmful if swallowed and were usually locked up in the shower room. Per interview, the resident residing in room 220, bed B was visually impaired, and could possibly confuse the products which would be harmful.

Interview with the UM #9 on 02/26/15 at 5:30 PM, revealed Alcohol, Hydrogen Peroxide, hairspray and Vicks Vapo Rub could possibly be harmful if a resident were to ingest the products. Per interview, personal care items were to be kept in drawers in residents' rooms. Continued interview revealed she did not know what the policy stated regarding storage of such products.

Interview with the Director of Nursing (DON) on 02/26/15 at 5:35 PM, revealed the products in room 220, were hazardous and they belonged to the resident in bed B. Continued interview revealed it was the facility's policy to allow residents to keep personal items, including hazardous chemicals, in their room per the resident's preference. However, the facility was not able to ensure cognitively impaired resident's safety with access to hazardous items.

Interview with the Administrator on 02/26/15 at 6:58 PM, revealed he felt the resident should be

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F 323 Continued From page 14
able to keep the items in his/her room per the facility's policy and the resident's preference. The Administrator stated the Rubbing Alcohol and Hydrogen Peroxide could be hazardous to cognitively impaired residents. Continued interview revealed the facility was not able to ensure cognitively impaired residents did not have access to the unlocked and unmonitored hazardous chemicals stored in a resident room.

F 323

F 411 483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS

F 411

The facility must assist residents in obtaining routine and 24-hour emergency dental care.

A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.

F 411 Routine/Emergency Dental Services in SNFS

The facility must assist residents in obtaining routine and 24 hour emergency dental care.

A facility must provide or obtain from an outside resource, in accordance with 483.75 of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.

1) Residents (#1, #7, #8, #9, #12, and #13) showed no ill effects from the alleged deficient practice. Evidence by no s/s of oral pain or discomfort.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to provide or obtain from an outside resource routine dental services or an annual inspection of residents' oral cavity for signs of disease or diagnoses of dental disease for six (6) of twenty-four (24) sampled residents (Residents #1, #7, #8, #9, #12 and #13). Record review revealed, there was no

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F 411	<p>Continued From page 15</p> <p>documented evidence these residents had been seen by a dentist for routine annual dental services.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing revealed the facility did not have a policy related to ensuring residents received an annual dental examination.</p> <p>1. Review of the medical record revealed the facility admitted Resident #1 to the facility on 09/05/10, and readmitted him/her on 12/18/11, with diagnoses which included Diabetes, Atrial Fibrillation, Esophageal Reflux and Dysphagia. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 12/28/14, revealed the facility assessed the resident as mildly cognitively impaired. Further review of the MDS Assessment revealed the facility assessed Resident #1 to have no concerns with dentures or mouth or facial pain, or discomfort or difficulty with chewing.</p> <p>Review of the Comprehensive Care Plan, dated 08/24/12, revealed Resident #1 had altered dental status related to required assistance with dental hygiene and poor dentition. Continued review of the care plan revealed interventions included: upper and lower dentures; staff to assist with oral care as needed; administer medications as ordered; and notify the charge nurse of any chewing problems or complaint of oral discomfort. Further review revealed staff were to consult with a dentist or orthodontist if needed or requested by the resident, family or Physician.</p> <p>However, further review of the medical record revealed no documented evidence the resident</p>	F 411	<p>2) A facility wide audit was conducted by DON on 2/25/15 on residents with s/s of oral pain or discomfort, weight loss, ill fitted dentures.</p> <p>3) A dental policy was put in place on 3/16/15 by Director of Nursing.</p> <p>4) Medical records conducted a facility wide audit on 3/16/15, 3/17/15, and 3/18/15 on residents who had not been seen by dentist in the last year, the residents who had not been seen were placed on the list to be seen next visit by dentist.</p> <p>5) Facility Dental Policy was initiated to ensure that all residents receive routine dental care. Medical Records and SW were educated on Dental Policy on 3/16/15 by Director of Nursing as they are assigned to ensure that residents are seen for routine dental care. All nursing staff will be in serviced on the Dental Policy by the Director of Nursing and/or Unit Manager no later than April 5, 2015.</p> <p>6) A QA will be conducted by the SW for every comprehensive MDS (ie Annual/Significant Change) to verify resident has been offered/seen by dentist for 1 year. The MDS nurse is responsible to cover for the Social Worker for care planning and verifying that the residents have been seen</p>	

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F 411 Continued From page 16
had been seen by a dentist for routine dental care and services since admission to the facility, 09/05/10.

2. Review of the medical record revealed the facility admitted Resident #7 to the facility on 10/29/10, and readmitted the resident on 12/31/12, with diagnoses which included Malaise, Fatigue, Altered Mental Status and Dysphagia. Review of the Quarterly MDS Assessment, dated 02/09/15, revealed the facility assessed the resident as mildly cognitively impaired, and to have no concerns with dentures or mouth or facial pain, or discomfort or difficulty with chewing.

Review of the Comprehensive Care Plan, dated 11/21/12, revealed Resident #7 had the potential for an altered dental status related to cognitive impairment and Dementia. Continued review of the Comprehensive Care Plan revealed Resident #7 had his/her own natural teeth and the interventions included requiring assist with oral care as needed for brushing daily as the resident would allow. Further review revealed to notify the Charge Nurse of any chewing problems or complaints of oral discomfort and to assist with referrals as needed.

However, further review of the medical record revealed no documented evidence a the resident had been seen by a dentist for routine dental care and services since admission to the facility, 10/29/10.

3. Review of the medical record revealed the facility admitted Resident #8 to the facility on 07/25/11 and re-admitted the resident on 10/01/13, with diagnoses which included

F 411:

by a dentist if the social worker is unavailable due to sick leave, vacation, etc. MDS nurses were educated by DON on Dental Policy and responsibilities of covering for the Social Worker in the event of absence on March 31, 2015 if a resident is identified as needing dental care, routine or acute care, the social worker and/or designee (i.e., MDS Nurse), will arrange for those dental services.

7)) The Director of Nursing will present the audit results to the Quality Assurance Committee, which consists of the Director of Nursing, Administrator, medical director, and unit managers at each quarterly meeting. The QA Committee will review the results of the audits to determine if any revisions to the policy are needed to ensure compliance. The Administrator will ensure compliance.

Alleged Date of Compliance: 04/06/15

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Leukocytosis, Hypertension, Anxiety, Depression, Diabetes and Alzheimer's Disease. Review of the Quarterly MDS Assessment, dated 02/03/15, revealed the facility assessed Resident #8 to have short term and long term memory loss. Further review of the MDS Assessment revealed the facility assessed Resident #8 to have no concerns with dentures or mouth or facial pain, or discomfort or difficult with chewing.

Review of the Comprehensive Care Plan, dated 08/21/12, revealed Resident #8 had a potential for altered dental status related to assistance was required with dental hygiene and the resident refused to wear his/her dentures. Continued review revealed staff were to observe for difficulty tolerating diet, and consult with a dentist or orthodontist if needed or requested by the resident, family or physician.

However, further review of the medical record revealed no documented evidence the resident had been seen by a dentist for routine dental care and services since admission to the facility, 07/25/11.

4. Review of the medical record revealed the facility admitted Resident #9 to the facility on 11/29/12 and was re-admitted on 12/30/13, with diagnoses which included Sepsis, Altered Mental Status, Debility, Esophageal Reflux, Dyskinesia (spasms) of Esophagus and Chronic Airway Obstruction. Review of the Quarterly MDS Assessment, dated 02/01/15, revealed the facility assessed the resident as having short and long term memory loss. Further review of the MDS Assessment revealed the facility assessed Resident #9 to have no concerns with dentures or mouth or facial pain, or discomfort or difficult with

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F 411	<p>Continued From page 18 chewing.</p> <p>Review of the Comprehensive Care Plan, dated 03/08/13, revealed Resident #9 had the potential for altered dental status related to required assist with dental hygiene and the use of dentures. Continued review of the Comprehensive Care Plan revealed interventions included full dentures, staff to assist with oral care as needed, to notify the Charge Nurse of any chewing problems or complaints of oral discomfort and to assist with referrals as needed.</p> <p>However, further review of the medical record revealed no documented evidence the resident had been seen by a dentist for routine dental care and services since admission to the facility, 11/29/12.</p> <p>5. Review of the medical record revealed the facility admitted Resident #12 to the facility on 04/28/11, with diagnoses which included Cardiac Dysrhythmias, Hypertension, Diabetes, Cerebrovascular Accident, Dementia and Parkinson's Disease. Review of the Quarterly MDS Assessment, dated 01/12/15, revealed the facility assessed the resident as having short and long term memory loss. Further review of the MDS Assessment revealed the facility assessed Resident #12 to have no concerns with dentures or mouth or facial pain, or discomfort or difficult with chewing.</p> <p>Further review of the medical record revealed no documented evidence the resident had been seen by a dentist for routine dental care and services since admission to the facility, 04/28/11.</p> <p>6. Review of the medical record revealed the</p>	F 411	

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F 411	<p>Continued From page 19 facility admitted Resident #13 to the facility on 03/28/12, with diagnoses which included Pneumonia, Paralysis Agitans, Dementia, Alzheimer's Disease and Diabetes. Review of the Annual MDS Assessment, dated 12/23/14, revealed the facility assessed the resident to have short and long term memory loss. Further review of the MDS Assessment revealed the facility assessed Resident #13 to have dental concerns of an obvious or likely cavity or broken natural teeth.</p> <p>Review of the Comprehensive Care Plan, dated 03/28/12, revealed Resident #13 had the potential for altered dental status related to the resident had his/her own natural teeth and required assistance with dental hygiene. Continued review of the Comprehensive Care Plan revealed interventions which included monitoring for chewing problems or complaints of oral discomfort and to assist with referrals as needed.</p> <p>However, further record review revealed no documented evidence the resident had been seen by a dentist for routine dental care and services since admission to the facility, 03/28/12.</p> <p>Interview with the Director of Nursing (DON), on 02/26/15 at 5:35 PM, revealed the facility did have a contract with a dental service; however, did not have a policy for ensuring annual examinations. The DON revealed the MDS nurse completed quarterly oral assessments for residents, and any issues identified would be referred to the dentist. Per interview, her expectation was for all residents to be seen by the dentist yearly unless the resident or family declined the examination. However, continued</p>	F 411		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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NAME OF PROVIDER OR SUPPLIER FLORENCE PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042
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F 411	Continued From page 20 interview revealed she was unable to provide documentation of annual resident dental examinations for Residents #1, #7, #8, #9, #12 and #13. Interview with the Administrator, on 02/26/15 at 6:58 PM, revealed the facility should ensure annual dental examinations were available to the facility's residents.	F 411		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431	F431 Drug Records, Labels/Storage Drugs & Biologicals The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient details to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions, and the expiration date when applicable In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys.	

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F 431 Continued From page 21
Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

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 drugs and biologicals were stored at the appropriate temperatures. Observation revealed the medication refrigerator thermometer on the Long Term Care (LTC) Unit, registered a temperature of thirty (30) degrees.

The findings include:

Review of the facility's policy titled, "Medication Storage", dated 03/01/10, revealed medications were to be stored at proper temperatures. Continued review revealed medications that required refrigeration were to be stored at a temperature of not less than thirty-five (35) degrees Fahrenheit, or more than forty-six (46) degrees Fahrenheit. Per the Policy, should the temperature of the refrigerator not register the required temperature, the medications inside would be moved to an alternate refrigerator immediately. The Policy revealed the medications would remain in the alternate refrigerator until the malfunctioning refrigerator was repaired or replaced. Further review revealed the Maintenance Director and the Director of Nursing (DON) should be notified of

F 431

The facility must provide separately locked permanently affixed compartments for storage of controlled drugs listed in schedule II of the Comprehensive Drug Abuse Prevention Control Act of 1976 and other drugs subject to abuse except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and missing dose can be readily detected.

1) All residents showed no ill effects from the alleged deficient practice. Evidence by no adverse effects from medication.

2) Immediately all medications were pulled and discarded and reordered from the Long Term Medication Refrigerator on 2/25/15 by Unit Manager.

3) On 2/25/15, updated refrigerator temperature log was placed on Long Term Care's Medication Refrigerator by Clinical Care Coordinator.

4) All nurses and medication aids/nurses were educated on Medication Storage Policy on 2/25/15 and 2/26/15 by Pharmacist Consult and MDS nurses.

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F 431 : Continued From page 22
the malfunction of the refrigerator in a timely manner.

Observation, on 02/25/15 at 12:40 PM, revealed the medication refrigerator thermometer on the LCT Unit registered thirty (30) degrees Farenheit. Further observation of the medication room refrigerator revealed it contained various medications all in suppository form.

Review of the medication "Refrigerator Temperature Log", which was taped to the front of the LTC Unit medication refrigerator, revealed the temperatures recorded for February 2015 were out of range for twenty-three (23) of the twenty-four (24) days recorded. Continued review revealed there was no documented evidence of a temperature recorded for 02/16/15. Further review revealed the temperatures recorded for February 2015, varied between twenty-eight (28) degrees Farenheit and thirty-four (34) degrees Farenheit, all less than the thirty-five (35) degrees Farenheit specified in the facility's policy.

Interview with Licensed Practical Nurse (LPN) #2, on 02/25/15 at 12:40 PM, revealed the nurses on the night shift were responsible for recording the temperatures for the medication refrigerators. Continued interview revealed she thought the medication refrigerator temperature should be between thrifty-two (32) degrees Farenheit and thirty-six (36) degrees Farenheit. LPN #2 stated the temperature should not be below thirty-two (32) degrees Farenheit due to the potential for the medication to freeze. Per interview, Maintenance should have been notified if the temperatures were out of range.

F 431

5) A QA will be conducted by Clinical Care Coordinator or designee (Weekend Supervisor) to check all Medication storage refrigerators to ensure the temperatures are within appropriate ranges per medication storage policy

6) At the end of the 12 weeks, the Director of Nursing will present the audit results to the Quality Assurance Committee, which consists of the Director of Nursing, Administrator, medical director, and unit managers. The QA Committee will review the results of the audits and determine a schedule for ongoing monitoring and to determine if any other interventions are needed to ensure compliance. The Administrator will ensure compliance.

Alleged Date of Compliance: 04/06/15

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F 431	Continued From page 23 Interview with the Memory Care Unit Manager, on 02/25/15 at 12:58 PM, revealed the medication refrigerator temperatures should have been below forty (40) degrees Fahrenheit. Continued interview revealed if the refrigerator temperatures were out of range, the medications should be removed from the defective refrigerator and placed in a refrigerator with the appropriate temperature. Interview with the Director of Nursing (DON), on 02/25/15 at 1:20 PM, revealed the temperature of the medication refrigerators should remain between thirty-five (35) degrees Fahrenheit and forty-six (46) degrees Fahrenheit. Continued interview revealed if the temperatures were out of range her expectation was for staff to remove the medications and place them in another medication refrigerator with the appropriate temperature. The DON stated staff should adjust the temperature of the refrigerator and recheck the temperature. Per interview, if the refrigerator was unable to maintain the correct temperatures, the refrigerator should be replaced. Additional interview with the DON, on 02/26/15 at 5:35 PM, revealed the temperature of a medication could alter the potency of the medication or change the chemical make up of the medication and therefore decrease the effectiveness of the medication.	F 431		
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		

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F 441	Continued From page 24 (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 and review of the facility's policy, it was determined the facility failed to establish and maintain an Infection	F 441	F441 Infection Control, Prevent Spread, Lines 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 the 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 prevents infections in the facility;	

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F 441	<p>Continued From page 25</p> <p>Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Observation during initial tour of the facility revealed two (2) bedpans stored unlabeled and uncovered in two (2) different shared resident bathrooms. Additionally, observation during the environmental tour of the facility revealed one (1) of the two (2) community shower rooms had a dried brownish substance on the privacy curtain. Also, observation during a medication (med) pass revealed staff not washing or sanitizing their hands as per the facility policy, and observation of a dressing change revealed staff did not wash their hands when moving from a soiled to clean area of the resident's body for one (1) of twenty-four (24) sampled residents (Resident #4), and two (2) of two (2) unsampled residents (Unsampled Residents A and B).</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Isolation/Quarantine", undated, provided by the facility as their Infection Control Guidelines revealed the facility would endeavor to practice infection control guidelines to prevent acquisition of and spread of infectious disease.</p> <p>1. Observation during initial tour of the facility, on 02/24/15 at 11:50 AM, revealed in the bathroom of room 203, a soiled unlabeled and uncovered bedpan placed in between the wall and the safety rail.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #2, on 02/26/15 at 11:10 AM, revealed bedpans were disposed of weekly by night shift staff and new bedpans were obtained. SRNA #2</p>	F 441	<p>2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing the Spread of Infection</p> <p>1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident</p> <p>4) The facility must prohibit employees with a communicable disease of infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease</p> <p>5) The facility must require staff to wash their hands after direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>c) Linens</p> <p>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p>	

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F 441 Continued From page 26
stated the facility's procedure was for bedpans to be labeled and dated. Continued interview revealed bedpans should be cleaned between use, covered or bagged and placed in the resident's drawer to decrease the risk of cross contamination which was an infection control issue.

Interview with Licensed Practical Nurse (LPN) #4, on 02/26/15 at 5:20 PM, revealed bedpans should be labeled and dated. Further interview revealed the soiled bedpan should have been cleaned after use, and placed in a plastic bag for infection control and cross contamination purposes.

2. Observation during the environmental tour of the facility, on 02/24/15 at 5:55 PM, revealed the privacy curtain in the toilet area of the community shower room on the Memory Care Unit had a dried brownish substance on the curtain.

Interview with SRNA #4, on 02/24/15 at 5:55 PM, revealed the dried brownish substance on the privacy curtain could be feces, and should not have been on the curtain as it was an infection control issue.

Interview with the Memory Care Unit Manager, on 02/24/15 at 6:15 PM, revealed the dried brownish substance on the privacy curtain was probably stool, and should not have been on the curtain for infection control purposes.

Interview with the Director of Nursing (DON)/Infection Control Nurse (ICN), on 02/26/15 at 5:35 PM, revealed the facility did not have a policy directly related to the storage of bedpans or personal items. Per interview, however, her expectation was bedpans should be labeled and

F 441

- 1) Residents who share the bathroom of 203 showed no ill effects from the alleged deficient practice. Evidence by no s/s of infection.
- 2) The (2) bedpans were removed and discarded from the bathroom on 2/26/15 by STNA.
- 3) A facility wide audit was conducted by (3) Unit Managers and Clinical Care Coordinator on 2/26/16 to ensure all person items were stored appropriately
- 4) All nursing staff were in-serviced on Infection Control Policy and Personal Items Policy on 3/2/15, 3/3/15, and 3/4/15 by Director of Nursing and Unit Managers.
- 5) A QA will be conducted by the Unit Managers or designee (Supervisor) to check 10 rooms a week for 12 weeks to ensure all personal items are stored appropriately.
- 6) Residents showed no ill effects from the alleged deficient practice. Evidence by no s/s of infection r/t the brown substance on the shower curtain.
- 7) The shower curtain was replaced immediately on 2/24/15 by Maintenance Director

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F 441	<p>Continued From page 27</p> <p>dated, stored in a plastic bag and placed in the resident's drawer to reduce infection control and cross contamination issues. Continued interview revealed she was unsure what the dried brownish substance was on the privacy curtain in the shower rooms; however, the substance should not have been on the curtain for infection control and cross contamination purposes.</p> <p>Interview with the Administrator, on 02/26/15 at 6:58 PM, revealed bedpans were to be labeled and bagged for infection control purposes. Continued interview revealed the privacy curtain should not be soiled as that was an infection control issue.</p> <p>3. Review of the facility's policy titled, "Hand Washing", undated, revealed the facility was committed to ensuring resident safety and infection control and containment through proper hand washing procedures. Further review of the facility's policy revealed staff should wash or sanitize their hands before and after wearing gloves, preparing or handling medications, and before and after administration of medications.</p> <p>Observation of a med pass, on 02/25/15 at 09:00 AM, revealed Licensed Practical Nurse (LPN) #6 prepared Unsampld Resident A's medication, carried the medication into the resident's room and handed the medication to him/her along with a cup of water. Continued observation revealed LPN #6 then exited Unsampld Resident A's room without washing or sanitizing her hands and prepared Unsampld Resident B's medications. Observation revealed LPN #6 entered Unsampld Resident B's room, handed the medication and a cup of water to the resident and monitored to ensure he/she took the medication.</p>	F 441	<p>8) A facility wide audit was conducted on 2/24/15, 2/25/15, 2/26/15 by Unit Mangers, Clinical Care Coordinator, and Maintenance Director to ensure there was no brown substance on any surface.</p> <p>9) In-servicing will be conducted for hand washing to all nursing staff on 4/1/15, 4/2/15, and 4/3/15 by Clinical Care Coordinator</p> <p>10) A QA will be conducted by Unit Managers or designee (Supervisor) on 10 rooms and shower rooms to ensure that surfaces are free from brown substances daily for 12 weeks.</p> <p>11) Resident (A) and (B) showed no ill effects from the alleged deficient practice. Evidence by no s/s of infection.</p> <p>12) On 2/25/15 the LPN #6 was in-serviced on hand washing policy by DON.</p> <p>13) In-servicing will be conducted for hand washing to all nursing staff on 4/1/15, 4/2/15, and 4/3/15 by Clinical Care Coordinator.</p> <p>14) A QA will be conducted by Unit Manager on 5 nurses a week to ensure proper medication pass practices for 12 weeks.</p> <p>15) Resident # 4 showed no ill effects from the alleged deficient practice. Evidence by no s/s of infection.</p>	

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F 441 | Continued From page 28

Further observation revealed LPN #6 then exited Unsampld Resident B's room without washing or sanitizing her hands, returned to her medication cart and again started to prepare another resident's medication.

Interview with LPN #6, on 02/25/15 at 09:15 AM, revealed she should have been washing her hands between residents to reduce possible cross contamination of infections from resident to resident.

4. Observation on 02/25/15 at 04:05 PM, of LPN # 2 performing a dressing change for Resident #4, revealed the nurse washed her hands, donned a clean pair of gloves, removed the resident's previous dressing and discarded the dressing and the gloves into the trash can. Observation revealed LPN #2 then put on another pair of gloves and proceeded to cleanse the wound area without washing or sanitizing her hands. Continued observation revealed LPN #2 then removed and discarded her gloves, and without washing or sanitizing her hands, donned clean gloves again and applied the resident's new dressing. Further observation revealed LPN #2 after application of the new dressing she removed her gloves and donned a clean pair of gloves without washing or sanitizing her hands and applied skin prep to the surrounding area. Additionally, observation revealed LPN #2 then discarded her gloves and washed her hands at the sink prior to leaving the room.

Interview with LPN #2, on 02/25/15 at 4:20 PM, revealed she should have been washing or sanitizing her hands every time she changed her gloves due to infection control precautions to help prevent the possible spread of infection.

F 441

16) LPN #2 was In-serviced on 2/25/15 by Director of nursing on proper hand washing during wound care.

17) A facility wide audit of the medical record of all residents with wounds for signs of Infection was conducted by Director of Nursing to ensure proper infection control practices with dressing changes.

18) In-servicing will be conducted for proper infection control on dressing changes to all nursing staff on 4/1/15 and 4/2/15 by Clinical Care Coordinator.

19) A QA will be conducted by Unit Manager on 5 nurses a week to ensure proper infection control practices with dressing changes for 12 weeks.

20) The Director of Nursing will present all of the audit results to the Quality Assurance Committee, which consists of the Director of Nursing, Administrator, medical director, and unit managers at each quarterly meeting. The QA Committee will review the results of the audits to determine if any revisions to the policy are needed to ensure compliance and to determine a schedule for ongoing monitoring. The Administrator will ensure compliance.

Alleged Date of Compliance: 04/06/15

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F 441 Continued From page 29

F 441

Interview with the DON/ICN, on 02/26/15 at 5:35 PM, revealed staff should wash or sanitize their hands prior to providing resident care, prior to preparing a resident's medications, as per the facility's policy for infection control and cross contamination purposes. Per interview, during a dressing change for a wound, staff should be washing and/or sanitizing their hands at a minimum of three (3) times, before, during and after the dressing change. The DON revealed if it was a complex dressing change staff should perform hand hygiene numerous times for infection control purposes. Further interview revealed her expectation was for staff to wash or sanitize prior to removal of the old dressing, after removing the old dressing, prior to the application of the new dressing and after the procedure was completed related to infection control and prevention of cross contamination.

Interview with the Administrator, on 02/16/15 at 6:58 PM, revealed staff should wash or sanitize their hands as per the facility's policy to prevent the spread of infection.

F 492 483.75(b) COMPLY WITH
SS=E FEDERAL/STATE/LOCAL LAWS/PROF STD

F 492

The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

F492 483.75(b) Comply with Federal/State/Local Laws/Prof STD

The facility must operate and provide services in Compliance with all Federal, State and Local laws, regulations, and codes and with accepted professional standards and principles that apply to professionals providing services in such a facility.

This REQUIREMENT is not met as evidenced

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/26/2015
NAME OF PROVIDER OR SUPPLIER FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042		
(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 492	Continued From page 30 by: Based on interview and review of the facility's vehicle safety inspection documentation, it was determined the facility failed to ensure its vehicles were in compliance with State Law. Review of the facility's safety inspection documentation revealed the facility failed to ensure the resident transportation vehicle was inspected annually for safety, as per Kentucky Administrative Regulations (KAR). The findings include: Review of the KAR revealed 603 KAR 5:072, Mandatory annual bus inspection, noted buses should undergo a safety inspection at least once each year. Per the KAR, the annual inspection would be performed by the Division of Motor Vehicle Enforcement, and might take place at any of Kentucky's weigh stations or arrangements could be made by contacting the Division of Motor Vehicle Enforcement. Review of the facility's policy titled, "Facility Bus Safety Policy", undated, revealed a Department of Transportation Vehicle Safety Inspection should be completed annually, per 603 KAR 5:072. Review of the facility's vehicle safety inspection documentation titled, "Bus Maintenance Log/General Check List", revealed monthly inspections of the vehicle were performed by facility maintenance staff. However, further review revealed no documented evidence of an annual safety inspection conducted by the Department of Transportation. Interview with the Maintenance Director, on 02/25/15 at 5:15 PM, revealed the facility	F 492	1. There were no negative outcomes to any resident as a result of the bus not being inspected by the Department of Transportation. a. The bus was inspected by the Department of Transportation on February 25 th , 2015 and it passed inspection. b. The Administrator educated the maintenance director and activity director on March 2, 2015 on completion of monthly inspections and the annual Department of Transportation inspection. c. The bus will have a monthly inspection by the maintenance director as instructed by the Administrator. d. The bus will have an annual inspection conducted by the Department of Transportation every year in February which will be arranged by the Maintenance Director and/or the designee who is the Activity Director. Inspection will be turned into the Administrator. The Administrator will audit every February to ensure that the annual inspection has been completed. e. The Administrator will turn in the monthly inspection log to the QA Committee quarterly for review and the annual inspection will be presented by the Administrator to the QA Committee at the 1 st quarterly meeting each year for review. f. The QA Committee will monitor the inspection reports for any concerns that may need addressed and will formulate a plan of action as necessary. Alleged Date of Compliance: April 6th, 2015		

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F 492 | Continued From page 31
acquired a new bus from out of state which was licensed in Kentucky; however, no safety inspection was completed for the bus. Per interview, the facility's previous bus was never licensed in this state and had never had a yearly safety inspection completed. The Maintenance Director revealed he was not aware the state regulations required the bus to have a yearly safety inspection (conducted by the Department of Transportation, Division of Motor Vehicle Enforcement).

F 492

Interview with the Administrator, on 02/26/15 at 6:58 PM, revealed he was not aware the vehicle required a yearly safety inspection (by the Department of Transportation, Division of Motor Vehicle Enforcement).

F 514 | 483.75(I)(1) RES
SS=E RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

F 514

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced

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F 514 : Continued From page 32

by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure the medical record was complete for three (3) of three (3) closed records (Residents #22, 23, 24), of a total sample of twenty-four (24) residents. Record review revealed the facility failed to ensure documented evidence the Discharge Summary or a recapitulation of the resident's stay was included in the residents' closed medical records.

The findings include:

Review of the facility's policy titled, "Policy for Transfer and Discharge Documentation", undated revealed when a resident was transferred or discharged, the reason for the transfer or discharge would be documented in the medical record, and signed by the Physician. Further review of the Policy revealed a copy of the Discharge Summary or recapitulation of a resident's stay would be placed in the resident's hard chart and a copy given to the resident or family.

1. Review of Resident #22's medical record revealed the facility re-admitted the resident on 01/11/14, with diagnoses which included Hypertension, Diabetes Mellitus, Anxiety, Coronary Artery Disease and Cognitive Impairment. Continued review revealed Resident #22 was receiving Palliative Care and expired at the facility 12/19/14. However, further record review revealed no documented evidence of a recapitulation of Resident #22's stay or Discharge Summary.

2. Record review for Resident #23 revealed the

F 514

F 514 483.75 (i) (1) RES RECORDS- COMPLETE/ ACCURATE/ ACCESSIBLE

1. Resident 22, 23, 24 showed no ill effects for the alleged deficient practice.
2. On 2/26/15 a facility wide audit was conducted by social service director on anticipated discharges.
3. The social services director conducted an in-service on policy of discharge summary and recapitulation of resident stay on 3/2/15 with unit managers, activity director, and dietician.
4. All discharge summaries and recapitulation of residents stay will be completed by day of residents discharge by social worker, unit manager, dietician, and activity director.
5. A QA will be conducted by social service director. Assessment for discharge summary and recapitulation of resident stay will be started when social worker is informed of anticipated discharges. The social worker will ensure that the closed charts will be completed with the signed recapitulation of resident stay within two weeks of discharge date for 12 weeks.
6. The Director of Nursing will present the audit results to the Quality Assurance Committee, which consists of Director of Nursing, Administrator, medical director, and unit managers at each quarterly meeting. The QA Committee will review the results of the audits to determine if any revisions to the policy are needed to ensure compliance. The Administrator will ensure compliance.

Alleged Date of Compliance: 04/06/15

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F 514 Continued From page 33

facility re-admitted the resident on 12/22/14, with diagnoses which included Congestive Heart Failure, Atrial Fibrillation, Chronic Kidney Disease, Coronary Artery Disease, Diabetes Mellitus and Chronic Pain. Continued review of the record revealed Resident #23 was sent to the hospital's Emergency Department (ED) and admitted to the hospital on 02/02/15. However, further record review revealed no documented evidence of a Discharge Summary or recapitulation of Resident #23's stay.

3. Record review for Resident #24 revealed the facility admitted the resident on 09/14/11, with diagnoses which included Leukocytosis, Acute Kidney Failure, Diabetes Mellitus, Drug Induced Dementia and Peripheral Vascular Disease. Continued review of the medical record revealed Resident #24 was sent to the hospital ED on 12/29/14 for treatment and was admitted to the hospital. However, further record review revealed no documented evidence of a Discharge Summary or recapitulation of Resident #24's stay.

Interview with Unit Manager (UM) #7 on 02/26/15 at 6:00 PM, revealed the Discharge Summary or recapitulation summary was dictated with medications and orders. Per interview, the resident should have a Discharge Summary or recapitulation of stay summary in their records.

Interview with the Director of Nursing (DON) on 02/26/15 at 5:35 PM, revealed her expectation was for all residents' medical records to be complete and accurate. The DON revealed the facility's medical records department should have ensured there was a Discharge Summary or recapitulation of stay summary in the residents'

F 514

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F 514	Continued From page 34 medical record which was signed by the Physician. Interview with the Administrator on 02/26/15 at 6:58 PM, revealed the Discharge or recapitulation Summary should have been in the medical records for Residents #22, 23 and 24.	F 514			
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced	F 520	F 520 483.75(o)(1) QAA COMMITTEE MEMBERS/MEET QUARTERLY/PLAN The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment of changes in care and treatment. 1) Resident #6 showed no ill effects from the alleged deficient practice. Evidence by resident had no s/s of hypo/hyperglycemia since 10/6/14. 2) Resident #6 CP was immediately updated on 2/26/15 by Director of Nursing. 3) A facility wide audit was conducted on 3/2/15, 3/3/15 and 3/4/15 by Director of Nursing and Unit Mangers to ensure no other residents were affected by the alleged deficient practice. This audit included reviewing the comprehensive plan of care for all residents with diabetes mellitus and verifying that medication orders are up-to-date.		

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F 520 Continued From page 35
by:
Based on observation, interview, review of the facility's policy and Plan of Correction (POC) with an alleged compliance date of 03/14/14, it was determined the facility failed to have an effective Quality Assessment and Assurance (QA) Program to monitor and implement the POC which was developed to address the findings of the Recertification Survey conducted 02/18/14 to 02/20/14, at 42 CFR 483.20 Resident Assessments (F280) and 42 CFR 483.65 (F-441).

The findings include:

Review of the facility's, "Quality Assessment and Assurance Plan" Policy, dated November 2011, revealed the QA Program was designed to provide a means to identify and resolve present and potential negative outcomes related to resident care and safety, establish and implement plans to correct deficiencies, and monitor the effects of the action plans. The Policy revealed the facility's owner and/or governing board were ultimately responsible for the facility's QA Program. Further review revealed the Administrator was responsible for assuring the facility's QA Program complied with Federal, State, and Local regulatory agency requirements.

1. Review of the facility's POC with a 03/14/14 compliance date, revealed all members of the Interdisciplinary Team (IDT) were re-educated by 03/07/14, related to the facility's policy regarding revising care plans. Continued review of the POC revealed audits would be conducted to ensure the care plan was accurate and interventions were being followed as advised. Per the POC, the Administrator would ensure compliance by checking and monitoring the

F 520

4) MDS, Unit Mangers and Clinical Care Coordinator were in-serviced by Director of Nursing on Policy: Care Plans-Comprehensive on 2/26/15.

5) A QA audit will be conducted by Director of Nursing or designee (Unit Manger/Clinical Care Coordinator) on 5 resident a week for 12 weeks. This audit will involve reviewing comprehensive care plans and verifying that they are updated with new physician's orders.

6) At the end of the 12 weeks, the Director of Nursing will present the audit results to the Quality Assurance Committee, which consists of the Director of Nursing, Administrator, medical director, and unit managers. The QA Committee will review the results of the audits and determine a schedule for ongoing monitoring and to determine if any other interventions are needed to ensure compliance. The Administrator will ensure compliance.

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

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F 520 Continued From page 36

audits at the end of each month, and take the results of the audits to the QA Committee quarterly for review. Further review of the POC revealed QA Committee would ensure the information from the audits was reviewed, analyzed and utilized to ensure compliance.

However, record review revealed the Comprehensive Care Plan for one (1) of twenty-four (24) sampled residents (Resident #14) was not updated and revised. Resident #14's Physician ordered the Sliding Scale Insulin to be discontinued in October of 2014 with no documented evidence the Comprehensive Care Plan was updated or revised to reflect the resident's current status. (Refer to F-280)

2. Continued review of the facility's POC, with the compliance date of 03/14/14, revealed all staff was re-educated between the dates of 03/07/14 and 03/10/14. Per the POC, rounds of the facility would be completed with monitoring and observation of the environment and equipment, and of staff providing resident care to assure equipment was functional, free from cracks and/or tears and the facility's infection control policy was followed.

However, observation during the current survey, revealed soiled bedpans unlabeled and unbagged in the floor of resident bathrooms. Further observation revealed, a privacy curtain in the Memory Care Unit community shower room to have a dried brownish substance on the curtain. (Refer to F-441)

Interview with the Director of Nursing (DON), on 02/26/15 at 5:35 PM, revealed the facility's process was monitored for appropriate care plans

F 520

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 the 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

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 the Spread of Infection

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F 520. Continued From page 37
to correspond to the resident's status and the Physician's Orders. Further interview revealed she was unsure where the facility's QA plan had failed, and stated she had new staff and lack of education might have been the issue.

Interview with the Administrator on 02/26/15 at 6:58 PM, revealed the facility's QA system regarding revising residents' Comprehensive Care Plans had failed due to human error and there was a need to educate and inservice staff.

F 520

- 1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident
 - 4) The facility must prohibit employees with a communicable disease of infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease
 - 5) The facility must require staff to wash their hands after 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.
- 1) Residents who share the bathroom of 203 showed no ill effects from the alleged deficient practice. Evidence by no s/s of infection.
- 2) The (2) bedpans were removed and discarded from the bathroom on 2/26/15 by STNA.

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3) A facility wide audit was conducted by (3) Unit Managers and Clinical Care Coordinator on 2/26/16 to ensure all person items were stored appropriately

4) All nursing staff were in-serviced on Infection Control Policy and Personal Items Policy on 3/2/15, 3/3/15, and 3/4/15 by Director of Nursing and Unit Managers.

5) A QA will be conducted by the Unit Managers or designee (Supervisor) to check 10 rooms a week for 12 weeks to ensure all personal items are stored appropriately.

6) Residents showed no ill effects from the alleged deficient practice. Evidence by no s/s of infection r/t the brown substance on the shower curtain.

7) The shower curtain was replaced immediately on 2/24/15 by Maintenance Director

8) A facility wide audit was conducted on 2/24/15, 2/25/15, 2/26/15 by Unit Managers, Clinical Care Coordinator, and Maintenance Director to ensure there was no brown substance on any surface.

9) In-servicing will be conducted for hand washing to all nursing staff on 4/1/15, 4/2/15, and 4/3/15 by Clinical Care Coordinator

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F 520

10) A QA will be conducted by Unit Managers or designee (Supervisor) on 10 rooms and shower rooms to ensure that surfaces are free from brown substances daily for 12 weeks.

11) Resident (A) and (B) showed no ill effects from the alleged deficient practice. Evidence by no s/s of infection.

12) On 2/25/15 (the LPN #6 was in-serviced on hand washing policy by DON.

13) In-servicing will be conducted for hand washing to all nursing staff on 4/1/15, 4/2/15, and 4/3/15 by Clinical Care Coordinator.

14) A QA will be conducted by Unit Manager on 5 nurses a week to ensure proper

medication pass practices for 12 weeks.

15) Resident # 4 showed no ill effects from the alleged deficient practice. Evidence by no s/s of infection.

16) LPN #2 was in-serviced on 2/25/15 by Director of nursing on proper hand washing during wound care.

17) A facility wide audit of the medical record of all residents with wounds for signs of infection was conducted by Director of Nursing to ensure proper infection control practices with dressing changes.

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18) In-servicing will be conducted for proper infection control on dressing changes to all nursing staff on 4/1/15 and 4/2/15 by Clinical Care Coordinator.

19) A QA will be conducted by Unit Manager on 5 nurses a week to ensure proper infection control practices with dressing changes for 12 weeks.

20) The Director of Nursing will present all of the audit results to the Quality Assurance Committee, which consists of the Director of Nursing, Administrator, medical director, and unit managers at each quarterly meeting. The QA Committee will review the results of the audits to determine if any revisions to the policy are needed to ensure compliance and to determine a schedule for ongoing monitoring. The Administrator will ensure compliance.

Alleged Date of Compliance: 04/06/15